STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Madison, LLC	625 State Highway 34 Matawan, NJ 07747

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 38080 Based on interview and observation, it was determined that the facility failed to a.) ensure staff did not use their cell phones in resident care areas and while performing resident care; and b.) ensure staff did not speak in a non-English language while rendering care to English-speaking residents. This deficient practice was identified by 4 of 4 residents during the Resident Council group meeting (Resident #9, #14, #57, and #79) and evidenced by the following: On 8/21/24 at 10:02 AM, the surveyor conducted a resident group meeting with four residents who were alert and oriented and selected by the facility to attend the group meeting. All four residents complained that staff, both certified nursing aides (CNAs) and nurses were on their phones and some spoke in a foreign language on the phone when providing resident care. Resident #14 and Resident #57 stated that nurses were on their bluetooth earpieces on the phone when preparing and administering medications, and they both were given incorrect medications that they refused to take. All four residents agreed it was an issue, and the facility was aware of it, but nothing was done. All four residents felt that since COVID, there have been staffing shortages, so the facility let the staff in the facility do whatever they wanted with no repercussions. On 8/21/24 at 11:59 AM, the surveyor interviewed the facility's Social Worker (SW), who stated that residents have complained about staff on their cell phones, and she conducted formal education as well with staff. The SW stated that staff was not to be on their cell phone. At that time, the surveyor requested a copy of the facility's cell phone policy and inservice conducted. On 8/21/24 at 12:25 PM, the surveyor observed CNA #1 in the hallway with a bluetooth earpiece in her ear. The surveyor did not observe CNA #1 actively in a phone conversation. On 8/21/24 at 1:03 PM, the surveyor reviewed the Inservice 7/25/24, provided by the SW, which included no cell phone, headphones or ear buds allowed on the floor; must use in breakroom, and only speak English around English-speaking residents. On 8/26/24 at 10:18 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated staff were reminded to speak in English in resident care areas and resident rooms. The LNHA stated that staff were expected to not use personal phones in resident care areas, as well as staff should not be using bluetooth earpieces, even if they were not providing resident care. The LNHA stated there were no cell phones allowed on the floor or during care because it was disrespectful to the residents. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 9:50 AM, the Acting Director of Nursing (DON) in the presence of the LNHA and survey team, stated that the residents had a concern with staff cell phone usage that the LNHA addressed in July. The LNHA acknowledged it was still a concern. The surveyor asked if the facility disciplined staff for using their cell phones, and the LNHA stated not since the meeting but the facility had in the past. The surveyor asked what happened to the staff who was found using their phone, and the LNHA stated the facility only suspended staff during investigations for abuse, and the staff would be written up for a cell phone. The surveyor requested a copy of any staff write-ups for cell phone usage. No additional information was provided. A review of the facility's Resident Rights policy dated updated April 2024, included federal and state laws guarantee certain basic rights to all residents of this facility. These rights include resident's right to include but not limited to: .to be treated with respect, kindness, and dignity .have facility respond to his or her grievances . A review of the untitled facility provided policy dated January 2022 Edition, included Personal Electronic Device .workplace use of these devices can raise a number of issues involving safety, security, and privacy . employees should conduct personal business during meal breaks and other rest periods. This includes the use of personal communication devices .violation of this policy may result in discipline, up to and including termination of employment. NJAC 8:39-4.1(a)12

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on interview and review of pertinent facility documents, it was determined that the facility failed to document complete and appropriate information on the New Jersey Universal Transfer Form (UTF) to communicate with the emergency room (ER) where a resident was being transferred, or to have a policy and procedure for UTF. This deficient practice was identified for 1 of 2 residents reviewed for hospitalization (Resident #100), and was evidenced by the following: Reference: NJ.gov: https://www.nj.gov/health/forms/hfel-7instr_1.pdf: INSTRUCTIONS FOR COMPLETING THE NEW JERSEY UNIVERSAL TRANSFER FORM dated [DATE], The purpose of the New Jersey Universal Transfer Form: A form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs. It conveys the patient information required under federal regulations and conveys specific facts that the physician and nurse need to begin caring for a patient. The word patient is used throughout the form, but refers to resident/client or the terminology used by a specific facility or program. Complete all boxes #1 - 29. On 8/27/24 at 10:30 AM, the surveyor reviewed the medical record for Resident #100. A review of the Admission Record face sheet (an admission summary) revealed the resident had diagnoses which included but were not limited to; unspecified psychosis, depressive disorder, and somatoform (health related anxiety and mental disorder) disorder. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 6/19/24, reflected the resident had a brief interview for mental status (BIMS) score of 5 out of 15, indicating a severe cognitive impairment. A further review of Active Diagnoses included non-Alzheimer's dementia, depression, and schizophrenia. A review of the Order Summary Report for 7/1/24 to 7/30/24, the physician's order (PO) dated 7/23/24, for contact and droplet precautions . for diagnosis of COVID-19. A review of the individualized comprehensive care plan (ICCP) included but not limited to the focus areas of ; Advanced Directives Full code; potential to be verbally aggressive . threaten staff with physical harm with interventions which included, when [Resident # 100] became agitated: intervene before agitation escalates [.]; an elopement risk/wanderer; a fall risk and as having had an actual fall 6/11/24; dated 7/23/24, requires isolation precautions related to COVID-19 with an intervention to educate staff, resident, family and visitors . of precautions. A review of the Progress Note (PN) dated 7/23/24 at 9:35 AM, indicated Resident #100 had begun shouting, get me an ambulance; resident became agitated and pounding fists into nursing station. The nurse called emergency services, and the resident was taken to [name redacted] hospital emergency room via ambulance. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the PN dated 7/23/24 at 6:43 PM, revealed that Resident #100 had returned to the facility. A review of the PN dated 7/24/24 at 7:24 AM, indicated Resident #100 was uncooperative, unable to be redirected, using vulgar language and threatening staff with physical abuse and expressing intent to elope the secured unit. Resident was placed on one-to-one observation. A review of the PN dated 7/24/24 at 11:18 AM, the Social Worker documented that Resident #100 still had behaviors of threatening staff, assault them and threatening to kill them and threatening to break the window to escape. Resident was transported to the emergency room . A review of the two UTFs, which documented on the top of the form Items 1 - 29 must be completed revealed the following: The first undated form revealed the reason for transfer as danger to others and self, elopement risk and the following areas were left blank: #2 date and time; #6 code status; #9 primary diagnosis including mental health diagnosis (if applicable); #12 isolation precautions with option for none; #18 personal items sent with patient with option for none; #20 at risk alerts with option for none; #21 mental status; #22 PASRR (pre-admission screening and resident review which indicates mental illness status); #23 function with option self; #25 bowels; #26 bladder; #27 no phone number of the facility sending the resident out for evaluation; and #29 who completed the UTF form. The first UTF indicated that only Resident #100's Face Sheet was attached and no other documents. The second undated form revealed the following areas were left blank: #1 transfer to what facility; #2 time of transfer; #6 code status; #8 reason for transfer; #9 primary diagnosis; #12 isolation precautions with option for none; #18 personal items sent with patient with options for none; #19 attached documents; #22 PASRR; #27 sending facility contact information; and #29 who completed the UTF form. On 8/26/24 at 11:13 AM, the surveyor interviewed the Infection Preventionist/Licensed Practical Nurse (IP/LPN), who stated if a resident was being sent out to the hospital, the staff completed the transfer form [UTF]. The IP/LPN further stated that the staff informed the transport staff verbally and that it was important in case the [hospital] staff did not get to the resident right away. On 8/26/24 at 1:05 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the facility had no policy or procedure for the staff to follow regarding the use of the UTF. The surveyor reviewed the two undated UTFs with the LNHA, who stated that the staff did not have to fill out all areas of the form regardless of the instructions on the form, but to just to fill out only relevant areas. On 8/27/24 at 9:50 AM, the LNHA in the presence of the Acting Director of Nursing (DON) and survey team stated that the medical records department, or the unit clerk were responsible to upload the UTF to the electronic medical record, but that was not done immediately. At that time, the Acting DON stated that the nurse who was sending the resident out was to ensure the UTF was completed prior to the resident leaving. A review of the facility provided policy, Transfer or Discharge, Emergency dated revised 12/1/22, .4.d. Prepare a universal transfer form to send with the resident . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-4.1(a)31

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38080 Complaint NJ #:171611 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan for a resident with a right elbow wound. This deficient practice was identified for 1 of 2 residents reviewed for pressure ulcer (Resident #3), and was evidenced by the following: On 8/19/24 at 11:20 AM, the surveyor observed the Certified Nursing Aide (CNA) outside Resident #3's room putting on personal protective equipment (PPE) prior to entering the room. The CNA stated that the resident was on transmission-based precautions for COVID-19, and staff were required to were PPE prior to entering the room. On 8/20/24 at 1:31 PM, the surveyor reviewed the medical record for Resident #3. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included expressive language disorder (difficulties with verbal and written expression); pressure ulcer of sacral (lower back) region stage 3; and contracture unspecified elbow. A review of the most recent quarterly Minimum Data Set, and assessment tool dated 8/9/24, indicated that the resident had short and long-term memory problems with a severely impaired cognition. A further review revealed the resident had one stage four pressure ulcer (full-thickness and loss that may extend to muscle, bone, tendon, or joint) with pressure reducing devices on chair and bed as well as the resident was on the turn and reposition program. A review of the Order Summary Report included a physician's order (PO) dated 8/16/24, to cleanse right elbow with normal saline solution; apply collagen powder, calcium alginate (wound dressing made from seaweed), and gauze pad and wrap with [brand redacted] antimicrobial woven gauze roll dressing every shift for wound care. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 6/18/21 and last revised on 12/15/23, that the resident had potential for impairment to skin integrity with regards to immobility. Interventions included to check and turn schedule while in bed; educate resident/family/caregivers of causative factors and measures to prevent skin injury; encourage me to off my load heels, and follow facility protocols for treatment of injury. The ICCP did not include the residents actual skin impairment or stage 4 pressure ulcer to right elbow. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 1:24 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated she was in charge of completing and updating residents' ICCPs. The UM/LPN stated ICCPs were updated daily for any changes, and the care plan included but not limited to: behaviors, wounds, skin integrity, treatments, medications, fall risks, and preventative care. The UM/LPN stated Resident #3 had a wound to their right elbow, and they were followed by the wound care doctor. The UM/LPN stated that the resident was repositioned frequently and the Physician wanted the resident out of bed limited time because they favored the right side, and put pressure on the right elbow. The UM/LPN continued the Physician also recommended a heel boot as a cushion around the elbow when out of bed to relieve the pressure. At that time, the surveyor with the UM/LPN reviewed the resident's ICCP, and she confirmed the care plan did not include the resident's wound. On 8/22/24 at 1:52 PM, the surveyor interviewed the Acting Director of Nursing (DON) who stated ICCPs were updated quarterly and as needed. At that time, the surveyor and the Acting DON reviewed the resident's ICCP, and the Acting DON confirmed the ICCP did not include the resident's elbow wound, and it should have. On 8/26/24 at 1:33 PM, the Acting DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team stated that in the resident's focus area for their pressure ulcer was marked as resolved in July when their sacrum wound healed, but the focus area for the right elbow should have remained. The DON acknowledged there was no active focus area for the right elbow wound at the time of inquiry. The Acting DON confirmed the facility did not have a policy for updating ICCPs, only the Care Plans - Baseline policy that was provided. A review of the facility's undated Care Plans - Baseline policy did not include care plan revisions. NJAC 8:39-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40744 Complaint NJ #: 163699; 172074 Based on observation, interview, and review of facility documents, it was determined that the facility failed to follow professional standards of clinical practice with respect to a.)administering pain medications as ordered for a resident with chronic pain (Resident #48); b.) increasing the dose of two medications for a resident with post traumatic stress disorder in accordance with the physician's orders (Resident #225); c.) following a physician's order for no adhesive tape to a gastronomy feeding tube site (Resident #68); and c.) following their Outbreak Plan and Isolation policy and procedures by not notifying emergency transport staff and receiving facility staff of a resident's isolation precaution status upon the resident's (Resident #100) transfer to the emergency room (ER). This deficient practice was identified for 4 of 38 resident reviewed for professional standards of practice. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The surveyor reviewed the policy titled, Administering Medications, the policy had a revision date of 10/2023. The policy statement indicated that medications shall be administered in a safe and timely manner and as prescribed. Number 2 of policy interpretation indicated that medications must be administered in accordance with the orders, including any required timeframe. Number 9 indicated that if a drug is withheld, refused, or given at another time other than scheduled the individual administering the medication will document in the medication administration record. The was evidence was as follows: 1. On 8/21/24 at 9:21 AM, during the 9:00 AM medication pass for Resident #48, the resident asked the Licensed Practical Nurse (LPN #1) why they did not receive their 6:00 AM dilaudid (a drug used to treat moderate to severe pain). The nurse stated she was unsure and would investigate the issue. LPN #1 asked the resident what their pain level was, and the resident responded, seven. (On the numeric pain scale pain of a seven was severe pain.) The surveyor then reviewed the narcotic book with LPN #1 for Resident #48 medications and the last dilaudid was signed out as removed from the cart on 8/20/24 at 12:00 PM. The surveyor then observed LPN #1 do an inventory count of the dilaudid tablets, and it was accurate with the narcotic book meaning no pills were removed after the dose on 8/20/24 at 12:00 PM. On 8/21/24 at 10:10 AM, the surveyor reviewed the medical record for Resident #48. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses that included but were not limited to; multiple myeloma (cancer in the bone marrow) and a back fracture. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 7/9/24, reflected the resident had a brief interview for mental status (BIMS) score of a 15 out of 15, which indicated a fully intact cognition. A further review revealed the resident was on a scheduled pain regimen. A review of the Medication Administration Record (MAR) revealed the dilaudid scheduled for 8/21/24 at 6:00 AM, the nurse documented it was administered. A review of the Order Summary Report included a physician's order (PO) dated 8/1/24, for dilaudid 4 milligram (mg) oral tablet; to give 1 tablet by mouth three times a day for chronic pain. A review of the individualized comprehensive care plan (ICCP) included the following focus areas: A focus area dated 5/5/22, that the resident used a back brace for support related to pain with an intervention that included to assess for pain every shift. A focus area dated 4/13/21, that the resident had chronic pain related to cancer, chronic pain, and multiple spine compression fractures. Interventions included to administer pain medication as per orders; give 1/2 hour before treatments or care; administer my pain medications per orders and notify the physician if goal was not met with regimen; anticipate the resident's need for pain relief and respond immediately to any complaint of pain; and assess my medications and adjust as needed. On 8/22/24 at 11:00 AM, surveyor interviewed the Acting Director of Nursing (DON) regarding the resident not receiving their dilaudid at 6:00 AM. The Acting DON stated that the resident was sleeping, and the nurse did not want to wake them up, and the nurse meant to sign as not given but she forgot. The Acting DON stated that the facility was going to change the dilaudid's scheduled time so the resident would not need to be woken up. 2. On 8/19/24 at 10:55 AM, during the initial tour of the facility, the surveyor observed Resident #225 in their room in bed. The resident informed the surveyor that the facility ran out of medications sometimes, For one or two days and I don't get my medicine. The resident was not able to tell the surveyor which medications. On 8/22/24 at 10:15 AM, the surveyor reviewed the medical record for Resident #225. A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included but were not limited to; subdural hemorrhage (a bleed in the brain), chronic obstructive pulmonary disease (group of lung diseases that block airflow and make breathing difficult), post-traumatic stress disorder (mental condition that develops after someone experiences or witnesses a terrifying or stressful event), anxiety disorder, and depressive disorder. A review of the most recent comprehensive Minimum Data Set (MDS) dated [DATE], that the resident had a BIMS score of 15 out of 15, which meant a fully intact cognition. A review of the August 2024 MAR revealed that the resident had POs dated 8/21/24, for mirtazapine 15 mg tablet; give one tablet by mouth every bedtime for depression and a PO dated 8/21/24, for prazosin 2 mg capsules; give two capsules by mouth every night at bedtime for post-traumatic stress disorder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Order Summary Report revealed that the PO dated 7/22/24, for mirtazapine 15 mg tablets at bedtime was discontinued on 8/21/24 at 8:23 PM, and a new order for mirtazapine 30 mg at bedtime was ordered to start on 8/21/24 at 10:00 PM. Further review of the physician orders revealed prazosin was increased by the physician from 2 mg to 4 mg at bedtime on 8/21/24 at 8:23 PM, with an order start time of 8/21/24 at 10:00 PM. A review of the corresponding MAR revealed that the medications were not signed as administered by the nurse on 8/21/24. On 8/22/24 at 11:11 AM, the surveyor interviewed Resident #225, who stated they did not get their medications last night like the physician ordered and stated, I have post-traumatic stress disorder. On 8/22/24 at 12:20 PM, the surveyor reviewed the resident's ICCP which included a focus area dated 8/5/24, that the resident used psychotropic medications related to the disease process and had a mood, anxiety, and depressive disorder. On 8/22/24 at 12:25 PM, the surveyor interviewed the Acting DON regarding the resident not receiving the medications, and the Acting DON confirmed that the resident should have received the medications when the order was changed. On 8/22/24 at 12:33 PM, the surveyor conducted a telephone interview with the resident's Physician, who stated that the Psychiatric Nurse Practitioner (Psych NP) made recommendations that they did not agree was best for the resident. The Physician stated that he decided to enter his own orders, which the surveyor confirmed he entered on 8/21/24 at 8:23 PM. The Physician confirmed he wanted the new orders to start that evening. On 8/22/24 at 1:15 PM, the Acting DON provided the surveyor with Progress Notes which revealed the nurse spoke to the Physician on 8/21/24 at 5:29 PM, and that the Physician told the nurse that he would be entering his own orders into the computer. The resident was notified of the Physician's decision at that time. On 8/27/24 at 9:50 AM, the surveyor interviewed the Acting DON regarding Resident #225's medication change, and the Acting DON stated that the supervisor spoke with the Physician and the Physician entered the order, but the order was not confirmed by the nurse until 8/22/24 at 1:00 AM. The surveyor asked the Acting DON if the nurse who was aware of the upcoming change should have followed up with the orders, and the Acting DON confirmed yes. 38080 3. On 8/19/24 at 11:18 AM, the surveyor observed Resident #68 sitting in their wheelchair in the dayroom during activities. At that time, the Resident's Representative (RR) who was with Resident #68, informed the surveyor that the facility's nurses did not communicate with each other. The RR stated that they visited the resident daily, and a few times a week, they noticed adhesive tape on the resident's abdomen for their gastronomy tube (g-tube, a feeding tube surgically inserted into the stomach to provide nutrition). The RR stated the resident could not use adhesive tape because it made their skin break out in a rash. The RR stated there was tape on the resident's stomach this morning when they arrived, and they had to remove it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 10:08 AM, the surveyor reviewed the medical record for Resident #68. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included Parkinson's disease; dementia; generalized anxiety disorder; failure to thrive (syndrome of weight loss, decreased appetite and nutrition); major depressive disorder, and bipolar. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/1/24, reflected the resident had a brief interview for mental status (BIMS) score of a 3 out of 15, which indicated a severely impaired cognition. A further review included the resident had a feeding tube (g-tube) which they received greater than 51% of their daily calories and over 501 milliliters (mL) of fluids via the g-tube. A review of the Medication Review Report (MRR) included a physician's order (PO) dated 3/15/24, to cleanse the g-tube with normal saline solution and cover with a four by four (4 x 4) drain sponge (gauze) daily. Do not use tape on skin. On 8/22/24 at 12:30 PM, the surveyor observed Resident #68 sitting in the dining room with the RR. At that time, the RR informed the surveyor that there was adhesive tape on the resident's abdomen, and they pulled up the resident's shirt to show the surveyor. The surveyor asked if they could go back to the resident's room to show the nurse, and the RR stated yes. On 8/22/24 at 12:35 PM, the surveyor asked the Unit Manager/Licensed Practical Nurse (UM/LPN #1) to accompany them to the Resident #68's room and look if the resident had adhesive tape on their abdomen. UM/LPN #1 with the resident's permission observed the resident's abdomen, and confirmed there was adhesive tape and removed it. The RR at that time stated that the Gastrointestinal (GI) Physician did not want adhesive tape on the resident's stomach because it caused a rash. The RR stated that the GI Physician instructed that the gauze should have been wrapped around the tube and not taped to the abdomen. On 8/22/24 at 12:45 PM, UM/LPN #1 provided the surveyor with the GI consultation dated 3/12/24, which she stated that the GI Physician only recommended limit use of tape with dressing and the GI Physician did not indicate no tape. The surveyor asked if the PO indicated do not tape, and UM/LPN #1 confirmed it did. The surveyor asked if the nurses were expected to follow the PO's as written, and UM/LPN #1 confirmed yes. On 8/22/24 at 1:03 PM, the surveyor interviewed Resident #68's nurse for the day, the Licensed Practical Nurse (LPN #2), who stated she was an Agency nurse, and it was her first day on the unit. LPN #2 stated when she arrived at the unit today, she was informed the resident's treatment was done, and she observed the dressing looked clean, so she did not touch it. LPN #2 stated she was unaware the dressing should not have adhesive tape until someone brought it to her attention when the RR informed them. On 8/22/24 at 1:15 PM, the surveyor continued to review the medical record. A review of the Progress Notes included a Nurse Practitioner (NP) note dated 3/15/24 at 1:00 PM, which the NP noted that the resident's skin at their g-tube site was red and irritated from the adhesive tape. The NP ordered to not use adhesive tape on the skin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 1:52 PM, the surveyor interviewed the Acting DON who stated nurses were expected to carry out a physician's order as written. The Acting DON confirmed the nurse should not have used adhesive tape on the resident's g-tube site. A review of the facility's Administering Medications policy dated updated October 2023, included medications must be administer in accordance with orders, including the required timeframe .if a drug is withheld, refused, or given at another time other than the scheduled time, the individual administering the medication will document in medication administration record . 38079 4. A review of the facility provided, Policy for Emergent Infectious Diseases [EID] (COVID-19) Outbreak Plan V10 dated updated 1/1/24, included but was not limited to; Goal: to protect residents, families, and staff from . exposure to an emergent infectious disease while they are in our care center. 2. Local Threat: . d. staff will be educated on the exposure risks, symptoms, and prevention of the EID . 3. Suspected case in the care facility: g. implements the isolation protocol .please refer to (Isolation-Categories of Transmission-Based Precautions). A review of the facility provided policy, Isolation-Categories of Transmission-Based Precautions revised/reviewed 1/2024, included but was not limited to; Policy Interpretation and Implementation: 1. Transmission-based Precautions will be used whenever measure more stringent than Standard Precautions are needed to prevent or control the spread of infection. Contact Precautions: 6 Resident Transport b. If the resident is transported . to another facility, the Infection Preventionist (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions. Droplet Precautions: 5 Resident Transport c. If the resident is transported . to another facility, the Infection Preventionist (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions. On 8/26/24 at 10:38 AM, the Infection Preventionist/LPN (IP/LPN) reviewed the facility's Line Listing (LL) with the surveyor. The IP/LPN revealed that residents who were COVID-19 positive would be noted on the LL and that contact tracing would be performed to evaluate if additional residents, staff, or visitors may have been exposed to COVID-19. Upon reviewing the provided information, the surveyor noted that Resident #100 had tested positive for COVID-19 on 7/23/24, and was the only resident listed as having had gone to the hospital with the comments documented, not COVID related. A review of the electronic Progress Notes (PN) included the following: A PN dated 7/23/24 at 9:35 AM, documented that Resident #100 was threatening, shouting, and attempting to elope and was transported to [name redacted] hospital. On the same date at 5:30 PM, that the resident returned from the hospital and was COVID-19 positive. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PN dated 7/24/24 at 10:18 AM, documented that Resident #100 was uncooperative, using vulgar language and threatening staff. On the same date at 11:18 AM, the resident was transported to [name redacted] hospital for evaluation. The resident was transported by two transporters at 12:20 PM. Resident #100 was admitted to the hospital. The next PN in the medical record was dated 7/30/24 at 10:00 PM, when the resident was readmitted to the facility. There was no evidence in the PN's that the facility informed the medical transporters or receiving hospital that Resident #100 required transmission-based precautions for COVID-19. A review of the New Jersey Universal Transfer Form dated 7/24/24, item #12 isolation/precaution was left blank. Item #19 Attached Documents which included items such as physicians orders, was left blank. A review of Resident #100's medical record Admission Record printed 8/27/24, revealed the resident had diagnoses which included but were not limited to; depression, dementia, and psychosis. The list of diagnoses failed to include COVID-19 onset date of 7/23/24. A review of the most recent quarterly MDS dated [DATE], reflected the resident had a BIMS score of 5 out of 15, indicating Resident #100 had severe cognitively impairment. A review of the Order Summary Report revealed an order dated 7/23/24, that the resident was on contact and droplet precautions [.] for diagnosis of COVID-19. A review of the ICCP included a focus area that the resident required isolation precautions specifically related to COVID-19 with interventions which included to educate staff, resident, family and visitors of COVID-19 signs and symptoms and precautions. On 8/26/24 at 11:13 AM, the surveyor interviewed the IP/LPN, who stated if a resident was going to the hospital, that the staff filled out the Universal Transfer Form and wrote isolation precautions on the form. The IP/LPN also stated that the staff called the hospital with a report, and they verbally informed the transport staff. The IP/LPN confirmed it was important to document in case the receiving staff did not get to the resident right away in the hospital. On 8/27/24 at 10:57 AM, the surveyor asked the IP/LPN and Acting DON in the presence of the survey team, about informing the transporters and receiving hospital regarding Resident #100 being COVID-19 positive. The Acting DON stated if it was not documented that it was reported to transport and the hospital staff that the resident was COVID-19 positive, it was not done. She further stated COVID-19 positive results should be documented on the New Jersey Universal Transfer Form to ensure whoever receives the resident was aware. The Acting DON stated that if the COVID-19 positive status was not conveyed, it could spread the infection. On 8/27/24 at 11:21 AM, the IP/LPN stated that the COVID-19 precautions were on the physician's orders, but she could not provide any documentation that transport or anyone at the receiving hospital was made aware that Resident #100 was COVID-19 positive. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided. NJAC 8:39-11.2, 27.1, 29.2

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44833 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure the narcotic count was completed on multiple days and shifts for August 2024 for 3 of 3 medication carts reviewed; b.) ensure accurate accountability for individual controlled medications for 3 of 3 medication carts reviewed; and c.) ensure the required Federal narcotic acquisition forms (DEA 222 forms) were dated and signed by the Medical Director as of the day it was submitted for filling for 1 of 1 forms provided. The deficient practice was evidenced by the following: 1. During medication storage review on 8/26/24 at 9:55 AM, the surveyor in the presence of the Registered Nurse (RN), reviewed the B-Wing nursing unit's Medication Cart #2's August 2024 Narcotic and Controlled Drug Sign-in Sheet (shift-to-shift accountability count sheet for controlled substance and narcotics (narc) signed by the incoming and outgoing nurses each shift) which revealed the following: The narcotic counts were blank for the incoming nurse Total # of Narcs for the following shifts: All shifts on: 8/1; 8/2; 8/5; 8/10; 8/13; 8/15; 8/16; 8/17; 8/18; and 8/23. For the day shift (7:00 AM to 3:00 PM) on: 8/3; 8/4; 8/6; 8/7; 8/11; 8/12; 8/14; and 8/26. For the evening shift (3:00 PM to 11:00 PM) on: 8/3; 8/6; 8/7; 8/8; 8/12; 8/14; 8/24; and 8/25. For the overnight shift (11:00 PM to 7:00 AM) on: 8/11; 8/12; 8/19; 8/20; 8/21; 8/22; 8/24; and 8/25. The narcotic counts were left blank for the outgoing Total # of Narcs for the following shifts: All shifts on: 8/1; 8/2; 8/5; 8/10; 8/13; 8/14; 8/15; 8/16; 8/17; 8/18; and 8/23. For the day shift on: 8/3; 8/4; 8/6; 8/7; 8/9; 8/11; 8/12; 8/20; and 8/26. For the evening shift on: 8/3; 8/6; 8/7; 8/8; 8/12; 8/22; 8/24; and 8/25. For the overnight shift on: 8/9; 8/11; 8/19; 8/21; 8/22; 8/24; and 8/25. Nursing signatures were missing for Incoming Nurse evening shift on 8/9 and Outgoing Nurse for 8/22 evening shift. A further review of the Individual Patient Controlled Substance Administration Record (declining inventory sheet; declining inventory log used to document individual resident-controlled substance administration) revealed the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #275's declining inventory sheet for oxycodone 10 milligram (mg), a pain medication, the nurse did not sign the dose for 8/20/24 at 5:25 PM. Resident #62's declining inventory sheet for morphine sulfate 100 mg/5 milliliter (mL), a pain medication, the nurse did not sign the dose for 8/18/24 at 9:00 PM and 8/19/24 at 10:00 PM. At that time, the RN confirmed that the narcotic shift-to-shift log and the declining inventory sheets were missing nurses' signatures and there should not be. On 8/26/24 at 10:37 AM, the surveyor in the presence of the Unit Manager/Licensed Practical Nurse (UM/LPN), reviewed the C-Wing nursing unit's Medication Cart #1's August 2024 Narcotic and Controlled Drug Sign-in Sheet which revealed the following: The narcotic counts were blank for the incoming nurse Total # of Narcs for the following shifts: All shifts on: 8/1; 8/2; 8/3; 8/4; 8/5; 8/6; 8/7; 8/8; 8/9; 8/10; 8/11; 8/12; 8/13; 8/14; 8/15; 8/16; 8/17; 8/18; 8/19; 8/20; 8/22; 8/23; and 8/25. For the day shift on: 8/24 and 8/26. For the evening shift on: 8/21. For the overnight shift on: 8/21. The narcotic counts were left blank for the outgoing Total # of Narcs for the following shifts: All shifts on: 8/1; 8/2; 8/3; 8/4; 8/5; 8/6; 8/7; 8/8; 8/9; 8/10; 8/11; 8/12; 8/13; 8/14; 8/15; 8/16; 8/17; 8/18; 8/19; 8/20; 8/22; 8/23; and 8/25. For the day shift on: 8/24. For the evening shift on: 8/21. For the overnight shift on: 8/21 and 8/24. Nursing signatures were missing for 8/25 Incoming Nurse evening and Outgoing Nurse evening shift. Further review of the Individual Patient Controlled Substance Administration Record revealed the following: Resident #46's declining inventory sheet for morphine sulfate solution 100 mg/5 mL was missing the date, time, and Nurse Administering signature for the fourth dose administered with a remaining balance of 28.5 mL. At that time, the UM/LPN acknowledged that there should be no missing signatures or documentation on any of the narcotic logs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 11:11 AM, the surveyor in the presence of the Licensed Vocational Nurse (LVN), reviewed the A-Wing nursing unit's Medication Cart #1's August 2024 Narcotic and Controlled Drug Sign-in Sheet which revealed the following: The narcotic counts were blank for the # of count sheets for the following shifts: For the day shift on: 8/12; and 8/25. For the evening shift on: 8/5; 8/11; and 8/25. For the overnight shift on: 8/1; 8/2; 8/4; 8/5; 8/8; 8/10; 8/11; 8/12; 8/15; 8/21; 8/24; and 8/25. The column labeled is count correct? was blank on the following shifts: For the evening shift on: 8/25. For the overnight shift on: 8/5; 8/9; 8/15; 8/22; and 8/23. Nurse's Signature Going off Duty was blank for 8/24 day shift and pre-signed for 8/26 evening shift. Further review of the Individual Patient Controlled Substance Administration Record revealed the following: Resident #11 declining inventory sheet for alprazolam 0.5 mg (a medication used to treat anxiety) was missing the Nurse Administering signature for the dose administered on 8/5/24 at 9:00 AM, and the 8/26/24 at 10:00 AM dose the LVN administered. Resident #70's declining inventory sheet for clonazepam 1 mg (seizure medication) was not signed by the LVN for the dose administered on 8/26/24 at 9:00 AM. Resident #28's declining inventory sheet for lorazepam 0.5 mg (seizure medication) was not signed by the LVN for the dose administered on 8/26/24 at 9:00 AM. At that time, the LVN acknowledged that there should be no missing documentation on the narcotic logs. The LVN stated that she did not sign the individual declining inventory sheets that morning because she got busy, and I would come back to them. The LVN also acknowledged that she had pre-signed the shift-to-shift count log for the end of her shift, and that was not the appropriate protocol. The LVN confirmed that the incoming and the outgoing nurses were to complete the count and sign together at the end of each shift. On 8/26/24 at 12:22 PM, the surveyor interviewed the Acting Director of Nursing (DON), who stated that the narcotic count for each medication cart was to be completed at each shift hand off by the incoming and the outgoing nurses. The Acting DON confirmed that there should be no missing documentation on narcotic logs, and there should also be no pre-signed fields, and the if it was not documented, it was considered not done. The Acting DON further stated that declining inventory logs were to be completed by the administering nurse for each dose at the time the medication was dispensed to keep accountability of the narcotics administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 8/27/24 at 10:11 AM, the surveyor in the presence of the Acting DON and the survey team, reviewed the facility provided DEA 222 forms which revealed that order form number 240132045 had been pre-signed by the facility's Medical Director prior to submission to the provider pharmacy for filling. At that time, the Acting DON confirmed that the DEA 222 form should not have been pre-signed by the physician. The facility was unable to provide a policy regarding the completion of the DEA 222 form. A review of the facility's Controlled Substances policy dated updated April 2024, included .nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services . The policy did not include resident's declining inventory sheets. NJAC 8:39-29.7(c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44833 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication. This deficient practice was identified in 3 of 3 medication carts inspected, and was evidenced by the following: On 8/26/24 at 9:55 AM, the surveyor, in the presence of the Registered Nurse (RN), inspected the B-Wing nursing unit's Medication Cart #2 and observed two unidentifiable, loose medication pills of varying shapes, color, and size in the bottom of the drawer containing the medication blister packages. At that time, the RN confirmed that there should be no loose pills in the medication cart, and that the nurses assigned to the cart were responsible for maintaining the organization and cleanliness of the cart and its contents. On 8/26/24 at 10:37 AM, the surveyor, in the presence of the Unit Manager/Licensed Practical Nurse (UM/LPN), inspected the C-Wing nursing unit's Medication Cart #1 and observed nineteen unidentifiable, loose medication pills of various colors, shapes, and sizes in the bottom of the drawer containing the medication blister packages. At that time, the UM/LPN confirmed that there should never be any loose pills in the medication cart, and that the nurses assigned to the cart were responsible for maintaining the organization and cleanliness of the cart and its contents. On 8/26/24 at 11:11 AM, the surveyor, in the presence of the Licensed Vocational Nurse (LVN), inspected the A-Wing nursing unit's Medication Cart #1 and observed six unidentifiable, loose medication pills of various colors, shapes, and sizes in the bottom of the drawer containing the medication blister packages. At that time, the LVN confirmed that there should never be any loose pills in the medication cart, and that the nurses assigned to the cart were responsible for maintaining the organization and cleanliness of the cart and its contents. On 8/26/24 at 12:22 PM, the surveyor interviewed the Acting Director of Nursing (DON), who stated all medications should be stored in the packaging in which it was received, and that there should be no loose pills in the medication carts. A review of the facility's Medication Storage policy dated reviewed January 2024, included the facility shall store all medication and biologicals in a safe, secure, and orderly manner .medications and biologicals shall be stored in the packaging, containers, or other dispensing system in which they are received . NJAC 8:39-29.4

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure psychiatric recommendations from 2/7/24 and 7/31/24, to check therapeutic levels of medication used to treat bipolar, were obtained in a timely manner. The deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #68), and was evidenced by the following: On 8/19/24 at 11:18 AM, the surveyor observed Resident #68 sitting in the dayroom during activities. They were unable to be interviewed. On 8/22/24 at 10:08 AM, the surveyor reviewed the medical record for Resident #68. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included Parkinson's disease; dementia; generalized anxiety disorder; failure to thrive (syndrome of weight loss, decreased appetite and nutrition); major depressive disorder, and bipolar. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/1/24, reflected the resident had a brief interview for mental status (BIMS) score of a 3 out of 15; which indicated a severely impaired cognition. A further review included the resident took antipsychotic and antidepressant medications daily. A review of the Medication Review Report included a physician's order dated 12/4/23, for lithium carbonate (a medication used to treat bipolar) 150 milligram (mg) capsule; give one capsule by mouth at bedtime for manic depression. A review of the individualize comprehensive care Plan (ICCP) included a focus area dated 10/24/23, that the resident used antidepressant medication fluvoxamine and lithium carbonate with regards to depression. Interventions included to administer medications as ordered. A review of the Psychiatry Progress Note dated 2/7/24, included for the plan to repeat lithium level (a laboratory (lab) test to determine the therapeutic levels of lithium in the blood). A review of the corresponding lab reports revealed that the lithium levels were not tested until 3/25/24. A review of the Progress Notes from 2/7/24 until the labs were completed on 3/25/24, did not include a note for the delay in labs. A review of the Psychiatry Progress Note dated 7/31/24, included for the plan to check lithium levels. A review of the corresponding lab reports did not include a lithium test was completed. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Progress Notes included a Nurse's Note dated 8/1/24 at 1:51 PM, that resident was seen by psychiatry at beside with Resident Representative (RR) present with a new recommendation to increase Seroquel (antipsychotic medication). The note did not include to check the lithium levels. On 8/22/24 at 12:48 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN), who stated after a resident was seen by Psychiatry, the nurse reviewed the consultation (consult), and if there were any new recommendations, the nurse called the resident's physician to tell them. The UM/LPN stated the physician was notified right away, and the nurse documented it. The UM/LPN stated if labs were recommended, the labs were usually ordered for the next day. The UM/LPN confirmed Resident #68 took lithium, and the physician ordered labs for the therapeutic levels she thought quarterly, but the labs were completed when ordered. At that time the surveyor reviewed with the UM/LPN the resident's Psychiatry Progress Notes from 2/7/24 and 7/31/24, which both recommended to check lithium levels. The UM/LPN confirmed the only labs in the electronic medical record were from 3/25/24, but she stated she would check to see if any labs were done and not in the electronic medical record. On 8/22/24 1:23 PM, the surveyor re-interviewed the UM/LPN confirmed the only lab report for the lithium level being checked was from 3/25/24. The UM/LPN stated that she had to call the physician to see if they wanted the resident's lithium levels checked, that it was usually done quarterly. On 8/22/24 at 1:52 PM, the surveyor interviewed the Acting Director of Nursing (DON), who stated after a resident had a consult, the nurse reviewed the consult with the resident's physician as soon as possible, and documented in the Progress Notes if the physician agreed or disagreed with the recommendation. At that time the surveyor with the Acting DON reviewed Resident #68's Psychiatry Progress Notes from 2/7/24 and 7/31/24, and the DON confirmed the physician should have been notified immediately. On 8/27/24 at 9:50 AM, the Acting DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, acknowledged that there was no documentation that the nurses notified the physician after the resident's consults, and that the physician either agreed of disagreed with the recommendation to check the lithium levels. The Acting DON confirmed the only labs for lithium levels that were performed this year was on 3/25/24. A review of the facility's Laboratory Services and Reporting policy dated revised April 2024, included the facility must provide or obtain laboratory services to meet the needs of the residents; the facility is responsible for the timeliness of the services . A review of the facility's Physician Orders policy dated revised December 2023, included Consultant Recommendations/Orders: in all cases, the attending physician must be notified of the order and approve per state regulation; findings and recommendations will be documented on the Consultation Form; the nurse will notify the physician of findings and recommendations; the attending physician, if in agreement, will order the specific treatments as outlined by the consultant. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Madison, LLC	625 State Highway 34 Matawan, NJ 07747

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 40744 Complaint NJ #: 172074 Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to provide Speech Therapy services to a resident in a timely manner. This deficient practice was identified for 1 of 1 resident reviewed for rehabilitation (Resident #226), and was evidenced by the following: On 8/19/24 at 11:04 AM, during the initial tour of the facility, the surveyor observed Resident #226 in their room in bed. The surveyor asked the resident if they were receiving speech, physical, or occupational therapy and the resident stated not yet, but that was the plan. On 8/19/24 at 1:00 PM, the surveyor reviewed the medical record for Resident #226. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; hemiplegia (paralysis of one side of the body), cerebral vascular accident (damage to the brain from an interruption of blood), hypertension (high blood pressure), and gastrostomy tube (a feeding tube (FT) into the stomach for artificial feeding). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 5/7/24, reflected the resident had a brief interview for mental status (BIMS) score 7 out of 15, which indicated a severely impaired cognition. A further review revealed that the resident had upper and lower extremity impairment on one side, and they required maximum assistance for eating. A review of the Order Summary Report included the following physician's orders (PO) dated 7/27/24, for Occupational Therapy (OT), Speech Therapy (ST), and Physical Therapy (PT) evaluation and treatment as recommended. A further review included a PO dated 7/31/24, for aspiration precautions (practices that help prevent food, fluids, saliva, or foreign objects from entering a person's lungs) every shift. On 8/20/24 at 12:03 PM, the surveyor reviewed the therapy schedule from C-wing which included names and times of all therapies for the unit residents. Resident #226 was not on the therapy schedule. On 8/20/24 at 12:07 PM, the surveyor interviewed the Director of Rehabilitation (DPT), who stated she was a ST. The DPT stated that the resident did not receive physical therapy or occupational therapy yet because the family wanted to wait to get the resident a Botox injection. On 8/22/24 at 10:58 AM, the surveyor reviewed Resident #226's physician's orders which included the PO dated 7/27/24, for the ST evaluation. The surveyor asked the DPT why the resident did not receive the ordered ST evaluation, and the DPT responded that she needed to check if it was completed. (continued on next page)

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	315015	A. Building B. Wing	08/27/2024

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 11:03 AM, the DPT informed the surveyor that the ST evaluation was missed, and she would complete the evaluation on the resident at lunch today. The DPT could not speak to why the evaluation was not done at the time ordered, and the surveyor asked if the evaluation should have been a priority since the resident had oral feeds, a FT, and was on aspiration precautions and the DPT responded, yes. The surveyor asked the DPT what the facility's process was for receiving new therapy orders, and the DPT stated that the nurse informed her in morning meeting, and the nurse probably did not inform her of Resident #226's ST evaluation order. On 8/26/24 at 1:05 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Acting Director of Nursing (DON), in the presence of the survey team, their concern. The Acting DON acknowledged that the resident was received a ST evaluation after surveyor inquiry. A review of the facility's Tender Touch policy dated revised February 2020, included evaluations may be performed by licensed Physical, Occupational, and Speech therapists. Evaluations should be initiated within 24 hours of the order and completed within 48 hours as feasible . NJAC 8:39-37.1

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 48782 Based on observations and interviews, it was determined that the facility failed to ensure that the resident call bell system functioned by: a.) ensuring call bell light illuminated outside of the resident's room when pushed; b.) call bell system volume was set to a level to be heard; and c.) the call bell system accurately identified the room in need of assistance. This deficient practice was identified for 3 of 10 call bell lights tested and was evidenced by the following: On 8/21/24 at 1:45 PM, the surveyor in the presence of the Regional Maintenance Director (RMD) observed that Resident Room A-5 (door) call bell light did not illuminate outside of the resident's room when tested by the RMD. The call bell system identified the room incorrectly as 0222, and there was no audible notification at the nurse's station call bell system. On 8/21/24 1:46 PM, the surveyor in the presence of the RMD observed that Resident Room A-5 (window) call bell did not illuminate outside of the resident's room and did not register a signal at the nurse's station call bell system when tested by the RMD. On 8/21/24 at 1:48 PM, the surveyor in the presence of the RMD, observed that Resident Room A-4 (door) call bell did not illuminate outside of the resident's room and there was no audible notification at the nurse's station call bell system when tested by the RMD. On 8/21/24 at 1:49 PM, the surveyor in the presence of the RMD, observed that Resident Room A-4 (window) call bell did not illuminate outside of the resident's room and there was no audible notification at the nurse's station call bell system when tested by the RMD. On 8/21/24 at 2:00 PM, the surveyor in the presence of the RMD, observed that Resident Room A-30 call bell did illuminate outside of the resident's room and was properly identified at the nurse's station call bell system when tested by the RMD but there was no audible notification. Interview at the time of the observations, revealed that the Licensed Nursing Home Administrator (LNHA) confirmed that there was no audible notification. Upon further investigation of the call bell system, the LNHA discovered that the audible notification volume was turned all the way down on the call bell system and proceeded to raise the volume so that audible notification could be heard. On 8/22/24 at 11:10 AM, the surveyor interviewed the facility's Resident Call Bell System Vendor (RCBSV), who stated that they were in the process of updating the call bell system on the computer. The RCBSV stated that the updates were to correct the room identification displayed at the nurse's station, and they would stay and verify that the system was working properly before they left. The LNHA was notified of the deficient practice at the Life Safety Code exit conference on 8/22/24. NJAC 8:39-31.2(e); 31.8(c)9