STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Shrewsbury LLC	89 Avenue at the Common Shrewsbury, NJ 07702

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based on observation, record review, interviews, and review of facility policy, the facility failed to ensure adequate supervision of residents by specifically failing to prevent Resident (R) #60 from wandering into other residents' rooms leading to physical altercations with other residents. Due to the vulnerable nature of the nursing home population, a potential for serious injury or serious physical or psychosocial impairment from being hit by R #60, or R #60 being hit, existed, and the likeliness of R #60 hitting another resident or being hit by another resident in the facility was high and required immediate action to prevent further events of physical abuse by or to R #60. This deficient practice was identified for one out of two residents (Resident #60) reviewed for resident to resident abuse. The Immediate Jeopardy began on 11/27/23, the date of the first incident of resident abuse by R #60. Review of Nurse Notes located in the EMR under the Progress Notes tab revealed the following entries related to R #60's continuous wandering in residents rooms: a) 11/27/23, Resident entered another resident's room and the resident stated they were hit by R #60. No injuries were noted and R #60 was sent to the hospital for an evaluation. Upon return, R #60 continued to wander into other residents' rooms; b) 04/07/24, Resident wandered into [R #24's] room without anybody knowing it. Then someone was yelling for help and aides went to the room and found R #60 on [his/her] right side on the floor with [his/her] left arm protecting [him/herself]. R #24 admitted that [he/she] was about to punch R #60 as [he/she] is not allowed in [his/her] room. R #60 continued to wander into residents' room daily. The facility's Administrator and Director of Nursing (DON) were informed on 05/24/24 at 6:54 PM that Immediate Jeopardy existed related to the failure to ensure adequate supervision of R #60 to prevent potential abuse to other residents by R #60 and prevent abuse to R #60 by other residents. An acceptable removal plan was received on 05/24/24 at 11: 34 PM and was verified on-site on 05/24/24 at 11:50 PM. Findings include: Review of the Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy last reviewed 05/2023 revealed, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to . physical abuse . the facility will develop and implement policies and protocols to prevent and identify abuse or mistreatment of others. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/03/23, revealed R #60 had a Brief Interview for Mental Status (BIMS) score of three 03 out of 15, indicating severe cognitive impairment. Review of the Quarterly MDS with an ARD of 02/29/24, revealed R #60 had a BIMS score of two 02 out of 15 indicating severe cognitive impairment. Review of the Census tab located in the electronic medical record (EMR) revealed R #60 was admitted to the facility on [DATE]. Review of R #60's Med Diag [Medical Diagnoses] tab located in the EMR revealed R #60 was admitted with moderate dementia with behavioral disturbance, and restlessness and agitation. Review of R #60's Care Plan initiated on 07/28/23, revealed the first concern/focus area for R #60 was wandering into other residents' rooms. The Care Plan Interventions included: -Educate me/family/caregivers on successful coping and interaction strategies. -If reasonable, discuss my behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. -Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for my disruptive behaviors by offering tasks which divert attention such as (activities including playing cards, word games, and arts & crafts). Provide a program of activities that is of interest and accommodates residents' status. -Assess for fall risk. -Distract residents from wandering by offering pleasant diversions, structured activities, food, conversation, television, books. Monitor location. Document wandering behavior and attempted diversional interventions in progress notes. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, visits with family. -WANDERGUARD in place. Review of R #60's Nurse Note located in the EMR under the Progress Note tab dated 07/29/23, [first documentation of R #60 wandering into rooms] revealed R # 60 was confused and wandering the unit freely. The note stated the staff must frequently assist R #60 from other resident rooms. The note continued to state the other residents were upset and complained. While doing rounds on the unit this writer found R #60 in room [ROOM NUMBER] in bed with another female resident. Attempted to remove [resident] from the bed and [resident] became very combative and verbally abusive to staff. Resident then proceeded to wander in and out of other resident's rooms, very hard to redirect. Will continue to monitor. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R #60's Nurse Note located in the EMR under the Progress Note tab dated 07/30/23 revealed, Resident confused, verbally aggressive when staff tries to redirect, combative, wandering in other resident rooms and getting into their beds, even when redirecting to his/her assigned room, resident does not stay inside. Review of the updated Care Plan located in the EMR under the Care Plan tab revealed a focus area related to R #60 being physically aggressive towards staff and a history of harm to others was initiated on 07/30/23, with interventions including for R #60 to be evaluated for more appropriate level of care [dementia unit]. There was a focus related to a behavior problem of entering other rooms, taking things, and lying on beds initiated on 07/28/23, with interventions including intervening as necessary to protect the rights of others. There was no documented evidence of a history of harm to others. Review of R #60's Nurse Note located in the EMR under the Progress Note tab dated 08/01/23, revealed the resident was roaming the hallways and going into several residents rooms on this shift. The note further revealed the resident was evaluated by the physician and recommended to continue Lexapro (for depression) and start a new order for Depakote for dementia with behavioral disturbances. It was also recommended the resident be transferred to a dementia unit in the Assisted Living Facility or another Skilled Nursing Facility. All the recommendations were reviewed with the resident's primary physician and his/her family. The resident remains at the facility and there is no documented evidence any attempts were made to transfer the Resident #60 to a facility with a dementia unit. Review of Nurse Notes located in the EMR under the Progress Notes tab revealed the following entries related to R #60's continuous wandering in residents rooms: - On 08/02/24, Resident still wandering the unit, observed going in other rooms, redirected by staff, sometimes difficult to redirect, not sitting quietly with other residents. - On 08/03/24, Resident was in bed, around 3 AM resident came out of his/her room walking the hallways and going into other resident's room. At 4 AM resident enter (sic) into rm [room] 307, Resident called the CNA [Certified Nursing Assistant} to get [him/her] out. Around 11:30 PM resident from 329 came out screaming to get resident out [his/her] room and [he/she] has wheelchair coming into [his/her] room, this writer redirects [him/her] back to [his/her] room. - On 08/04/24, Resident confused, forgetful, requires constant monitoring, wandering on the unit in/out of other rooms, other residents upset, redirecting this resident is difficult at times and [he/she] can be combative and become verbally angry, ongoing behavior monitoring, frequent checks as to [his/her] whereabouts. - On 08/05/24, Patient [R #60] mood is pleasant but continues to walk in and out of other resident's rooms taking their belongings and lying in their beds. - On 09/05/23, Received resident in [his/her] room, during this shift resident got out of [his/her] bed and was going into other resident's room. Patient was redirect (sic) back to [his/her] room on several occasion. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- On 10/29/23, Received pt [R# 60] in [his/her] room . Patient has been going into other resident room and cursing resident. Resident was redirected back to [his/her] room several times. - On 10/30/23, Resident was constantly redirected back to [his/her] room after entering other resident room, Patient has been cursing residents when they asked [him/her] to leave, they room. - On 11/12/23, Received resident in [his/her] room, when awake resident was going into other rooms. Needs constant redirection. Frequently curses at residents and staff. Another resident, [name redacted] in room [ROOM NUMBER] A called police on [R #60]. Stated [R #60] came into [his/her] room while [he/she] was resting in bed and wouldn't leave. Incident was unwitnessed. No physical altercation. The Care Plan was updated for R #60 on 11/28/23, after the 11/27/2023 incident to include that the resident would have frequent monitoring and be kept close to the nursing station. Review of additional Nurse Notes located in the EMR under the Progress Notes tab revealed the following entries related to R #60's continuous wandering in residents rooms: - On 12/14/23, Resident [R #60] went into another resident's room and was asked to leave by the resident. R #60 walked backwards out of the room and lost [his/her] balance and fell to the floor. - On 12/16/23, Resident continues to wander halls and go into patient rooms. Found 2 times sleeping in another resident's bed. continue to redirect back to [his/her] own room. Further review of Resident #60's Care Plan revealed that after the 04/07/24, incident between R #60 and R #24, the following interventions were added: Redirect resident to public areas when [he/she] is noted walking toward other resident's rooms. Review of Nurse Note dated 05/10/24 revealed, Resident alert with confusion using word salad when speaking. Resident continues to go into other resident's rooms. Resident redirected when entering another resident's room. Resident is aggressive at times and yells and using profanity when redirected. Psych [psychiatry] consult pending. MD [medical doctor] and family made aware. Engage resident in conversation, redirect, take her outside, offer tasks that diverts her attention. On 05/21/24 at 2:16 PM, the surveyor observed R #60 wandering in and out of other resident rooms. Staff were not observed redirecting R #60. On 05/24/24 at 2:15 PM, the surveyor interviewed the Certified Nursing Aid (CNA #3) who stated there wasn't a protocol with R #60. The staff redirect R #60 out of other resident's rooms when he/she was seen in the rooms. On 05/24/24 at 7:15 PM, the surveyor interviewed the Director of Nursing (DON) who stated she was new and was not familiar with R #60's behaviors or wandering. An acceptable removal plan was received on 05/24/24 at 11:34 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including placing Resident #60 on 1:1 supervision until appropriate placement was found. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The survey team verified the removal plan on-site on 05/24/24 at 11:50 PM. NJAC 8:39-4.1(a) NJAC 8:39-9.4(f) NJAC 8:39-13.4

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based on interview, record review, and facility policy review, the facility failed to report an injury of unknown origin in a timely manner for one (Resident (R) 13) out of one resident reviewed for injury of unknown origin out 21 sampled residents. The facility further failed to report an allegation of abuse between R60 and R24 in out of two residents reviewed for abuse in a timely manner out of 21 sampled residents. This failure had the potential to place residents at risk of not receiving appropriate care and protection. Findings include: 1. Review of the Census tab located in the electronic medical record (EMR) revealed R13 was readmitted to the facility on [DATE]. Review of a quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/29/23 revealed R13 had a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating the resident was severely impaired in cognition. Review of R13's nurse Progress Note dated 04/15/23 and located in the EMR under the Progress Note tab revealed R13 was found to have bruising on the top of her right hand at 8:30 AM by the Certified Nursing Assistant (CNA) and let the nurse know. Review of an Administrative Progress Note located in the EMR under the Progress Note tab dated 04/15/23 at 1:25 PM revealed the previous Administrator was informed by the nurse on duty of the bruises on the hand of R13. The note indicated R13 had pointed to her hand and told the nurse that, she beat the hell out of me. The police were called, and an investigation was initiated. Review of the [NAME] Police Department report provided by the facility dated 04/15/23 revealed the facility called the police at 12:29 PM and officers responded. The report revealed the call was for a welfare check and would be reported to the State Agency (SA). Review of the Reportable Event Record/Report dated 04/16/23 at 12:00 PM provided by the facility revealed the time of event of the unknown injury/bruises was at 5:00 AM on 04/15/23, however was not reported to the SA until the next day on 04/16/23. 2. Review of the admission MDS with an ARD of 06/03/23 located in the EMR revealed R60 had a BIMS) score of three out of 15 indicating severe cognitive impairment. Review of the quarterly MDS with an ARD of 02/29/24 revealed R60 had a BIMS score of two out of 15 indicating severe cognitive impairment. Review of R24's quarterly MDS with and ARD of 03/38/24 revealed a BIMS score of 15 out of 15 indicating the resident was cognitively intact. The resident had no behaviors. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Note dated 04/07/24 revealed, [R60] wandered to [R24's] room without anybody knowing it. Then someone was yelling for help and aides went to the room and found [R60] on her right side on the floor with her left arm protecting herself. [R24] admitted that she was about to punch [R60] as she is not allowed in her room. This incident was not reported to the SA and R60 continued to wander into residents' room daily. During an interview on 05/24/24 at 7:15 PM the Director of Nursing (DON) stated the facility had questioned the resident [R24] involved with R60 during the 04/07/24 incident, however, the facility did not report the incident to the SA. Review of the Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating policy last reviewed 05/2023 revealed, all reports of resident abuse including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies as required by current regulations. Findings of all investigations are documented and reported. NJAC 8:39-9.4(f)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46592 Based on interview, record review, and facility policy review, the facility failed to thoroughly investigate a resident to resident abuse incident between two (Residents (R) 60 and R24) out of two residents reviewed for abuse out of a sample size of 21. This failure has the potential for further resident-to-resident abuse occurring and not being investigated so interventions can be put in place. Findings include: Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/03/23 and located in the electronic medical record (EMR) revealed R60 had a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating severe cognitive impairment. Review of the quarterly MDS with an ARD of 02/29/24 revealed R60 had a BIMS score of two out of 15 indicating severe cognitive impairment. Review of R24's quarterly MDS with an ARD of 03/38/24 revealed a BIMS score of 15 out of 15 indicating the resident was cognitively intact. The resident had no behaviors. Review of the Progress Note located in the EMR under the Progress Note tab dated 04/07/24 revealed, [R60] wandered to [R24's] room without anybody knowing it. Then someone was yelling for help and aides went to the room and found [R60] on her right side on the floor with her left arm protecting herself. [R24] admitted that she was about to punch [R60] as she is not allowed in her room. The incident was not investigated and R60 continued to wander into residents' room daily. During an interview on 05/24/24 at 7:15 PM the Director of Nursing (DON) stated the facility had questioned the resident [R24] involved with R60 during the 04/07/24 incident, however, confirmed the facility did not complete a thorough investigation. Review of the Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating policy last reviewed 05/2023 revealed, all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. NJAC 8:39-9.4(f)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview, record review, and review of the facility's transfer form, the facility failed to notify the Ombudsman program of the transfer of two of five residents (Resident (R) 17 and R38) reviewed for hospitalization out of a sample of 21 residents. This failure has the potential for residents to not be aware of their transfer rights. Findings include: 1. Review of the Progress Notes in the electronic medical record (EMR) revealed, on 04/20/24 R17 was taken to the emergency room (ER) for altered mental status and hypotension. R17 returned to the facility on [DATE]. Review of R17's EMR and hard chart located on the third floor held no documentation related to a transfer notice having been issued to the resident. 2. Review of the Progress Notes in the EMR revealed R38 had a doctor's appointment on 04/02/24 with his primary care provider; during this appointment the physician's office sent the resident to the ER due to tightness in his chest with congestion. R38 was readmitted to the facility on [DATE] with a diagnosis of shortness of breath (SOB.) Review of R38's Progress Notes tab in the EMR revealed no documentation of notification into the responsible party or the attending physician. Review of the Miscellaneous tab in the EMR revealed no documentation related to related to transfer rights. During an interview on 05/24/24 at 8:28 AM, Licensed Practical Nurse (LPN) 2 stated during a normal transfer to the hospital the nurse assigned to the resident would complete the Transfer/Bed Hold notice prior to hospitalization or Therapeutic Leave form and provide to the resident, or their responsible party if present, or by phone prior to sending the resident out. LPN2 stated a copy would be maintained in the hard chart on the unit and the business office manager would receive a copy of the form. During an interview on 05/24/24 at 2:13 PM, the Business Office Manager (BOM) stated she was responsible for gathering the information from bed hold/transfer notices and entered them into a spreadsheet and sent a copy of the spreadsheet to the Ombudsman related to the acute care transfers. The BOM was unable to locate copies of the notice of transfer for R17 and R38. Review of the form titled Transfer/Bed Hold notice prior to hospitalization or Therapeutic Leave dated 12/06/19 revealed the form was to be completed and given to the resident or responsible party at the time of the transfer. The form had spaces for the resident's name, resident responsible party, date of transfer, date notice was being issued, and the location to which the resident was being transferred. R17 and R38 did not have a copy of this form in their EMR or hard chart. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Transfer or Discharge, Emergency last revised 12/01/19 revealed . Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: . prepare a transfer form to send with the resident, notify the representative (sponsor) or other family member . NJAC 8:39-5.1(a) NJAC 8:39-5.3(b)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on document review and interview, the facility failed to provide copies of the facility's bed hold policy to four of five residents (Resident (R) 343, R17, R38 and R27) reviewed for hospitalization out of a sample of 21 residents. This failure created the potential for residents and/or responsible parties to not have the information needed to safeguard their return to the facility. Findings include: 1. Review of R343's electronic medical record (EMR), under the Census tab revealed an admitted [DATE], a discharge to the hospital date of 05/02/24, and readmission to the facility on [DATE]. The clinical record lacked evidence that the resident and/or responsible party was given a copy of the facility's bed hold policy when the resident was transferred to the hospital. During an interview on 05/24/24 at 10:14 AM, the Administrator confirmed the facility failed to provide a copy of the bed hold policy to residents and/or the responsible party upon transfer to the hospital. 2. Review of the Progress Notes in the electronic medical record (EMR) revealed, on 04/20/24, R17 was taken to the emergency room (ER) for altered mental status and hypotension. R17 returned to the facility on [DATE]. Review of R17's EMR or hard chart located on the third floor held no documentation bed hold information had been issued to the resident. During an interview on 05/24/24 at 8:28 AM, Licensed Practical Nurse (LPN) 2 stated during a normal transfer to the hospital the nurse assigned to the resident would complete the bed hold/transfer notice and provide to the resident or their responsible party if present or by phone prior to sending the resident out. LPN2 stated a copy would be maintained in the hard chart on the unit and the business office manager would receive a copy of the form. During an interview on 05/24/24 at 2:13 PM, the Business Office Manager (BOM) stated she was responsible for gathering the information from bed hold/transfer notices and entered them into a spreadsheet and sent a copy to the Ombudsman related to the acute care transfers. The BOM was unable to locate copies of the bed hold notices for R17. 3. Review of the Progress Notes in the EMR revealed R38 had a doctor's appointment on 04/02/24 with his primary care provider; during this appointment the physician's office sent the resident to the ER due to tightness in his chest with congestion. R38 was readmitted to the facility on [DATE] with a diagnosis of shortness of breath (SOB.) Review of R38's Miscellaneous tab in the EMR revealed no documentation bed hold information had been issued to the resident. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/24/24 at 2:13 PM, the BOM stated was unable to locate copies of the bed hold notices for R38. 4. Review of the Census tab located in the EMR revealed R27 was admitted to the facility on [DATE]. Review of Progress Notes located in the EMR revealed R27 was transferred to the hospital due to uncontrolled high blood pressure and dizziness on 10/29/23 and readmitted to the facility on [DATE]. Further review revealed R27 was transferred to the hospital due to generalized weakness in both legs on 12/26/23 and readmitted to the facility on [DATE]. Review of the EMR revealed no documentation bed hold information had been issued to the resident. During an interview on 05/24/24 at 12:15 PM, the Regional Nurse supplied a transfer notice and Ombudsman notice for R27's hospital transfers. The Regional Nurse stated R27 did not receive a bed hold notice for the two hospital transfers. Review of the form titled Transfer/Bed Hold notice prior to hospitalization or therapeutic leave dated 12/06/19 revealed the form was to be completed and given to the resident or responsible party at the time of the transfer. The form had spaces for the resident's name, resident responsible party, date of transfer, date notice was being issued, and the location to which the resident was being transferred. Review of the facility policy titled, Bed-Holds and Returns last revised 10/2019 stated, . Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: . rights and limitations of the resident regarding bed-holds; the reserve bed payment policy as indicated by the state plan (Medicaid residents); .the details of the transfer (per the Notice of Transfer) . NJAC 8:39-5.1(a) NJAC 8:39-5.3(b) 21382

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	315136	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Shrewsbury LLC	89 Avenue at the Common Shrewsbury, NJ 07702

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, record review, interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure "Minimum Data Set (MDS)" assessments accurately reflected residents' status for one of three residents reviewed for elopement from 21 sampled residents (Resident (R) 29). R29's "MDS" did not reflect R29's wandering behaviors. This had the potential for R29 to have unmet care needs. Findings include: Review of R29's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia with behavior disturbances, repeat falls, and unsteadiness on feet. Review of R29's "Admission Elopement Assessment," dated 05/03/24 and located in the EMR under the "Assessment" tab, revealed R29 had a history of wandering behaviors in the past month. Review of R29's "Physician's Orders" for the month of May 2024, located in the resident's EMR under the "Orders" tab, revealed an order dated 05/03/24 for a Wander Guard/Wander Elopement Device due to poor safety awareness every shift check placement and functionality. Review of R29's admission "MDS" with an Assessment Reference Date (ARD) of 05/04/24, located in the resident's EMR under the "MDS" tab, revealed the resident's wandering behaviors and the physician's order for a wander-guard bracelet were not reflected. During an observation on 05/22/24 at 3:05 PM, R29 was in bed with eyes closed and a wander-guard bracelet on the right ankle. During an interview on 05/24/24 at 9:05 AM, the Unit Manager/Licensed Practical Nurse (UM/LPN) revealed R29 had a history of exhibiting wandering behaviors and had physician orders to wear a wander-guard bracelet. UM/LPN stated the wandering behaviors, and the wander guard bracelet should be documented on the "MDS." During an interview on 05/24/24 at 1:30 PM, the Director of Nursing (DON) revealed that since R29's wandering behaviors were identified in the admission elopement assessment it should have been reflected on the admission "MDS" and it was not. Review of the RAI Manual," revised October 2023, indicated information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the Interdisciplinary Team completing the assessment. NJAC 8:39-33.2

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on document review, interview, and observation, the facility failed to discuss and present a copy of the baseline care plan for one of 21 sampled residents (Resident (R) 84) within 48 hours of admission; and for one of 21 sampled residents (R29) the facility failed to address the resident's use of a wander-guard. This failure had the potential for care to be provided that may not be consistent with the resident's goals for care. Finding include: 1. Review of the electronic medical record (EMR) under the Census tab for R84 revealed an admitted [DATE] with the diagnosis of a fractured hip. Review of the Minimum Data Set (MDS) with an Assessment Reference Date of 05/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. Review of the EMR Care Plan tab revealed a baseline care plan was created on 05/15/24. During an interview on 05/21/24 at 11:42 AM, R84 and his family member denied knowledge of a baseline care plan to include activities of daily living, toileting, frequency of therapies and goals of care. During an interview on 05/23/24 at 3:00 PM, Minimum Data Set Coordinator, who coordinates assessments and care plans confirmed the nurse that documented the creation of the baseline care plan failed to discuss or present the resident and/or responsible party of the care plan document. 2. Review of R29's "Admission Record," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia with behavior disturbances, repeat falls, and unsteadiness on feet. Review of R29's "Admission Elopement Assessment," dated 05/01/24 and located in the resident's EMR under the "Assessment" tab, revealed the resident had a history of wandering behaviors in the past month. Review of R29's "Physician's Orders" dated 05/03/24 located in the resident's EMR under the "Orders" tab revealed order for Wander Guard/Wander Elopement Device due to poor safety awareness every shift check placement and functionality. Review of 29's admission "MDS" with an ARD of 05/04/24 located in the EMR under the "MDS" tab revealed the resident's wandering behaviors were not reflected. Review of R29's baseline "Care Plan" developed on 05/03/24 located in the resident's EMR tab "Care Plan" revealed the care plan identified the resident as an elopement risk however the interventions did not include the physicians' order for the resident to wear a wander-guard bracelet. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/22/24 at 3:05 PM, R29 was in bed with eyes closed and a wander-guard bracelet on the right ankle. During an interview on 05/24/24 at 1:30 PM, the Director of Nursing (DON) revealed the floor nurse developed the baseline care plan and the Interdisciplinary Team (IDT) developed the comprehensive care plan. The DON confirmed R29's care plan was not developed to reflect the use of wander-guard bracelet. Review of the facility's policy titled Care Plans, without a review date, directed staff to create a baseline care plan and discuss or present a copy of the care plan to the resident and/or responsible party within 48 hours of the resident's admission. NJAC 8:39-11.1, 11.2 NJAC 8:39-12.1 20940

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 16752 Based on record review, interview, and review of facility policy, the facility failed to ensure that seven of eight supplemental residents (R19, R51, R40, R7, R16, R49, and R58) receive adequate assistance obtaining weekly showers. During the group meeting the residents voiced concerns about not getting scheduled showers. This failure has the potential for the residents to experience a decline in their ability to perform their ADLs. Findings include: Review of the facility policy titled "Activities of Daily Living, Supporting" updated October 2021 documented as follows "Residents will be provided with care, treatment and services as appropriate lo maintain or improve their ability to carry out activities of daily living (ADLs) ." During a group meeting held on 05/23/24 at 2:30 PM, seven (R19, R51, R40, R7, R16, R49, and R58) of the eight residents attending the meeting voiced concerns about not receiving showers according to their wishes. The following comments were made during the group meeting. R19 stated he was told that a staff member must be present to assist with showers and there was not enough staff available to assist the resident with showers. R19 stated it had been several weeks since he had a shower. R51 stated all needed was for the staff setup the shower room for her and she could take the shower alone. R51 stated she was told there were not enough staff to help with her shower. R51 confirmed it had been several weeks since she had a shower. R40 stated he had been told the same thing about not enough staff to assist with showers. R7, R16, R49, and R58 agreed with what R19, R51, and R40 stated. The following residents agreed it had been several weeks since they were offered a shower according to their preference: R7, R16, R19, R40, R49, R51, and R58. 1. Review of R7 annual Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 02/07/24, located in R7's electronic medical records (EMR) "MDS" tab, revealed R7 had a Brief Interview for Mental Status (BIMS) score of 15 out 15 points which indicated the resident's cognition was intact. The resident required substantial to maximum assistance with showers. Review of R7's "Care Plan" with a revision date of 11/02/23, located in R7's EMR "Care Plans" tab, revealed R7 was scheduled for showers on the Tuesday and Fridays on the 3-11 shift with the assistance of one staff person. Review of R7s "Bath/Shower Sheets" for the month of May 2024 provided by the facility revealed the resident had only received one shower since 05/01/24. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R16's Medicare MDS" with an ARD of 05/20/24, located in R16's EMR MDS tab revealed R16 had a BIMS score of 15 out of 15 points which indicated R16's cognition was intact. R16 was assessed to require substantial to maximum assistance with showers and toileting. Review of R16's "Care Plans" with a revision date of 11/02/23, located in the resident's EMR "Care Plans" tab, revealed R16 was scheduled to receive showers on Tuesdays and Fridays on the 3-11 shift with the assistance of one staff person. Review of R16's "Bath/Shower Sheets for the month of May 2024 provided by the facility revealed R16 had not received any showers since 05/01/24. 3. Review of R19's annual MDS" with an ARD of 05/07/24, located in the resident's EMR "MDS" tab, revealed R19 had a BIMS score of 15 out of 15 points which indicated the resident's cognition was intact. R19 was assessed to require substantial to maximum assistance with showers and toileting. Review R19's "Care Plan" with a revision date of 11/21/23, located in the resident's EMR "Care Plans" tab, revealed R19 was to receive showers on Wednesday and Saturdays on 7-3 shift with the assistance of one staff member. Review of R19's "Shower Sheets" for the month of May 2024 provided by the facility revealed the resident has not received any showers since 05/01/24. 4. Review of R40's Medicare MDS" with an ARD of 03/31/24, located in R40's EMR "MDS" tab revealed R40 had a BIMS score of 10 out of 15 points which indicated R40's cognition was moderately impaired. R40 was assessed to require substantial to maximum assistance with toileting. The resident was not observed for showers during the assessment period. Review of R40's "Care Plan" with a revision date of 02/14/24, located in R40's EMR "Care Plans" tab, revealed R40 was scheduled for showers on Wednesdays and Saturdays on the 3-11 shift with the assistance of one staff member. Review of R40's "Shower Sheets" for the month of May 2024 provided by the facility revealed the resident had not received any showers since 05/01/24. 5. Review of R49's annual MDS" with an ARD of 02/17/24, located in R49's EMR "MDS" tab revealed R49 had a BIMS score of 15 out 15 points which indicated R49's cognition was intact. R49 did not require assistance with showers. Review of R49's "Care Plan," with a revision date of 01/04/24, located in R49's EMR "Care Plans" tab, revealed R49 required the assistance one person for showers. The care plan did not identify the resident schedule shower days. Review of R49's "Shower Sheets" for the month of May 2024, provided by the facility, revealed R49 had not received any showers since 05/01/24. 6. Review of R51's quarterly MDS" with an ARD of 02/13/24, located in R51's EMR "MDS" tab, revealed R51 had a BIMS score of 13 out 15 points which indicated R51's cognition was intact. R51 was assessed to not require assistance with showers. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R51's "Care Plan" with a revision date of 02/21/24, located in R51's EMR "Care Plans" tab, revealed R51 required the assistance of one staff person for showers. The care plan did not identify R51's scheduled shower days. Review of R51's "Shower Sheets" for the month of May 2024, provided by the facility, revealed R51 had not received any showers since 05/01/24. 7. Review of R58's annual MDS" with an ARD of 02/23/24, located in R58's EMR "MDS" tab, revealed R58 had a BIMS score of eight of 15, which indicated R58's cognition was moderately impaired. R58 was assessed as not requiring any assistance with showers. Review of R58's "Care Plan" with a revision date of 04/13/23, located in R58's EMR "Care Plans" tab, revealed R58 was scheduled for showers on Tuesdays and Fridays on the 3-11 shift with assistance of one staff member. Review of R58's "Shower Sheets" for the month of May 2024 provided by the facility revealed R58 had only received two showers since 05/01/24. During an interview on 05/23/24 at 3:54 PM, Certified Nurse Aide (CNA) 1 revealed the residents use the showers in their rooms. The residents are scheduled for showers twice a week on each shift. Those scheduled showers are attached to the CNAs assignment sheets. The CNAs are responsible for assisting those residents that require assistance. An interview with the Director of Nursing (DON) on 05/24/24 at 1:30 PM revealed the residents are scheduled to take showers twice a week in their rooms. The DON reviewed the residents' showers and stated that lacked documentation of the residents receiving the scheduled showers. The DON stated it was the facility's expectation residents would receive showers as they were scheduled. An interview on 05/24/24 at 1:36 PM with the Administer revealed the issue of the residents receiving the showers was discussed with the staff. The Administrator was asked to interpret the shower sheets for the month of May. The Administrator stated that it was possible that the CNAs did give the showers but forgot to document the residents received the showers. The Administrator was reminded that this was a concern voiced by the residents. The Administrator stated this lack of documentation indicates that a performance improvement plan needs to be developed. NJAC 8:39-27.1(a) NJAC 8:39-27.2

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, record review, interview, and review of facility policy, the facility failed to ensure that one of two residents (Resident (R) 76) reviewed for oxygen therapy from a total sample of 21 residents had nebulizer tubing changed per physician's orders and had an order for oxygen therapy. This had the potential for R76 to develop respiratory issues. Findings include: Review of R76's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease (COPD), emphysema, and asthma. Review of R76's "Physician's Orders," dated 04/23/24 and located in the resident's EMR under the "Orders" tab, revealed orders to change and date the nebulizer tubing every Wednesday on the 11-7 shift. There were no physician's orders for the resident to receive continuous oxygen therapy. During an observation on 05/22/24 at 10:15 AM, R76 was lying in bed wearing a nasal cannula with oxygen infusing at two liters per minute (lpm). The oxygen tubing had a change date of 05/15/24. The oxygen concentrator had a buildup dust debris around the flow meter; the concentrator machine was sticky to the touch. The concentrator filter had a heavy buildup of dust debris. The nebulizer set up with tubing located at the resident's bedside was dated 05/15/24. During an observation on 05/23/24 at 8:28AM, Licensed Practical Nurse (LPN) 3 confirmed the oxygen tubing and nebulizer tubing for R76 was still dated 05/15/24. The oxygen concentrator filter still had a heavy buildup of dust debris. The concentrator machine was sticky to the touch and had dust debris around the flow meter. LPN3 revealed the night shift was responsible for changing the oxygen tubing on the oxygen concentrator and nebulizer weekly. LPN3 stated the night staff were responsible for cleaning the oxygen concentrator and filter. During an interview on 05/24/24 at 9:05 AM, the Unit Manager/LPN (UM/LPN) revealed the 11-7 shift nurse was responsible for changing the tubing on the oxygen concentrators and nebulizers on a weekly basis. UM/LPN was unaware that R76's tubing had not been changed since 05/15/24. UM/LPN was also unaware that R76 was receiving continuous oxygen therapy without a physician's order. UM/LPN further stated that the maintenance staff was responsible for cleaning the oxygen concentrators. Review of the facility's policy titled "Oxygen Administration" with a revision date of 2019 revealed in part ". Verify that there is a physician's order for oxygen therapy. Review the physicians order or facility policy for oxygen administration ." NJAC 8:39-19.4

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20940 Based on observation, documents review, and interview, the facility failed to assess and document an assessment for the use of one-quarter bed (side) rails and care plan the use of bed rails for one resident (Resident (R) R75) reviewed for bed rails out of 21 sampled residents. This failure had the potential for residents with bed rails to be uninformed of the risk of severe injury and/or death associated with bed rail use. Findings include: Review of the electronic medical records (EMR) under the Census tab revealed R75 revealed an admitted [DATE] with diagnosis including heart surgery and diabetes. Review of the admission Minimum Data Set assessment with an assessment reference date of 04/29/24 revealed R75's Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Review of the EMR Physician's Orders revealed an order dated 04/22/24 for bilateral enablers (quarter) side rails in use as needed for mobility. Review of the EMR Assessment tab and Miscellaneous tab lacked documentation of an assessment for the use of the side rails. Review of the EMR lacked evidence that risk versus benefits were discussed with the resident and informed consent was given. Review of the EMR under the Care Plan tab revealed the use at the side rails was not included in the care plan dated 04/22/24. During an observation on 05/22/24 at 9:43 AM, R75 was resting in bed with one-quarter side rails up on both sides at the head of the bed. During an observation on 05/22/24 at 1:24 PM, R75 was in bed with upper one-quarter side rails up on both sides of the bed. R75 used the right side rail to assist with movement from lying in bed to sitting on the side of the bed. During observation on 05/23/24 at 4:39 PM, R75 was in bed with the upper one-quarter side rails raised. During an interview on 05/24/24 at 6:51 PM, the Administrator confirmed there was no assessment of R75 prior to the use of bed rails and confirmed the facility lacked policies and procedures for the routine maintenance and safety checks for siderails on residents' beds. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy titled Bed Safety revealed Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails and an assessment was to be completed to determine the least restrictive means for the resident. NJAC 8:39-27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46592 Based on observation, interview, review of the Food Services Director (FSD) job description, and facility policy review, the facility failed to ensure one refrigerator on the second floor in the nourishment room of three refrigerators in the facility observed had all food labeled, dated and was free of dirt and sticky shelves. The facility further failed to ensure a freezer on the third floor nourishment room out of two observed was free of ice buildup. Findings include: During an observation and interview with the Food Services Director (FSD) on [DATE] at 7:18 AM of the refrigerator on the second floor revealed the following food items not labeled, dated, and/or expired: 1. There were three to-go containers of beans with rice, a small box containing two pieces of fried chicken, a sub sandwich, a to-go container of pasta with bread with no label or date, a clear gallon-sized bag with fried chicken and a biscuit, two 10 ounce bottles of separated liquids that appeared to be apple juice and orange juice, a container of steak, peppers, and mashed potatoes, a to-go soup container in a plastic bag, a clear bag containing four slices of pizza, a small clear container of fruit, a bag of grapes, a piece of cake wrapped in wax paper, a black bag containing a 32 ounce coffee creamer, a clear bag of chocolate, an eight ounce cup of liquid, a container of fruit, a container of cookies, a clear bag of salad, and bag of almonds all with no label or date. There was a clear container of 1.5 pounds (lbs.) of cut watermelon with an expiration date of [DATE], a one-third full two-liter bottle of cream soda with an expiration date of [DATE], a to-go wrap with an expiration date of [DATE], and a half of a peanut butter and jelly sandwich with an expiration date of [DATE]. The refrigerator was observed to have dirty/sticky shelves. The FSD confirmed the above observations and confirmed the food in the refrigerators should be labeled, dated and food with expiration dates should be thrown out. 2. During an observation on [DATE] at 7:51 AM of the third-floor nourishment room, one of two freezers had ice build-up throughout the freezer. The FSD confirmed the findings and revealed the door to the freezer did not seal properly. Review of the undated Receiving & Storage Policy provided by the facility revealed it is the responsibility of the facility to, ensure that all foods follow the first in first out (FIFO) method and are labeled and dated. Review of the Foods Brought by Family/Visitors last reviewed ,d+[DATE] revealed, containers will be labeled with the resident's name, the item, and the use by date. The policy further revealed the nursing staff will discard perishable foods on or before the use by date. Review of the undated Dining Services FSD job description provided by the facility revealed it is the responsibility of the FSD to direct and personally engage in food procurement and storage. NJAC 8:,d+[DATE].2(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, record review, and interview, the facility failed to ensure personal protective equipment (PPE) was readily available and that staff donned (put on) the appropriate PPE for two of five residents (Resident (R) 9 and R140) on Enhanced Barrier Precautions (EBP) out of a total sample of 21 residents. This failure had the potential to increase the risk of the spread of infections. Findings include: 1. Review of R9's "Admission Record" located in the resident's electronic medical records (EMR) "Profile" tab revealed R9 was admitted to the facility on [DATE] with diagnoses that included cellulitis of right lower leg. Review of R9's "Physicians Orders" dated 05/06/24 located in the resident EMR tab "Orders" revealed the resident received dressing changes to right lower leg with Medi Honey ointment (antimicrobial ointment). During an observation on 05/21/24 at 11:14 AM, R9's room had signage posted on the door frame that indicated the resident was on Enhanced Barrier Precautions. The signage directed the staff to perform hand hygiene before and after entering the room. Staff were to wear gloves and gowns when performing direct care. The isolation cart outside R9's room contained only gloves and blue face masks, but no gowns. Certified Nurse Aide (CNA) 7 performed hand hygiene and donned gloves and entered the resident's room. CNA7 assisted R9 with personal hygiene and dressing. During an interview on 05/21/24 at 2:30 PM, CNA7 acknowledged R9 was on Enhanced Barrier Precautions but there were no gowns available on the isolation cart when she provided cares to R9. CNA7 stated she was unsure who was responsible for stocking the isolation carts. 2. Review of R140's "Admission Record" located in the resident's EMR tab "Profile" revealed the resident was admitted to the facility on [DATE]. Review of R140's "Physician Orders" dated 05/19/24 located in R140's EMR "Orders" tab revealed R140 was placed on Enhanced Barrier Precautions related to wounds. During an observation on 05/21/24 at 12:45 PM, R140 room's had signage on the doorframe indicating R140 was on Enhanced Barrier Precautions. There was no PPE available on the isolation cart outside the resident's room. Licensed Practical Nurse (LPN) 3 performed hand hygiene and donned gloves and entered R140's room without a gown to perform wound care on R140's feet. During an interview on 05/21/24 at 3:20 PM, LPN3 confirmed R140 was on Enhanced Barrier Precautions due to the wound on his heels that required dressing changes. LPN3 stated there were no gowns available on the isolation cart. LPN3 stated R140 was in hurry to be discharged and that was why she did not attempt to obtain an isolation gown. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Shrewsbury LLC	89 Avenue at the Common Shrewsbury, NJ 07702

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/24/24 at 9:05 AM, Unit Manager/LPN (UM/LPN) revealed she was responsible for ensuring the isolation carts on the unit had adequate PPE supplies. UM/LPN confirmed she had not restocked the isolation carts on 05/21/24. NJAC 8:39-19.4