STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Arbors	1750 Route 37 West 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)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 40039 Based on observation and interview, it was determined that the facility failed to make survey results readily accessible to residents and visitors. This deficient practice was evidenced by the following: On 05/02/2024 from 11:02 AM to 11:37 AM, the surveyor conducted the resident council task with five (5) long-term care residents, who regularly attend resident council meetings. When asked if the residents were made aware of the location of the most recent survey results, 4 out of 5 residents (Resident #28, #55, #62, and #79) responded that they were not aware of where the most recent survey results were located. The surveyor reviewed the April 17th, 2024, resident council meeting minutes. Under standards to be discussed at each meeting, standard #5 revealed: The location of the State Survey Book is in the reception area. On 05/02/2024 at 12:01 PM, the surveyor went to the reception area of the facility, which was located at the main entrance. The surveyor did a thorough observation of the reception desk and the reception area. The surveyor did not observe any survey result book in the reception area or at the reception desk readily accessible. The surveyor interviewed the Business Manager (BM) who was behind the reception desk along with the receptionist who had just arrived to start her shift. The surveyor asked the receptionist where the survey result book was located. The receptionist responded, What is a survey book? I'll find out. At the time the surveyor requested to see a copy of the survey results book, the BM pulled a book out of a cabinet behind the reception desk and stated that the last survey was completed on March 3, 2023. The surveyor explained to the BM that the requirement was that the survey results book must be accessible to residents and visitors. The BM stated, Ok, that's good to know. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Arbors		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 Route 37 West Toms River, NJ 08757	

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	On 05/02/24 at 12:40 PM, the surveyor interviewed the Regional Licensed Nursing Home Administrator (Regional LNHA). The surveyor made the Regional LNHA aware that 4 out of 5 residents at the resident council meeting reported that they were unaware of the location of the latest survey results. The surveyor explained that when trying to locate the survey result book, the surveyor was unable to find access to the survey results book. The surveyor informed the Regional LNHA that the book was located by the BM in a cabinet behind the reception desk. The Regional LNHA stated that the facility had done some recent renovations and that the survey book may have gotten put away. He further stated that he would make sure that residents and staff were informed of the location of the survey results book and that they would be accessible. On 05/10/24 at 09:33 AM, the Licensed Nursing Home Administrator (LNHA) stated in the presence of the Regional LNHA, the Director of Nursing, the Infection Preventionist and the survey team that the survey results book was at the receptionist and that the residents were informed of the location of the book every month at resident council. The LNHA did not speak to the survey results book being readily accessible. N.J.A.C. 8:39-9.4(b)

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NAME OF PROVIDER OR SUPPLIER: Complete Care at Arbors		STREET ADDRESS, CITY, STATE, ZIP CODE: 1750 Route 37 West Toms River, NJ 08757	

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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 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 49094 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) develop and implement a baseline person-centered care plan to meet a resident's medical needs and b.) implement a focus and interventions that are specific to the resident's respiratory needs for 1 of 1 (Resident #148) investigated for respiratory care. The deficient practice was evidenced by the following: On 05/01/24 at 11:02 AM, during the initial tour, the surveyor observed Resident #148 lying in bed asleep receiving oxygen (O2) at two (2) liters per minute (lpm) via nasal cannula. On 05/02/24 at 11:03 AM, the surveyor observed Resident #148 lying in bed awake receiving oxygen at 2 lpm via nasal cannula. At that time, the surveyor interviewed the resident who stated that she received oxygen most the time. The surveyor reviewed the medical record for Resident #148. According to the Admission Record, Resident #148 was admitted to the facility with diagnoses that included, but were not limited to, congestive heart failure (heart muscle does not pump blood as well as it should), pulmonary hypertension (high blood pressure that affects the blood vessels in the lungs), and chronic kidney disease (kidneys are damaged and cannot filter the blood). According to the Entry Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, dated 04/24/24, Resident #148 had a Brief Interview for Mental Status Score (BIMS) of 15 out of 15, indicating he/she was cognitively intact. Section I of the MDS revealed that Resident #148's primary reason for admission was due to debility cardiorespiratory conditions (range of conditions that affect the heart and lungs). According to Section O: Special Treatments, Procedures and Programs reflected the resident received intermittent oxygen therapy on admission and while a resident. A review of Resident #148's Baseline Care Plan, initiated 04/29/2023, revealed that it did not address oxygen therapy as an intervention for the resident's respiratory needs. On 05/07/2024 at 10:22 AM, the surveyor interviewed the Licensed Practical Nurse/ Unit Manager (LPN/UM). The LPN/UM stated that the unit manager completed the baseline care plan upon admission and updated it as needed. The LPN/UM further stated that each department would complete their section of the care plan. When asked which areas should be included on the care plan, the LPN/UM stated we include skin care, falls, pain, and ADL's [Activities of Daily Living]. She then stated she would review the resident's medications and diagnosis and would add pertinent things to the care plan. The surveyor then asked if oxygen therapy should be on the care plan and the LPN/UM replied yes, if the resident was on oxygen there should be a care plan for it. The LPN/UM verified that oxygen therapy was not on resident #148's baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/2024 at 11:55 AM, the surveyor interviewed the Director of Nursing (DON) regarding the care plan process. The DON stated, the interdisciplinary team along with the social worker, risk management, physical therapy, and the dietician work together to create the care plans. Baseline care plan areas include falls, admitting diagnosis, medications, skin care, and pain. The surveyor then asked if oxygen therapy be included on the baseline care plan? The DON stated yes, if they are receiving oxygen or if they have a respiratory diagnosis. The DON confirmed that resident #148 should have a base line care plan for oxygen therapy. On 05/10/2024 at 09:28 AM, during a follow up interview the surveyor asked if resident #148 was receiving oxygen on admission if it should be on the baseline care plan and the DON stated, Yes, it should have been on the baseline care plan. The surveyor reviewed the facility policy titled, Care Plans - Baseline, updated 1/2024. The following was revealed under Policy Statement: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The following was revealed under Policy Interpretation and Implementation: 2. The Interdisciplinary Team will review the healthcare practitioners orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the residents immediate care needs including but not limited to: a. Initial goals base on admission orders; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable. N.J.A.C. 8:39-11.2 (e)2

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 33106 Based on observation, interview, and medical record review, the facility failed to follow professional standards of clinical practice with respect to a.) obtaining a physician's order for the application of a treatment device utilized to manage a resident's edema, and b.) update the care plan to reflect a device utilized to manage edema for 1 of 22 residents reviewed (Resident #64). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. According to the Admission Record (AR), Resident #64 was admitted to the facility with the diagnoses which included but was not limited to; diabetes mellitus, cellulitis (infection of the skin) and edema (swelling). The admission Minimum Data Set (MDS) and assessment tool that facilitates a resident's care, indicated that the resident was cognitively intact and required maximum assistance with activities of daily living (ADLs). On 05/01/24 at 11:49 AM, the surveyor observed Resident #64 lying in bed and was observed with edema to the bilateral lower extremities. The surveyor observed that the resident was wearing ace bandages to bilateral lower extremities. The surveyor reviewed Resident #64's physician Order Summary Report (OSR) dated 04/26/24, which indicated that the resident was to have a compression stocking applied to the right leg in the morning and to be removed in the evening. The Treatment Administration Record (TAR) dated 04/26/24, contained a physician orders indicating that the resident was to have a compression stocking applied to the right leg in the morning and to be removed in the evening. There were no physician orders for the resident to have ace wraps applied to the bilateral lower extremities. The surveyor reviewed the resident's Care Plan (CP) which also did not indicate that the resident was to wear ace wrap bandages to the bilateral lower extremities to manage lower extremity edema. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/02/24 at 01:55 PM, the surveyor interviewed Resident #64 who stated that he/she had a history of bilateral lower extremity edema. Resident #64 stated that he/she was supposed to wear a compression stocking on the right lower leg and an ace wrap on the left lower leg. The resident stated that he/she had a wound on the left foot and had it wrapped in an ace wrap instead of a compression stocking. The resident then revealed that the staff had been wrapping both lower extremities with an ace wrap and that he/she had not been wearing a compression stocking to the right lower extremity. On 05/02/24 at 02:01 PM, the surveyor observed that the nurses were documenting in the TAR that they had applied and removed a compression stocking to the right lower extremity, however the resident was wearing ace wraps bandages to the bilateral lower extremities. The surveyor also observed that there was not a physician's order for the resident to be wearing ace wrap bandages to the bilateral lower extremities to manage the resident's edema. On 05/02/24 at 02:05 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who documented in the TAR that the resident refused to have the compression stocking applied to the resident's right lower extremity. The LPN then stated that the order should have been written for the ace wraps to be applied to the bilateral lower extremities and that she would get the ordered clarified to reflect the accurate devices that should have been applied. On 05/07/24 at 09:30 AM, the surveyor observed that the resident was lying in bed wearing bilateral ace bandage wraps to the lower extremities. The resident stated that he/she did not wear compression stockings to his right or left lower extremity. The surveyor reviewed the physician orders and the order still reflected that the resident was to have a compression stocking applied to the right lower extremity. There was not a physician's order to apply ace wraps bandages to the bilateral lower extremities. On 05/07/24 at 09:40 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the nurses applied the ace wraps to the bilateral lower extremities and that she had not seen the resident wearing compression stockings. On 05/07/24 at 09:48 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that she had been employed in the facility for approximately 1 (one) year. The LPN UM reviewed Resident #64's physicians orders in the presence of the surveyor and confirmed that the physicians order written was to apply a compression stocking to the right lower extremity in the morning and to remove the compression stocking in the evening. The LPN/UM stated that the resident had not been wearing the compression stockings and had been wearing ace wraps to the bilateral lower extremities to manage edema. The LPN/UM stated that the order should have been clarified to reflect that the resident was wearing ace wraps to the bilateral lower extremities. She also stated that the nurses should not be signing the TAR that they were applying and removing the compression device when the resident did not utilize it. The LPN/UM then stated that she would get the physician order clarified to reflect the appropriate devices that should be worn. The LPN/UM revealed that the resident had been wearing the ace wrap bandages to the lower extremities and that there should have been a physician's order to reflect the use of these ace bandages. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/24 at 09:54 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that if the resident was not utilizing the compression stocking to the right lower extremity, then the nurses should not have been documenting that they were applying and removing the compression stocking. She stated that any application of any devices or treatments need to have a physician's order and if the resident was wearing ace wraps to the bilateral lower extremities, then a physician's order should reflect the use of the device. The DON also stated that the use of ace wraps to the bilateral lower extremity to manage bilateral lower extremity edema should have been reflected in the resident's care plan. On 05/10/24 at 09:24 AM, the survey team met with the DON. The DON stated that the nurses should have notified the physician regarding the resident's refusal to wear the compression stocking to the right lower extremity and a physician's order should have been obtained for the application of ace wraps bandages to be applied to the resident's bilateral lower extremities. The facility policy titled, Medication Orders dated 01/2024 indicated that when recording treatment orders, specify treatment, frequency, and duration of the treatment. The facility policy titled; Physician Orders dated 03/2024 indicated that all medications and treatments orders are received from a credentialed practitioner before implementing. The policy also indicated that the physician's order must be written on the appropriate physician's order sheet and interim plan of care. The facility policy titled, Care Plans, Comprehensive Person-Centered dated 01/2024 indicated that that CP would contain services that were furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. NJAC 8:39-27.1(a)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41260 Complaint #: NJ 166493 Based on interview, record review, and review of facility documents, it was determined that the facility failed to thoroughly investigate a facility acquired pressure ulcer for 1 of 3 residents (Resident #146) reviewed for pressure ulcers. This deficient practice was evidenced by the following: The surveyor reviewed the closed record for Resident #146. According to the Admission Record, Resident #146 was admitted with diagnoses which included, but were not limited to, COVID-19, major depressive disorder, severe protein-calorie malnutrition, and unspecified dementia. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 06/02/23, included the resident had a Brief Interview for Mental Status score of 06, which indicated the resident's cognition was severely impaired. Further review of the MDS included the resident did not have any unhealed pressure ulcers upon admission to the facility. Review of a progress note, dated 07/04/23, revealed, opened area to left buttock noted . new treatment of Santyl [topical cream to remove dead tissue] and foam border gauze noted. Review of the care plan, revised 08/03/23, included a focus of potential for skin breakdown r/t [related to] a recent surgery and immobility. Left buttocks unstageable pressure ulcer, and an intervention, dated 07/04/23, for treatments and dressings as ordered per physician. Review of the Wound Care Consultant report, dated 07/10/23, included recommendations for the Left Buttock wound to include, daily wound care with normal saline cleanse, apply Santyl, cover with silicone foam dressing. On 05/08/24 at 1:00 PM, the surveyor requested all incident/accident reports with complete investigations for Resident #146 for July 2023. During an interview with the surveyor on 05/09/24 at 9:00 AM, the Licensed Nursing Home Administrator (LNHA) stated the facility did not have any incident/accident reports for Resident #146. During an interview with the surveyor on 05/09/24 at 9:26 AM, the Certified Nursing Assistant (CNA) stated that if a resident obtained a facility acquired pressure ulcer, she would report it to the nurse. The CNA further stated that she would be required to write a statement including any details of the skin injury. The CNA explained it was important for the facility to investigate facility acquired pressure ulcers because they need to know how it was obtained. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 05/09/24 at 9:30 AM, the Licensed Practical Nurse (LPN) stated that if a resident obtained a facility acquired pressure ulcer, the nurse would report it to the supervisor. The LPN further explained that it would be important for the facility to investigate all facility acquired pressure ulcers so that the appropriate interventions could be implemented. During an interview with the surveyor on 05/09/24 at 9:37 AM, the LPN/Unit Manager (LPN/UM) stated if a resident obtained a facility acquired pressure ulcer, the nurse would have to complete an investigation to determine how the wound developed and to initiate interventions. During an interview with the surveyor on 05/09/24 at 11:15 AM, the Director of Nursing (DON) stated that if a resident obtained a facility acquired pressure ulcer, the wound team would be alerted. The DON further stated that the nurse would complete an incident report and obtain statements from staff. The DON explained that it was important to investigate facility acquired pressure ulcers to determine the cause of the wound. When asked about the missing incident/accident report for Resident #146, the DON verified that the nurse who discovered the facility acquired pressure ulcer should have initiated the incident report. Review of the facility's Accidents and Incidents - Investigating and Reporting policy, updated 01/2024, included, The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident, and, The following data, as applicable, shall be included on the Report of Incident/Accident form: the nature of the injury/illness (e.g. bruise, fall, nausea, etc.). NJAC 8:39-27.1(a)

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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 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. 49094 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to obtain a physician's order for oxygen therapy. This deficient practice was identified for 1 of 1 resident (Resident #148) reviewed for respiratory care. This deficient practice was evidenced by the following: On 05/01/24 at 11:02 AM, during the initial tour the surveyor observed Resident #148 lying in bed sleeping receiving oxygen (O2) at two (2) liters per minute (lpm) via nasal cannula. On 05/02/24 at 11:03 AM, the surveyor observed Resident #148 lying in bed awake receiving oxygen at 2 lpm via nasal cannula. At that time, the surveyor interviewed the resident who stated that she received oxygen most the time. The surveyor reviewed the medical record for Resident #148. According to the Admission Record, Resident #148 was admitted to the facility with the following but not limited to diagnoses: congestive heart failure (heart muscle does not pump blood as well as it should), pulmonary hypertension (high blood pressure that affects the blood vessels in the lungs), and chronic kidney disease (kidneys are damaged and cannot filter the blood). According to the Entry Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, dated 4/24/24, Resident #148 had a Brief Interview for Mental Status Score (BIMS) of 15 out of 15, indicating they were cognitively intact. Section I of the MDS revealed Resident #148 had an active diagnosis of congestive heart failure, pulmonary hypertension, and chronic kidney disease. Section I also revealed that Resident #148's primary reason for admission was due to debility cardiorespiratory conditions (range of conditions that affect the heart and lungs). According to section O: Special Treatments, Procedures and Programs reflected the resident received intermittent oxygen therapy on admission and while a resident. A review of Resident #148's April 2024 Physician Order Summary Report (POS) located in the electronic medical record (EMR) did not include any orders for oxygen therapy. On 05/07/2024 at 10:22 AM the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated there should be a physician's order for anyone receiving oxygen because it was considered a treatment. The surveyor and LPN/UM reviewed the physician's orders in the EMR. The LPN/UM confirmed that a physician's order for oxygen 2 lpm via nasal cannula every 24 hours as needed for SOB[shortness of breath]/wheeze (a high-pitched whistling sound made while breathing) was written on 05/02/2024. The LPN/UM further stated that there should have been an physician's order written for the oxygen on 04/24/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/24 at 11:55 AM, the surveyor interviewed the Director of Nursing (DON) who stated any resident that needed oxygen therapy needed to have a physician's order. The DON confirmed that on 04/24/2024 resident #148 was receiving oxygen at 2 lpm via nasal cannula and did not have a physician's order on that date. The DON further stated there should have been a physician's order written on that date for the oxygen. On 05/10/2024 at 09:28 AM, the Director of Nursing stated in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, if a resident is on oxygen therapy there needs to be a physicians order. The DON confirmed that resident #148 did not have a physician's order for oxygen therapy. A review of the facility's Oxygen Administration policy, dated updated 10/2019, included, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. N.J.A.C. 8:39-11.2 (e)

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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 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** 43308 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to label, date, and store potentially hazardous foods appropriately to prevent food borne illness. This deficient practice was evidenced by the following: On [DATE] at 10:24 AM, the surveyor in the presence of the Food Service Director (FSD), toured the kitchen and observed the following in the dry storage pantry: 1. Two (2) packs of 12 bread that was identified as hamburger buns, had a used by date of [DATE]. 2. A bag of [NAME] couscous toasted pasta was opened and not dated. 3. A bag of instant nonfat dry milk was opened with a used by date of [DATE]. On [DATE] at 11:08 AM, the surveyor interviewed the FSD who stated that everything should have an opened date, used by date, and received by date on it. He stated that anything that came into the kitchen should have a sticker with the date it was received on it, a sticker for when it was opened and a used by date sticker. He explained anything opened and was a bulk item such as the couscous had a six (6) months expiration. The FSD confirmed there should be an opened date sticker on the couscous, to show when it was opened and when to use it by. He then confirmed that the 2 packs of 12 hamburger buns dated [DATE] and the instant nonfat dry milked dated [DATE] should have been discarded. The FSD concluded that the items were discarded on [DATE]. On [DATE] at 09:31 AM, the Licensed Nursing Home Administrator (LNHA) stated in the presence of the Director of Nursing (DON), the Regional LNHA, the Infection Preventionist (IP) and the survey team that the FSD generally conducted a walk through on Wednesdays to check for all expired items and that everything would have been discarded and labeled by then. A review of the facility's Food Storage policy, undated, included All foods will be properly stored in a safe, sanitary manner. Dry Storage 2. Plastic containers with tight-fitting covers will be used for storing products such as grains, sugar, dried vegetables and broken lots of bulk foods. All containers must be legible and accurately labeled and dated. 4. All foods will be stored either wrapped or in closed storage containers and be clearly dated and labeled. A review of the facility's Dry Food policy, undated, included 2. Immediately after delivery all products will be dated for proper rotation. A review of the facility's Dating and Labeling policy, undated, included All foods are to be labeled and dated appropriately to ensure food safety regulations are followed. 1. Upon receiving and storing, all items must be labeled with the name of food and received date. Once opened, the label must be updated with the current date and a use by date of 3 days (including date opened) unless indicated on labeling and dating protocol. 3. All items with an expired use by date must be discarded immediately. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Arbors	1750 Route 37 West 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:,d+[DATE].2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. Building B. Wing	05/17/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41260 Complaint #: NJ 166943 Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to accurately document in the medical records for 3 of 26 residents (Resident #146, #147, and #245) medical records reviewed. This deficient practice was evidenced by the following: 1.) The surveyor reviewed the closed record for Resident #146. According to the Admission Record, Resident #146 was admitted with diagnoses which included, but were not limited to, COVID-19, major depressive disorder, severe protein-calorie malnutrition, and unspecified dementia. Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 06/02/23, included the resident had a Brief Interview for Mental Status score of 06, which indicated the resident's cognition was severely impaired. Further review of the MDS included the resident did not have any unhealed pressure ulcers upon admission to the facility. Review of a progress note, dated 07/04/23, revealed, opened area to left buttock noted . new treatment of Santyl [topical cream to remove dead tissue] and foam border gauze noted. Review of the care plan, revised 08/03/23, included a focus of potential for skin breakdown r/t [related to] a recent surgery and immobility. Left buttocks unstageable pressure ulcer, and an intervention, dated 07/04/23, for treatments and dressings as ordered per physician. Review of the Wound Care Consultant report, dated 07/10/23, included recommendations for the Left Buttock wound to include, daily wound care with normal saline cleanse, apply Santyl, cover with silicone foam dressing. Review of the Treatment Administration Record (TAR) for July 2023, included a physician's order, dated 07/04/23, to apply Santyl ointment to left buttock daily. Further review of the TAR revealed the treatment was not signed out as completed and was left blank on 07/05/23 or 07/15/23. During an interview with the surveyor on 05/09/24 at 9:26 AM, the Certified Nursing Assistant (CNA) stated that when a resident obtained a facility acquired pressure ulcer, she would report it to the nurse. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 05/09/24 at 9:30 AM, the Licensed Practical Nurse (LPN #1) stated that when a resident obtained a facility acquired pressure ulcer, the nurse would obtain a treatment order. LPN #1 further stated that when a treatment was completed, the nurse would sign off on the TAR. If the resident was unavailable or refused the treatment, LPN #1 explained that the nurse would use the corresponding code when signing the treatment off on the TAR. LPN #1 added that it was important not to leave the TAR blank, to let everyone know that the treatment was done or not. During an interview with the surveyor on 05/09/24 at 9:37 AM, the LPN/Unit Manager (LPN/UM) stated that nurses knew which treatments to complete because they checked the TAR. The LPN/UM further stated that when the treatment was completed (or not due to unavailability or refusals) the nurse would sign off on the TAR. The LPN/UM explained that it was important to sign the treatments on the TAR so that staff could follow-up on the treatments. During an interview with the surveyor on 05/09/24 at 11:15 AM, the Director of Nursing (DON) stated that when a resident obtained a facility acquired pressure ulcer, the nurse would notify the physician for a treatment order. The DON further stated that the nurses reviewed the TAR for current treatment orders and signed off the treatments when they were completed. The DON explained that if there was a blank on the TAR, it would appear the treatment wasn't done, and that the nurse should make sure to sign the TAR, to take credit for what they did. At that time, the surveyor notified the DON of the blanks on Resident #146's July 2023 TAR and the DON verified that the nurse should have documented if they did the treatment or if the resident was unavailable or refused the treatment. Review of the facility's Pressure Ulcers/Skin Breakdown policy, updated 01/2024, included, The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. 43308 2.) The surveyor reviewed the closed medical record for Resident #147. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included, cognitive communication deficit, dementia with other behavioral disturbance, anxiety disorder and major depressive disorder. A review of the quarterly Minimum Data Sheet (MDS), an assessment tool, dated 1/18/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 05 out of 15, which indicated the resident had severe cognitive impairment. A review of the Facility Reportable Event (FRE) indicated an incident occurred on 2/22/24 between Resident #147 and Resident #245. It reflected the residents were immediately separated, assessed and no injuries were noted. It further reflected there were descriptions from the nurse and both residents of the incident as well as the written statements from staff with the incident reports. A review of the February 2024 Progress Notes (PN) revealed there were no documentation in the PNs related to the incident that occurred on 2/22/24. A further review reflected a PN on 2/22/24 at 20:58 (8:58 PM) that the psychiatrist conducted rounds and to follow up as needed. 3.) The surveyor reviewed the closed medical record for Resident #245. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included, Down Syndrome, anxiety disorder, dysphagia (difficulty swallowing), and Attention-Deficit Hyperactivity Disorder (ADHD - may have trouble paying attention, controlling impulsive behaviors (may act without thinking about what the result will be), or be overly active.) A review of the quarterly Minimum Data Sheet (MDS), an assessment tool, dated 12/29/23, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had an intact cognition. A review of the February 2024 Progress Notes (PN) revealed there were no PN on 2/22/24 or any documentation in the PN related to the incident that occurred on 2/22/24. On 05/08/24 at 01:14 PM, the surveyor interviewed the Registered Nurse (RN) who stated that after an incident they documented in the electronic medical record (EMR). She explained they documented what occurred, the assessment, and that the physician and the family were notified. She further explained they completed an incident report and wrote a PN. The RN stated it was important to write a PN in the EMR, so everyone was aware of what occurred with the resident. She further stated that the staff generally did not go into the incident section of the EMR and that was the importance of writing PNs. On 05/09/24 at 09:31 AM, the surveyor interviewed the Director of Nursing (DON) who stated that there should be progress notes in the EMR related to any incident, but staff have not been consistence with documenting in the PN. On 05/09/24 at 09:47 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #2) who stated that after an incident occurred, they assessed the resident and obtained witness statements from any staff that witnessed the incident. He then explained if it was unwitnessed then they would obtain statements from the Certified Nursing Assistant (CNA) and any other staff members that may have cared for the resident to document what the resident was doing the last time they were observed. LPN #2 stated that they completed a paper handwritten incident report and then document in the PN in the EMR on what occurred and what they did. He stated the importance of PN were to inform the next nurse and other staff that had access to the EMR what occurred. He stated the PN allowed them to coordinated care and allowed everyone to be aware on how to monitor the resident the next few days. LPN #2 stated that if there was a resident-to-resident incident then there should be a progress note in the EMR, so the staff was aware of what occurred and ensure the residents were safe and secure. On 05/09/24 at 09:56 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that after an incident occurred and the resident was assessed, they obtained written statements right away from staff that was around. She stated that they completed an incident report form to investigate what happened, how it occurred, and the next steps needed. The LPN/UM stated that they documented in the EMR under the risk management tab and in the progress notes which were separate. She stated that PN were important because the PN allowed them to follow up with the resident after the incident. The LPN/UM stated that if there was a resident-to-resident incident that occurred then it should be documented in the PN so they could follow up with the residents and see if any additional interventions should be put into place. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/24 at 11:35 AM, the DON stated in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team that a lot of times the nurses would document on the incident report in the nursing description section and not in the PN. The DON confirmed that staff should be documenting in the PN and that after they completed an incident report it should be followed by a PN in the EMR. The DON stated that a progress note was a description of the occurrence and that it was a communication tool for all clinicians and staff to be aware of what occurred with the resident. The DON acknowledged that there should be progress notes for both Resident #147 and #245 in addition to the incident report from 2/22/24. On 05/10/24 at 09:29 AM, the DON acknowledged in the presence of the LNHA, the Regional LNHA, the Infection Preventionist (IP) and the survey team that there was no PN in the EMR and that it was an over site. A review of the facility's Charting and Documentation policy, updated 01/2022, included All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 2. The following information is to be documented in the resident medical record: e. events, incidents, or accidents involving the resident. NJAC 8:39-35.2 (d)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 33106

Based on observation, interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to ensure that the infection control practices for residents on transmission-based precautions (TBP) were followed to prevent the potential spread of infection by not utilizing contact precautions in accordance with facility policy and accepted national standards for 1 (one) of 2 (two) resident (Resident #79) reviewed for TBP and was evidenced by the following:

According to the Admission Record, Resident #79 was admitted to the facility with the diagnoses that included but was not limited to C-diff (infection of the large intestine (colon) caused by the bacteria Clostridium difficile) and MRSA (methicillin-resistant Staphylococcus aureus, a type of bacteria that is resistant to several antibiotics).

A review of the quarterly Minimum Data Set (MDS) an assessment tool that facilitated a resident's care dated 02/22/24 indicated that the resident was cognitively intact.

On 05/01/24 at 10:28 AM, the surveyor observed a sign posted on Resident #79's door indicating that the resident was on enhanced barrier precautions (EBP). There were also signs posted to indicate what type of personal protective equipment (PPE) must be worn when caring for the resident. There was an isolation cart in front of the resident's door containing necessary PPE such as gloves and isolation gowns. The surveyor did not observed signs posted on the resident's door that the resident was on contact isolation. The resident was observed sitting in the wheelchair in his/her room. The resident was interviewed at this time and the resident stated that the staff only utilized the PPE such as gowns and gloves when they took direct care of her/him. Resident #79 stated that they were not aware of any infection that she/he had at this time.

On 05/02/24 at 08:57 AM, the surveyor reviewed Resident #79's medical record which revealed the following information:

The physician Order Summary Report (OSR) dated 02/21/24, indicated that Resident #79 was on Contact Isolation Precautions because the resident was positive for the infection c-diff (stool infection) and MRSA (methicillin-resistant Staphylococcus aureus, a type of bacteria that is resistant to several antibiotics) of wound.

The OSR dated 02/21/24, indicated that Resident #79 required Enhanced Barrier Precautions for a diagnosis of ESBL (Extended Spectrum Beta-Lactamase (ESBL)-producing Bacteria) and MRSA every shift.

The resident's Care Plan (CP) indicated that Resident #79 was on enhanced barrier precautions related to a wound, indwelling medical device and infection or colonization. The CP was initiated on 11/16/2023.

Interventions included:

-Clear signage must be posted on the door or wall outside of the resident room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicating the type of precautions and required PPE (e.g., gown and gloves). For Enhanced Barrier Precautions, signage should also clearly indicate the high contact. resident care activities that require the usage of gown and gloves. Date Initiated: 11/16/2023. - EBP will in place for the duration of a residents stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Date Initiated: 11/16/2023. The CP also indicated that the resident was on Contact Isolation for the diagnoses of urinary tract infection and ESBL of the urine. The CP indicated that contact isolation was discontinued on 01/02/24, however there was still an active physician's order for the resident to be on contact isolation. The surveyor reviewed the Medication Administration Record (MAR) which contained a physician's order dated 02/21/24, for Resident #79 to be on contact isolation for c-diff and MRSA of the wound. The surveyor also observed that there were nurses' signatures documented on the MAR from April 2024 till present, which indicated that the staff were maintaining contact isolation for Resident #79. On 05/02/24 09:12 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that she had been employed in the facility for [AGE] years. CNA #1 stated that she was very familiar with Resident #79. She stated that Resident #79 required limited to extensive assistance with activities of daily living (ADLs). She stated that the resident was alert and oriented to person, place, and time. She stated that the resident was on EBP for MRSA in a foot wound. She stated that the resident had no bacteria in her urine and that personal protective equipment (PPE) only had to be worn during direct resident care only. She explained that a gown and gloves had to be worn only when in direct contact with the resident. She stated that it was important to wear PPE to prevent the spread of infection or protect the resident from acquiring an infection from the staff. On 05/02/24 at 09:15 AM, the surveyor was standing outside Resident #79's room and observed CNA#2 providing direct resident care (toileting) for Resident #79 in the resident's room. The CNA was only wearing a surgical mask and a pair of gloves. The surveyor did not observe the CNA wearing an isolation gown when providing direct resident care for Resident #79. On 05/02/24 at 09:20 AM, the surveyor interviewed CNA #2 who stated that she had been employed through the agency. CNA #2 stated that Resident #79 required limited assistance with ADLs. The surveyor asked the CNA why she was in the resident's room providing care and not wearing an isolation gown? CNA #2 stated that she was only wearing a glove and a mask. CNA #2 stated that she was not aware that the resident had an infection of any kind. The CNA accompanied the surveyor to Resident #79's room and CNA #2 stated that she did not notice the sign that was posted on the resident's door which indicated that the resident was on enhanced barrier precautions and that gloves and a gown were required when providing direct patient care. CNA #2 confirmed that she was not wearing an isolation gown when providing direct resident care for Resident #79 and added that she should have read the sign that was posted on the resident's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/02/24 at 09:27 AM, the surveyor interviewed the primary care Licensed Practical Nurse (LPN) who stated that she had been employed in the facility since July 2023. The LPN explained to the surveyor the difference of Enhanced barrier precautions and Contact precautions. She stated that Enhanced barrier precautions were provided to any resident with any access to the body such as tubes, wounds, IVs [intravenous], tracheostomy's etc. She stated that when a resident was on EBP, gown and gloves were to be worn only when providing direct resident care. She stated that when a resident was on contact precautions that meant the staff must wear the required PPE (gown and gloves) when entering the room, when in contact with the resident and when in contact with the resident's environment. She stated that it was important to adhere to what type of transmission-based precaution (TBP) a resident was on to prevent the spread of infection. The LPN then added that if Resident #79 had an order to be on contact isolation, then the sign on the resident's door should have specified that. The LPN confirmed that the precaution sign on the resident's door should have indicated that the resident was on contact isolation instead of enhanced barrier precautions. The LPN admitted that she did sign the MAR indicating that the resident was on contact precautions, however there was no sign on the resident's door nor were the staff following contact precautions when entering the residents room. On 05/02/24 at 09:38 AM, the surveyor interviewed the Licensed Practical Nurse/Infectionist Preventionist (LPN/IP) who stated that she had been employed in the facility for [AGE] years. The LPN/IP explained that EBP were required to protect residents with any kind of inner body access such as tubes, wounds, catheters, and IVs ect. She explained that application of PPE such as gowns and gloves were required when providing direct patient care. She stated then when a resident was on EBP, PPE would not have to be applied if only delivering a food tray or just going in to talk to the resident or to administer medications. She stated that when a resident was on contact isolation the staff were required to wear PPE prior to entering the room, when in direct contact with the resident and the resident's environment. She stated that when a resident was on contact precautions the resident had an active infection and it was important to wear the appropriate PPE to prevent the spread of infection. She stated that Resident #79 did not have an active infection. The surveyor asked the LPN/IP why the resident had a physician's order for contact precautions and she stated that that order should have been discontinued. She then added that if the order was not discontinued then Resident #79 should have still been on contact isolation and the sign posted on the resident's door should have indicated as such. She also stated that when CNA#2 was providing resident care this morning she should have been wearing a gown and gloves when providing direct resident care. She also added that the LPN should have questioned the physicians for contact precautions in the MAR and should not have signed the MAR that contact precautions were being done if she was not following the order. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/02/24 at 09:50 AM, the surveyor interviewed the Director of Nursing (DON) who stated that EBP were for residents with access to their external fluids. She explained that PPE such as gown and gloves were required for direct resident care to prevent transmission of infection to the resident. She stated that EBP was instituted to protect the resident from infection that could be transmitted from the staff. The DON then explained what contact precautions meant. She stated that contact isolation was required for specific microorganisms the resident had and that PPE such as gowns and gloves were required when in contact with the resident and the resident's environment. She stated that there was a confusion related to what type of TBP Resident #79 was on because there was an order for the resident to be on contact isolation as well as enhanced barrier precautions. She stated that if the resident had an order for contact precautions, then the sign posted on the resident's should have been posted on the resident's door should have reflected that. She also stated that if the nurses were signing the MAR that the resident was on contact precautions then the nurses should have been adhering to the order. She confirmed that when CNA #2 was providing direct resident care to Resident #79 she should have worn a gown and gloves. On 05/10/24 at 09:29 AM, the surveyor interviewed the LPN/IP who stated that the resident had a history of c-diff which was resolved on 2/27/24. The LPN/IP confirmed that the staff should have obtained a physician's order to discontinue the contact isolation. She stated that the resident's MRSA in the wound was colonized so there was no need for contact isolation. The LPN/IP continued to add that if there was no order to discontinue contact isolation and the nurses were documenting in the MAR that they were adhering to contact isolation, then nurses should continue to follow the order until the order was discontinued. The order for the resident to be on contact isolation was discontinued after surveyor inquiry. The facility policy titled, Enhanced Barrier Precautions dated 04/2024, indicated that the implementation of EBP will reduce transmission of resistant organisms by employing targeted use of gown and glove use during high contact resident care activities. The policy indicated that high-contact care activities included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care and wound care. The Policy also described Contact Isolation which indicated that this type of TPB was used when pathogen transmission was not completely interrupted by standard precaution alone. Contact precautions were intended to prevent the transmission of infectious agents and gloves and gowns were required on entry to the resident's room. The policy indicated that gloves and gowns were to be applied before entry to the resident room and removed before exiting the resident's room. The facility policy titled, Categories of Transmission-Based Precautions dated 03/2021, indicated that Contact Precautions was implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident care items in the resident's environment. The policy also indicated that gowns, gloves, and handwashing was to be utilized while caring for resident or indirect contact with the residents environmental surfaces or resident care items in the resident's environment. NJAC 8:39-19.4 (m)(n), 27.1 (a)