

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Holiday City		STREET ADDRESS, CITY, STATE, ZIP CODE 4 Plaza Drive Toms River, NJ 08757	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility policy, the facility failed to protect a resident's right to dignity while dining for one out of one resident (Resident (R)18) in a total sample of 22. The facility failed to ensure R18 was dressed and fully covered while in the dining room. This failure placed the resident at risk of a diminished quality of life and embarrassment.</p> <p>Findings included.</p> <p>Review of the facility policy titled, Promoting/Maintaining Resident Dignity, dated 09/01/24 revealed, .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality .All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights .</p> <p>Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R18 was admitted to the facility on [DATE] with diagnoses that included heart failure, irregular heart rhythm, and anxiety disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR revealed R18 had a Brief Interview of Mental Status (BIMS) score of five out of 15 which indicated R18 was severely impaired in cognition.</p> <p>During an observation on 02/11/25 at 12:56 PM, R18 was observed seated at the dining table in a geri chair (a specialized recliner.) He/She was wearing a hospital gown that was untied in the back exposing his/her back to all other residents, family members and staff members when he/she leaned forward to eat. Registered Nurse (RN) 1 was observed to have provided R18 with his/her meal tray, however, she did not tie the hospital gown in the back or cover R18 up with a blanket to prevent further exposure.</p> <p>During an interview on 02/11/25 at 1:10 PM, Unit Manager (UM)2 was asked about R18's exposed back while he/she was eating. UM2 stated, She should have covered him/her up, I will take care of it.</p> <p>During an interview on 02/11/25 at 4:30 PM, the Director of Nursing (DON) stated, Staff should be maintaining residents' dignity by keeping them covered.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>N.J.A.C. 8:39-4.1(a)(2)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility investigation, and in the course of a complaint investigation, the facility failed to conduct a thorough investigation in one of one resident to resident altercation (Resident (R)9 and R21) out of a total of 22 sampled residents. This failure had the potential to affect all the residents in the facility who were at risk of abuse.</p> <p>Findings include:</p> <p>1. Review of R9's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R9 had been readmitted to the facility on [DATE] with the diagnosis of chronic kidney disease, stage five, diabetes mellitus, and anxiety disorder.</p> <p>Review of R9's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 07/14/23 coded R9 as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This represents R21 was cognitively intact. R9 was not coded for exhibiting behaviors in the seven day look back period for this MDS.</p> <p>2. Review of R21's undated Face Sheet located under the Profile tab in the EMR revealed R21 had been admitted to the facility on [DATE] with the diagnosis of diabetes mellitus and adjustment disorder with mixed anxiety and depressed mood.</p> <p>Review of R21's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 06/14/23 coded R21 as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This represents R21 was cognitively intact. R21 was not coded for exhibiting behaviors in the seven day look back period.</p> <p>A review of the facility's self-reported dated 08/30/23 of the resident-to-resident altercation investigation was performed. Through this review, on 08/29/23 at 3:00 PM, R9 was wheeling himself/herself down the hall, another resident [R21] spoke to him/her [R9] briefly and then as he/she [R9] passed by he/she [R21] hit him/her [R9] on his/her back [sic]. No injuries occurred.</p> <p>Further review of the investigation revealed a statement from the Administrator and a statement from a staff member that witnessed the exchange between R9 and R21 on 08/21/23. There was also a resident statement that was reviewed. There was no further documentation of statements from the staff that were working with R9 and R21 on the date of this incident nor were there statements from the other residents that could have been interviewed. The Administrator and the staff statements were from staff that are no longer employed at the facility.</p> <p>During an interview on 02/12/25 at 11:00 AM, the present Administrator reviewed the investigation and stated, This is not a complete investigation. There are no other statements from the staff and the residents. I have questions like did [R21] have a psychiatrist or psychotherapy consult, did R21 have any past behaviors like this, and how did R9 feel after this altercation? I just don't see a lot that was done or asked during this investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy Abuse, Neglect, and Exploitation dated 09/01/24 stated, .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation . Increased supervision of the alleged victim and residents .</p> <p>N.J.A.C. 8:39-4.1(a)(5)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for two (Residents (R)5, R10) in a total sample of 21. The facility failed to accurately code the significant change assessment for falls and the quarterly assessment for pressure ulcers for R5. In addition, the facility failed to accurately code pain on the admission assessment for R10. These failures placed the residents at risk of unmet care needs and a diminished quality of life.</p> <p>Findings included.</p> <p>Review of the October 2024 RAI, manual, page 1-5 revealed, .An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations .It is important to note here that information obtained should cover the same observation period as specified by the MDS (minimum data set) items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) by the IDT (interdisciplinary team) completing the assessment .</p> <p>1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed that R5 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.</p> <p>Review of the significant change MDS located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/24/24 revealed R5 was staff assessed to be severely impaired in cognition and had not sustained any falls since the previous assessment.</p> <p>Review of a 12/27/23 fall incident report, provided by the Director of Nursing (DON) revealed R5 had fallen out of bed and sustained a small cut above his/her right eye. R5 was transported to the hospital for evaluation and treatment.</p> <p>Review of the quarterly MDS located in the MDS tab of the EMR with and ARD of 04/25/24 revealed R5 had three Stage 3 pressure ulcers.</p> <p>Review of an 12/20/23 Health Status Note located in the Progress Notes tab of the EMR revealed R5 had one sacral pressure ulcer. There was no other pressure ulcers identified through the EMR from 12/20/23 to 04/25/24.</p> <p>2. Review of the admission Record located in the Profile tab of the EMR revealed R10 was admitted to the facility on [DATE] with a diagnosis of a right hip fracture.</p> <p>Review of the admission MDS located in the MDS tab of the EMR with an ARD of 11/01/24 revealed that R10 was coded has not been administered either as needed pain medication or scheduled pain medication during the seven-day observation period. In addition, the assessment revealed that R10 had frequent pain and rated his/her pain 10 out 10 (worse pain possible) on the pain scale.</p> <p>Review of the October 2024 Medication Administration Record (MAR) located in the Orders tab of the EMR revealed R10 had been administered Oxycodone (a narcotic pain medication) daily during the observation period.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/13/25 at 9:25 AM, the Regional MDS Coordinator confirmed that R5 and R10's assessments were coded inaccurately.</p> <p>N.J.A.C. 8:39-11.1(h)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the facility policy and the Resident Assessment Instrument (RAI) manual, the facility failed to develop a comprehensive Care Plan with a person-centered focus, measurable goals, and resident-specific interventions for two (Residents (R)8, and R17) in a total sample of 22. The facility failed to develop a comprehensive Care Plan related to pain for R8. In addition, the facility failed to develop a comprehensive Care Plan related to diabetes and insulin use for R17. These failures placed the residents at risk of unmet care needs and a diminished quality of life.</p> <p>Findings included:</p> <p>Review of the facility policy titled, Comprehensive Care Plans, dated 09/01/24 revealed, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .</p> <p>Review of the October 2024 RAI manual, page 1-2 revealed, .Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing, and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluated goal achievement and revision care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound critical interventions, the care plan becomes each resident's unique path toward achieving or maintaining their highest practicable well-being .</p> <p>1. Review of R8's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R8 had been admitted to the facility on [DATE] with the diagnosis of end stage renal disease, anemia in chronic kidney disease, and diabetes mellitus.</p> <p>Review of R8's Nursing Progress Notes located under the Progress Note tab in the EMR revealed a note dated 07/31/24 at 10:19 PM which stated, Resident fail [sic] from stretcher doing transport to dialysis. As a result, did not have dialysis [sic] Resident was then transported to [name of hospital] . Right shoulder fracture . Order to put in Sling [sic]. Sling is in place .</p> <p>Review of R8's Care Plan located under the Care Plan tab revealed no documentation of a care plan which had been developed for the fracture of the right shoulder or for pain.</p> <p>During an interview on 02/12/25 at 10:35 AM, Unit Manager (UM)2 confirmed there was no development of a care plan after R8 sustained a right shoulder fracture or for pain after R8 fell from a stretcher during transport to dialysis in 07/31/24.</p> <p>2. Review of the admission Record located in the Profile tab of the EMR revealed R17 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus, type 2.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the annual Minimum Data Set (MDS) located in the MDS tab of the EMR revealed R17 had a BIMS score of 13 out of 15 which indicated that R17 was cognitively intact. In addition, R17 had been administered insulin seven out of seven days during the observation period.</p> <p>Review of the current Order Summary located in the Orders tab of the EMR revealed a physician order, dated 01/24/25 for Insulin Aspart (short-acting insulin) 5 units subcutaneously three times a day for diabetes. In addition, R17 had a physician order, dated 12/19/24 for Lantus (Glargine-a long-acting insulin) 7 units subcutaneously at bedtime for diabetes.</p> <p>Review of the Comprehensive Care Plan located in the Care Plan tab of the EMR did not show a focus, measurable goal, or resident-centered approaches for R17's diabetes and insulin use.</p> <p>During an interview on 02/12/25 at 11:43 AM, Licensed Practical Nurse (LPN) 1 was asked who was responsible for the development for the Diabetic Care Plan. LPN 1 stated, The nurses, unit managers, and the MDS coordinator.</p> <p>During an interview on 02/12/25 at 5:00 PM, the Director of Nursing (DON) stated, There should have been a Care Plan developed for R17 for diabetes and insulin.</p> <p>N.J.A.C. 8:39-11.2(i)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to review and revise a care plan for insulin for one out of a total of 22 sampled residents(Resident (R)16). This failure had the potential for R16 not to receive the necessary care.</p> <p>Findings include:</p> <p>Review of R16's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R16 had been admitted to the facility on [DATE] with the diagnosis of diabetes mellitus and displaced fracture of the upper end of the left humerus.</p> <p>Review of R16's admission Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 02/04/25 revealed R16 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This represented R16 was cognitively intact. R16 was also coded as having received insulin during the seven day look back period.</p> <p>Review of R16's Physician Orders located under the Orders tab in the EMR revealed an order dated 01/29/25 for Insulin Glargine inject 15 units subcutaneously at bedtime for diabetes mellitus.</p> <p>Review of R16's Care Plan located under the Care Plan tab in the EMR dated 02/10/25 which stated, The resident has Diabetes Mellitus. The interventions were Fasting Serum Blood Sugar as ordered by the doctor, Monitor/document/report PRN [as needed] and s/s [signs/symptoms] of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd [abdominal] pain. Kussmaul breathing, acetone breath (smells fruity), stupor, coma [sic], and Monitor/document/report PRN [sic] any s/s of hypoglycemia: Sweating, tremor, Increased [sic] heart rate (tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait [sic]. There was no documentation R16 was taking insulin at bedtime in the care plan.</p> <p>During an interview on 02/12/25 at 2:30 PM, asked Unit Manager (UM)1, if R16 was receiving insulin should that be included on the care plan and UM1 stated, Yes, it should be.</p> <p>During an interview on 02/12/25 at 1:30 PM, the Director of Nursing stated, [R16] was receiving insulin so yes, the insulin should have been included in the care plan.</p> <p>N.J.A.C. 8:39-27.1(a)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, document review the facility failed to follow professional standards in diabetic management of two of four residents (Resident (R)16 and R17) reviewed out of a 22 total sampled residents. This failure had the potential for residents that have diabetes to be mismanaged in their care.</p> <p>Findings include:</p> <p>1. Review of R16's undated Face Sheet located under the Profile tab in the electronic medical record revealed R16 had been admitted to the facility on [DATE] with the diagnosis of diabetes mellitus.</p> <p>Review of R16's admission Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 02/04/25 revealed R16 was coded as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This represented R16 was cognitively intact. R16 was also coded as receiving seven injections of insulin during the seven day look back period.</p> <p>Review of R16's Physician Orders located under the Orders tab in the EMR revealed an order dated 01/29/25 for Lantus 15 units subcutaneously at bedtime for diabetes mellitus.</p> <p>Review of R16's Care Plan located under the Care Plan tab in the EMR revealed a care plan dated 02/10/25 which stated, The resident has Diabetes Mellitus. Interventions were Fasting Serum Blood Sugar as ordered by the doctor, Monitor/document/report PRN [as needed] and s/s [signs/symptoms] of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd [abdominal] pain. Kussmaul breathing, acetone breath (smells fruity), stupor, coma [sic], and Monitor/document/report PRN [sic] any s/s of hypoglycemia: Sweating, tremor, Increased [sic] heart rate (tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait [sic]. There was no documentation R16 was taking insulin at bedtime in the care plan.</p> <p>Review of the January and February 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR), weights/vitals, and progress notes did not reveal documentation of blood sugars to be obtained for monitoring.</p> <p>Review of R16's Comprehensive Metabolic Panel dated 02/06/25, located under the Results tab in the EMR revealed a blood sugar level of 206. This result was alerted as being High by the laboratory. There was no documentation to show the physician or nurse practitioner were notified of the blood sugar result.</p> <p>Review of the Physician Progress Note dated 01/30/25 at 10:51 AM revealed R16 had been seen however, the progress note did not show that the physician/Nurse Practitioner had addressed the diabetes or insulin usage. No order was given for blood sugar monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/12/25 at 11:44 AM, Licensed Practical Nurse (LPN)2 was asked when you have a resident on insulin, how do you determine the effectiveness of the insulin you are giving? LPN2 replied, If I don't see signs of hypo or hyperglycemia. LPN2 was asked when a resident is admitted to the facility and is on long-acting insulin, and you do not see orders for blood glucose monitoring, what do you do? LPN2 stated, I call the doctor and ask if he wants to continue the medication or change it.</p> <p>During an interview on 02/12/25 at 1:57 PM, Physician 1 stated, Blood sugars should be done on a daily basis. That is the standard that we do. If there are no blood sugars ordered, then the nurses missed it as well as we missed it.</p> <p>During an interview on 02/12/25 at 3:30 PM, the Director of Nursing (DON) stated, The nurses will only do blood sugars if they are ordered by the physician. I see what you are saying, and I don't disagree. But the nurses won't be doing blood sugars unless they have been ordered by the physician to do so.</p> <p>2. Review of the admission Record located in the Profile tab of the EMR revealed R17 was admitted to the facility on [DATE] with diagnoses that included diabetes, chronic obstructive pulmonary disease (COPD) and heart disease with heart failure.</p> <p>Review of the annual MDS located in the MDS tab of the EMR with an ARD of 11/25/24 revealed R17 had a BIMS score of 13 out of 15 which indicated she was cognitively intact. The assessment further showed that R17 had been administered insulin seven out seven days during the observation period.</p> <p>Review of the Weights and Vitals tab in the EMR revealed R17 had fingerstick blood sugar (FBS) monitoring three times daily.</p> <p>Review of the Order Summary' located in the Orders tab of the EMR did not show a physician order to obtain the FBS.</p> <p>During an interview on 02/12/25 at 11:15 AM, Licensed Practical Nurse (LPN)1 was asked if R17 was receiving FBS daily. LPN1 stated, When he/she came back from the hospital, he/she came back without orders to do the FBS.</p> <p>During an interview on 02/12/25 at 2:28 PM, Physician 2 stated, The expectation is that when a resident has insulin orders, there should be a sliding scale to check the FBS. I was not aware that he/she did not have FBS orders. It is the nurses' responsibility to tell me this.</p> <p>Review of the undated facility policy titled, Diabetes-Clinical Protocol revealed, . For the resident receiving insulin who is well controlled: monitor blood glucose levels twice a day (for example, before breakfast and lunch as necessary); monitor 3-4 times a day if on an intensive insulin therapy or sliding-scale insulin . Monitor A1C on admission .</p> <p>Review of Diabetes Management found at website https://www.lantus.com/diabetes-management stated, . Lantus should be taken once a day at the same time every day. Test your blood sugar levels while using insulin, such as Lantus .</p> <p>N.J.A.C. 8:39-11.2(b)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Holiday City		STREET ADDRESS, CITY, STATE, ZIP CODE 4 Plaza Drive Toms River, NJ 08757	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview and in the course of a complaint investigation, the facility failed to follow physician orders for medications for two of four residents (Resident (R)7 and R22) out of a total sampled of 22 residents. This failure lead to R7 not receiving medications that were ordered by the physician to be given.</p> <p>Findings include:</p> <p>1. Review of R7's undated Face Sheet located under the Profile tab in the EMR revealed R7 had been admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease, hypertension, and history of cerebral infarction without residual effects.</p> <p>Review of R7's Brief Interview for Mental Status (BIMS) located under the Evaluation tab in the EMR and conducted on 04/29/24 revealed R7 had a score of 15 out of 15 which represented R7 was cognitively intact.</p> <p>Review of R7's Physician Orders located under the Orders tab in the EMR revealed orders dated 04/29/25 for the following medications:</p> <ul style="list-style-type: none"> -Clopidogrel Bisulfate (Plavix) 75 mg (milligram) Give one tablet by mouth one time a day for blood clot prevention -Folic Acid one mg Give one tablet by mouth one time a day for supplement -Lasix 20 mg Given one tablet by mouth one time a day for fluid retention -Prednisone five mg Give one tablet by mouth one time a day <p>Review of R7's Medication Administration Record (MAR) located under the Orders tab in the EMR and dated for the month of April 2024 revealed these medications were coded as 7 for 04/29/24 which according to the Chart Codes means to refer to Nurses' Notes.</p> <p>Review of R7's Nursing Progress Notes located under the Progress Note tab in the EMR revealed notes dated for 04/29/24 which stated Awaiting delivery for the medications listed above.</p> <p>Review of the Pyxis Inventory which was provided by the facility revealed the medications listed above were available to the staff.</p> <p>During an interview on 02/11/25 at 3:15 PM, Unit Manager (UM)1 stated, They [nurses] have to call the doctor and get approval from him before medications can be ordered from pharmacy. After this approval, the nurse can go to the pyxis and get whatever medications that are needed that are in the pyxis and give to the resident. If the nurse does this, and it is past the time the resident was scheduled to get the medication, then the nurse has to get a one-time order for it to be given off schedule. This should be documented in the nurses' notes.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/11/25 at 4:00 PM, the Director of Nursing confirmed that Clopidogrel Bisulfate (Plavix), Folic Acid, Lasix, and Prednisone were available in the pyxis and could have been administered to the resident as ordered by the physician.</p> <p>2. Review of the admission Record located in the Profile tab of the EMR revealed R22 was admitted to the facility on [DATE] with a diagnosis of Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 11/15/24 revealed R22 had a BIMS score of 14 out of 15 which indicated he/she was cognitively intact.</p> <p>During a medication pass observation on 02/11/25 at 7:50 AM, LPN7 administered Fluticasone (an allergy medication) 50mcg via nasal spray to R22. LPN7 was not observed to have shaken the container prior to administration. When she inserted the nozzle into the left nostril, she was unable to get any medication out. She then removed the nozzle after attempting several times and then shook the medication bottle and said it was empty. LPN7 then returned to the medication cart and retrieved an additional bottle of Fluticasone. LPN7 returned to R22 and inserted the nozzle into the right nostril and pumped three times.</p> <p>During an interview on 02/11/25 at 8:00 AM, LPN7 was asked why she administered several sprays into the left nostril. LPN7 stated, The bottle was empty, but I did get some out. LPN7 was asked what the physician order state on how many times the medication was to be administered in each nostril. LPN 7 stated, One in each nostril. LPN7 was asked why she gave three sprays in the right nostril instead of one. LPN7 stated, It wasn't coming out. LPN7 was asked why she did not shake the bottle first before administering the medication. LPN7 stated, You don't need to shake it.</p> <p>During an interview on 02/11/25 at 9:05 AM, Unit Manager (UM)2 was told about the medication pass observation with LPN7. UM2 stated, If the order reads one spray, then do only one spray.</p> <p>During an interview on 02/11/25 at 11:30 AM, the DON was told about the medication pass observation. The DON stated, Fluticasone should be shaken prior to administration. The DON confirmed that there was an error in administering the medication.</p> <p>N.J.A.C. 8:39-11.2(b)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and facility document review and in the course of a complaint investigation, the facility failed to serve food at the appropriate temperatures on one of three units (Applewood Unit) in the facility. This failure had the potential for residents to experience untoward effects from eating food not served at the appropriate temperatures.</p> <p>Findings include:</p> <p>An observation was conducted on 02/11/25 at 11:45 AM at which time temperatures were taken o food on the tray line. The temperatures were as follows:</p> <ul style="list-style-type: none"> -Moreshae Soup 186 degrees -Fritten Vegetable 188 degrees -Tomeolo 166 degrees -Mashed Potatoes 171 degrees -Mixed Vegetables 165 degrees -Eggplant 165 degrees -Whole Milk 39 degrees -Apple Juice 42 degrees -Pudding 37 degrees <p>The meal trays began to be filled at 12:45 PM and ended at 1:00 PM. The trays were followed by the surveyor and the Dietary Manager (DM) to the Applewood unit where they arrived at 1:05 PM. Half of the meal trays were placed in an enclosed food cart while the other half was in an open food cart. The trays were given out by staff to the residents on the floor.</p> <p>At 1:13 PM, the last meal tray was served from the open food cart, and the test tray temperatures were taken. The temperatures are as follows:</p> <ul style="list-style-type: none"> -Fritten Vegetable 133 degrees -Mixed Vegetables 111 degrees -Moreshae Soup 136 degrees -Whole Milk 53 degrees -Apple Juice 53 degrees <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Pudding 48 degrees</p> <p>During an interview on 02/11/25 at 1:15 PM, the DM stated, The cold foods should be no higher than 42 degrees and the hot foods minimum temperature is 135 degrees.</p> <p>During an interview on 02/11/25 at 3:00 PM, the Regional Food Service Director stated, We had received complaints from residents that they were getting cold food. We started taking temperatures every week and we have not had the food temperature problems that we had today. Going forward we will continue to look at our process and improve so that we are not serving cold food.</p> <p>Review of the undated facility's policy Food Temperatures and Holding Policy stated, Guidelines for Holding Food: .Hot food at 135 [degrees] or above . Cold food at 41 [degrees] or below .</p> <p>N.J.A.C. 8:39-17.2 (g)</p>