

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	

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>33106</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide care and services in a manner that maintained and promoted dignity by not applying an appropriate device to protect a resident's clothing for 1 of 19 residents (Resident #24) reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the Admission Record, Resident #24 was admitted to the facility with the diagnoses which included, but were not limited to, depression and unspecified dementia with other behavior disturbances.</p> <p>The quarterly Minimum Data Set (MDS), an assessment that facilitates resident care, dated 03/04/24, indicated that Resident #24 was sometimes understood, and ability was limited to making concrete request and that the resident responded to simple direct communication, however able. The MDS also indicated that the resident was dependent with activities of daily living ADLs.</p> <p>On 05/15/24 at 10:56 AM, during the initial tour, the surveyor observed Resident #24 sitting up in a wheelchair with a shower blanket (medical linen that provides comfort and warmth after a bath or shower) draped around the resident's neck and being used as a clothing protector (something specifically designed to prevent food and drink that is spilled from soaking through and staining clothes during mealtimes). The surveyor observed the resident drooling and mumbling words, unable to communicate with the surveyor. The resident was able to shake his/her head yes or no when asked direct questions, however, the resident's speech was slurred and difficult to understand.</p> <p>On 05/16/24 at 09:54 AM, during a second observation, the surveyor observed Resident #24 sitting up in a wheelchair with a shower blanket draped around the resident's neck and being used as a clothing protector. The surveyor interviewed the Certified Nursing Assistant (CNA) at that time who indicated that she had worked for the nursing agency and had been coming to the facility for three months. The CNA stated that the resident had been provided a shower today and the shower consisted of washing the resident and changing the resident's bed linen. When the surveyor asked the CNA why Resident #24 had a shower blanket draped around his/her neck, the CNA stated that the resident wore a shower blanket around his/her neck because the resident drooled and it protected his/her clothing. She then added that she put a towel around the resident's neck to protect his/her clothing and was not sure who applied the shower blanket.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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>On 05/16/24 at 10:06 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she had been employed for five years. The LPN stated that the resident had a diagnosis of multiple sclerosis (MS) and required complete care with all aspects of ADL's. She also added that the resident required complete care with feeding him/her meals. When the surveyor asked the LPN why the resident had a shower blanket draped around his/her neck, the LPN stated that it was because the resident drooled and it protected his/her clothing. The LPN explained that it would have been more appropriate if the resident wore a clothing protector, but she had not seen clothing protectors utilized at the facility since the new company took over. She then revealed that the staff had been using sheets, towels, and blankets as clothing protectors. The LPN stated that she had seen the resident this morning when she administered medications to Resident #24 and did notice that the resident was wearing a shower blanket as clothing protector and confirmed that it could be a dignity issue.</p> <p>On 05/16/24 at 10:30 AM, the surveyor interviewed 3 out of 7 unsampled residents in the dining room who stated that they were provided with clothing protectors if needed during meals.</p> <p>On 05/16/24 at 11:08 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that she asked the CNA to provide Resident # 24 with a clothing protector. She confirmed that the resident should not have had a shower blanket draped around his/her neck and that if the resident drooled, then he/she should have been provided with a clothing protector. The LPN/UM then accompanied the surveyor to the area where the clothing protectors were stored. The surveyor observed that the clothing protectors were located with the other clean linen, that all staff had access to. The LPN/UM stated that it was a dignity issue not to apply the appropriate clothing protector and that if the supplies were available then it should have been provided to the resident.</p> <p>On 05/17/24 at 11:03 AM, the surveyor interviewed the Director of Nursing (DON) who stated if any resident had the potential to drool, then a clothing protector should be provided to the resident to protect the resident's clothing. She stated that it would not be appropriate to drape a shower blanket around a resident's neck. She stated that was a dignity issue for the resident.</p> <p>There was no documentation on Resident #24's Care Plan that indicated it was Resident #24's preference to drape a shower blanket around his/her neck to protect his/her clothing from drool.</p> <p>The facility policy titled; Quality of Life-Dignity dated 01/2024 indicated that each resident shall be cared for in a manner that promotes dignity and enhances quality of life, dignity, respect, and individuality. Treated with dignity meant that the resident would be assisted in maintaining and enhancing his or her self-esteem and self-worth.</p> <p>NJAC 8:39-4.1(a)12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>43308</p> <p>Complaint # NJ168787</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to notify the resident's representative of a change in condition for 1 of 22 residents (Resident #231) reviewed.</p> <p>This deficient practice was evidence by the following:</p> <p>According to the Admission Record, Resident #231 was admitted to the facility with diagnosis which included, but were not limited to, acute respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in the body), Alzheimer's Disease, and chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Further review of the Admission Record included contact information for the resident's responsible party.</p> <p>Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 08/02/23, included the resident's cognition was moderately impaired.</p> <p>A review of the individualized Care Plan (CP), initiated 05/12/23, included a focus that the resident has a POLST [Physician Orders for Life Sustaining Treatment - a form that enables patients to indicate their preferences regarding life-sustaining treatment], with an intervention to keep family informed of changes in condition.</p> <p>A review of the Progress Notes (PN) reflected the following:</p> <p>On 10/14/23 at 11:44 AM, temperature (temp) 99.2, covid swab negative, will continue to monitor, and call PMD [primary medical doctor] for changes. There was no evidence that the resident's family was notified.</p> <p>On 10/14/23 at 23:50 [11:50 PM], temp 100.6 at 6:25 PM, Tylenol 650mg [milligrams] given, rechecked temp 99.1, the physician was informed of the fever, lung sounds diminished, and the negative rapid covid swab. New physician orders were received for a urinalysis, urine culture, chest x-ray and lab work. There was no evidence that the resident's family was notified.</p> <p>10/15/23 at 15:03 [3:03PM], the resident had a low-grade temp, the physician was made aware of the recent chest x-ray results and a new order for Ceftin (an antibiotic) 250mg PO [by mouth] for seven (7) days was obtained. At that time, the resident's family was made aware of the resident's status.</p> <p>The PN revealed the resident had a change in condition on 10/24/23 at 11:44 AM, but the resident's representative was not notified until 10/15/23 at 3:03 PM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/20/24 at 09:40 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA). The DON stated that the family should be notified in real time of any change in condition. She stated that if there was no answer then the nurses should follow up with another phone call to assure the family was notified. The DON further stated after the nurses called the resident's representative, the nurse should document it in the PN.</p> <p>On 05/20/24 at 10:32 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) for the 2nd floor Starlight Unit who stated that families were notified of any changes as they occurred. She stated that if a resident was started on an antibiotic, then the family would be notified. She then explained the family would be notified for any change in condition and if the physician ordered anything. The LPN/UM stated that she would notify the resident's representative in real time of any change in condition. She stated if something occurred during the late hours/early morning, the nurses should not wait until the afternoon or the next day to notify the family. The LPN/UM stated that it was important to keep the family aware of any significant changes that occurred with the resident.</p> <p>On 05/21/24 at 10:29 AM, the surveyor and the DON reviewed the PN in the electronic medical record (EMR) which revealed the resident's representative was not notified of the change in condition until 10/15/23 at 3 PM. The DON acknowledged the family should have been notified on 10/14/23 or 10/15/23 in the morning, and not on 10/15/23 in the afternoon.</p> <p>A review of the facility's Notification policy, updated 1/2024, included, 3. The Nurse/Supervisor/Charge Nurse will notify the resident's family or representative when: 2. There is a significant change in the resident's physical, mental, or psychosocial status. 6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>NJAC 8:39-13.1(c)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>43936</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to keep a resident's room clean by placing a soiled incontinence brief in a garbage receptacle without a bag liner, leaving used disposable gloves on the floor, and not emptying a closed-lid garbage receptacle with exposed personal protective equipment.</p> <p>The deficient practice effected 2 of 7 residents (Resident #22 & #57) and was evidenced by the following:</p> <p>On 05/20/2024 at 12:09 PM, while visiting Resident #22 in his/her room, the surveyor observed a soiled incontinence brief in the garbage receptacle adjacent to his/her bed. The receptacle did not have a bag liner in it. The surveyor also observed a pair of inside-out disposable gloves on the floor.</p> <p>On 05/21/2024 at 08:42 AM, while outside of the same room, the surveyor observed the closed-lid garbage receptacle overflowing with yellow, disposable, protective gowns. The surveyor also observed a disposable glove and a piece of paper-like product on the floor near Resident #57's bed.</p> <p>On 05/21/2024 at 09:33 AM, during an interview with the surveyor, a family member confirmed that the trash receptacle was emptied by the family at least one time a day.</p> <p>On 05/21/2024 at 11:20 AM, during an interview the surveyor, the Environmental Services Supervisor (ESS) stated that trash bags were removed daily and as needed from resident rooms. Secondly, he confirmed that housekeeping was responsible for removing them during their shift. Thirdly, the ESS confirmed that soiled briefs should not be placed in resident garbage cans and that the trash receptacles should have bag-liners. At that time, the surveyor showed the ESS a photo of the trash receptacle with the soiled brief and the ESS confirmed that it was not okay. Lastly, after viewing the photo of the overflowing closed-top trash receptacle, the ESS confirmed that it was not okay.</p> <p>On the same date at 12:43 PM, during an interview with the surveyor, the [NAME] President of Clinical Services replied, No when the surveyor asked if soiled incontinence briefs should be placed in a resident's trash can, especially without a bag liner.</p> <p>A review of the undated facility-provided policy titled, Routine Cleaning and Disinfection revealed under, Policy that, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.</p> <p>NJAC 8:39-31.4 (a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>33106</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to a.) provide services according to the resident's communication needs documented on the Care Plan (CP) and b.) update the CP to accurately reflect the communication needs for 1 of 1 resident (Resident #24) evaluated for communication.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the Admission Record, Resident #24 was admitted to the facility with the diagnoses, which included but were not limited to, depression and unspecified dementia with other behavior disturbances.</p> <p>The quarterly Minimum Data Set (MDS), an assessment that facilitates resident care, dated 03/04/24, indicated that Resident #24 was sometimes understood, and ability was limited to making concrete request. The MDS also indicated that the resident responded to simple direct communication, however able.</p> <p>On 05/15/24 at 10:56 AM, the surveyor observed Resident #24 sitting in his/her wheelchair. The resident's call bell was observed in reach of the resident's right hand. The resident was unable to communicate with the surveyor and mumbled words. The resident was able to shake his/her head yes or no when the surveyor asked direct questions, however, the resident's speech was slurred and difficult to understand. The surveyor did not observe any communication devices in the resident's room to assist with communication.</p> <p>On 05/16/24 at 09:54 AM, the surveyor observed Resident #24 sitting up in his/her wheelchair. The resident was unable to communicate with the surveyor and the surveyor did not observe a communication board or device to enhance communication in the resident's room. At that time, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the resident was able to shake his/her head yes or no, however, the CNA was not sure how reliable the resident was. The CNA stated that the resident did not have a communication device in his/her room and added that she was not sure if the resident ever had a communication tablet because she has not seen one utilized before.</p> <p>The surveyor reviewed the resident Care Plan dated 08/28/23, which revealed that Resident #24 had difficulty communicating related to the resident having slurred or mumbled words. The interventions included:</p> <ul style="list-style-type: none"> -Participate in Speech Therapy (ST) maintenance program one time per week. -Restorative Communication Program utilizing the communication tablet. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/16/24 at 10:06 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that Resident #24 was able to communicate his/her needs and wants and explained that the staff would ask the resident questions and the resident would shake his/her head yes or no. The surveyor asked the LPN if there were any communication devices that the resident or staff utilized that assisted the resident in communicating his/her needs and wants and the LPN stated, not that she was aware of.</p> <p>On 05/16/24 at 11:08 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that Resident #24 was able to communicate his/her needs and wants by shaking his/her head yes or no. The surveyor asked the LPN/UM if the facility provided the resident with any communication devices so that the resident was better able to express needs and the LPN/UM stated that the resident did not utilize a communication device. The LPN/UM reviewed Resident #24's Care Plan in the presence of the surveyor and the LPN/UM stated that the even though the CP indicated that that the resident utilized a communication tablet and was on a Restorative Nursing program to address communication needs, the resident did not use a tablet or receive Restorative Nursing. She stated that she would find out who implemented those interventions on the CP. The LPN/UM further stated that CPs were updated frequently and that she was not sure why these interventions were still on the CP since August of 2023.</p> <p>On 05/16/24 at 11:16 AM, the surveyor interviewed the Speech Language Pathologist (ST) who stated she had been employed in the facility since July 2023. The ST stated that she was not familiar with Resident #24 and had not received any referrals regarding the need for a communication device or restorative ST once a week. The ST stated that she had not worked with Resident #24 regarding cognition or communication needs.</p> <p>On 05/17/24 at 10:31 AM, the surveyor interviewed LPN #2 who stated that Resident #24 was non-verbal and dependent on staff for his/her care. She stated that the resident would sometimes shake his/her head and nod but not sure how reliable the resident was. LPN #2 stated that she remembered that the resident used to have a tablet in his/her room which was used for communication, however she has not seen it.</p> <p>On 05/17/24 at 11:07 AM, the surveyor interviewed the Director of Nursing (DON) who stated that CPs were tailored to the residents needs, preferences, and goals, and should be updated as needs change. She also added that CPs measure goals to determine if the resident was meeting their goals. She stated that CPs should be accurate because they are a picture of what was currently going on with the resident. She stated that CPs were also utilized as a communication tool so that the staff knew how to care for the resident and what the resident's preferences and goals were. The DON reviewed Resident #24's CP in the presence of the surveyor and stated that she would have to review Resident #24's CP interventions pertaining to: [Participate in Speech Therapy (ST) maintenance program one time per week] and [Restorative Communication Program utilizing the communication tablet]. She stated that she was not sure if these interventions were being provided to the resident or not.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/17/24 at 12:09 PM, the surveyor interviewed the residents Responsible Party (RP) who stated that he was a nurse in the community and that Resident #24 had not utilized a communication tablet in a while due to the residents decline and decrease in the range of motion in his/her hands. He stated that he did not know if the resident had been evaluated neurologically and that the resident's communication was limited. He then stated that it would be a good idea for Resident #24 to be evaluated by ST for a picture communication device or board because maybe it would be helpful in aiding the resident to be able to effectively communicate his/her needs. He stated that he did not know if the resident was evaluated by a ST or not.</p> <p>On 05/20/24 at 09:44 AM, the surveyor interviewed the Director of Rehabilitation (DOR) who explained that restorative programs were developed for residents upon the recommendation of the rehabilitation department. He stated that follow through with the recommendations were done by nursing. The DOR reviewed Resident #24s CP in the presence of the surveyor and stated that it appeared that interventions for Resident #24 to be on a restorative nursing program for communication and communication tablet was implement on 08/28/23, however, the program must have been developed by the Unit Manager on the unit because the resident was never evaluated by speech therapy during the time the interventions were implemented on the CP. The DOR stated that the resident was only screened by ST for dysphasia on 03/04/24 for dysphasia, not cognition or communication needs.</p> <p>On 05/21/24 at 11:04 AM, the surveyor interviewed the LPN/UM who stated that she could not provide the surveyor with any documentation that Resident #24 participated in a ST maintenance program 1x/week or that the resident had a communication tablet.</p> <p>On 05/22/24 at 09:35 AM, the DON stated that the CP should have been updated quarterly to reflect the accurate care the resident was receiving. The DON confirmed that the CP was not an accurate reflection of the communication needs that the resident was receiving.</p> <p>The DOR provided the surveyor with a ST evaluation dated 05/21/24, after surveyor inquiry.</p> <p>The facility policy titled; Communication dated 01/2024 indicated that the facility was to provide necessary supportive services for adaptive communication to help individuals with language skills to express themselves. The policy also indicated that the facility would have knowledge of resident specific communication methods and interventions such as use of communication devices i.e. (communication apps on tablets).</p> <p>The facility policy titled; Care Plans, Comprehensive Person-Centered indicated that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The policy indicated that areas of concern were identified during the resident assessment and would be evaluated before interventions were added to the care plan. The policy also indicated that the resident's care plan would be updated and revised as information about residents and the residents' condition changed. The policy indicated that care plans were updated at least quarterly.</p> <p>NJAC 8:37-27.1 (a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>37547</p> <p>Complaint # NJ169666, NJ170088, NJ167481</p> <p>Based on observation, interview, and review of the medical records and other facility documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner.</p> <p>This deficient practice was identified for 3 of 3 residents (Residents #23, #30 and #12) on 1 of 2 nursing units (Starlight Unit) observed for incontinence care and was evidenced by the following:</p> <p>Refer to F725</p> <p>1.) On 05/20/24 at 9:17 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated the unit census was 42 residents, six (6) aides and three (3) nurses.</p> <p>On 05/20/24 at 9:23 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated that she was assigned to nine (9) residents. CNA #1 further stated that seven of the nine residents that she was assigned to were incontinent and that she still had four incontinent residents left to change.</p> <p>At that time, CNA #1 entered Resident #23's room and requested permission to provide incontinence care to the resident in the presence of the surveyor. The resident who was lying in bed agreed. When interviewed at that time, Resident #23 stated that he/she was changed a couple of hours ago. When CNA #1 pulled back the linens that covered the resident and unfastened the resident's brief, a second brief was noted beneath it that was soiled, but had not soaked through to the outer brief or onto the multiple chux (disposable, absorbent, incontinence pads) that were placed beneath the resident. When the surveyor asked CNA #1 why the resident wore two briefs instead of one, she stated, Either the resident was a heavy wetter or they were short staffed. The surveyor asked if any other residents that she had already changed wore double briefs this morning. CNA #1 stated, yes, [Resident #9] and [Resident #24]. The surveyor asked CNA #1 if she placed two briefs on Resident #9 and Resident #24 when she changed them and she stated, Another aide on the day shift told me to double brief, so I did. CNA #1 further stated that when she last worked at the facility, date unknown, she observed residents that wore two briefs. CNA #1 stated on that date, they were very short staffed and there were only two aides for the whole floor.</p> <p>Review of Resident #23's Admission Record (an admission summary) revealed that the resident was admitted with diagnoses which included, but were not limited to, retention of urine, type 2 diabetes mellitus without complications (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and acquired absence of left leg below knee.</p> <p>Review of Resident #23's Quarterly Minimum Data Set (MDS, an assessment tool) revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was fully cognitively intact. Further review of the MDS revealed that the resident was always incontinent of both bowel and bladder.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #23's Care Plan revealed an entry dated 07/24/23, which indicated that the resident had an ADL (activity of daily living) self-care performance deficit r/t (related to) decreased mobility. Interventions included that the resident required assistance with incontinence care. Further review of the Care Plan revealed an entry dated 05/04/23 and revised 09/07/23, with a focus that Resident #23 had potential risk for pressure ulcer development and skin breakdown Hx (history) of ulcers, immobility, recurrent MASD (moisture-associated skin damage, caused by prolonged exposure to urine, stool, perspiration etc.), inc (incontinent) of B + B (bowel and bladder) with a goal that the resident will have intact skin, free of redness, blisters or discoloration by/through review date. Interventions included teaching resident/family the importance of changing positions for prevention of pressure ulcers. Further review of the Care Plan revealed an entry dated 04/22/24, with a focus that the resident had urine retention with a goal that the resident will be continent at all times through the review date and the resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included cleaning the peri-area with each incontinence episode and encouraging fluids during the day to promote prompted voiding responses.</p> <p>2.) On 05/20/24 at 9:36 AM, CNA #1 entered Resident #30's room and requested permission to provide incontinence care to the resident in the presence of the surveyor. The resident who was lying in bed agreed. The resident was not able to state when they were last changed. When CNA #1 pulled back the linens that covered the resident, three briefs were noted. CNA #1 stated that the resident wet through the first brief and the other two outer briefs were dry. When CNA #1 assisted the resident to turn onto their right side, there were multiple chux noted beneath the resident. CNA #1 stated that the chux that was directly beneath the resident was soaked through with urine. The surveyor asked how it was possible for the two outer briefs to be dry, yet the chux was soaked through. CNA #1 stated, The resident was not properly cared for or changed every two hours. CNA #1 explained that the night shift aides started AM care at 05:00 AM. CNA #1 further stated that when residents wore more than one brief and multiple chux were placed beneath them, it could lead to skin break down.</p> <p>Review of Resident #30's Admission Record revealed that the resident was admitted to the facility with diagnoses which included, but were not limited to, morbid (severe) obesity due to excess calories, aphasia (language disorder) following cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis) following cerebral infarction affecting right dominant side, pressure ulcer of unspecified site, unspecified stage.</p> <p>Review of Resident #30's Quarterly MDS revealed that the resident had a BIMS score of 12 out of 12, which indicated that the resident was cognitively intact. Further review of the MDS revealed that the resident always incontinent of bowel and bladder.</p> <p>Review of Resident #30's Care Plan revealed that the resident had an entry dated 06/13/23 and revised 11/21/23, with a focus that the resident was at risk for pressure ulcer/injury development s/t [sic.] decreased mobility/functional ability, inc. (incontinent) of B + B (bowel and bladder) with a goal that the resident will not develop further skin impairment. Interventions included assisting with making frequent changes in position as per tissue tolerance and comfort level, and avoiding positioning the resident on sacrum for prolonged periods of time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.) On 05/20/24 at 09:44 AM, CNA #1 entered Resident #12's room and requested to provide incontinence care to the resident in the presence of the surveyor. The resident who was lying in bed agreed. When interviewed at that time, the resident stated that he/she was last changed at 05:00 AM, and was not normally changed again until 10:30 AM. The resident wore two briefs, a blue brief that was a size large and a yellow/tan brief that was a size extra large, according to CNA #1. CNA #1 stated that the resident had soaked through the blue brief and then proceeded to change the resident at that time at the resident's request.</p> <p>Review of Resident #12's Admission Record revealed that the resident was admitted to the facility with diagnoses which included, but were not limited to, urinary tract infection, obesity, and sepsis (a serious condition resulting from harmful microorganisms in the blood or other tissues).</p> <p>Review of Resident #12's Quarterly MDS revealed that the resident had a BIMS score of 12 out of 15, which indicated that the resident was cognitively intact. Further review of MDS revealed that the resident was frequently incontinent of urine and always incontinent of stool.</p> <p>Review of Resident #12's Care Plan revealed that the resident an entry dated 07/01/23 and revised 8/9/23, which revealed the resident had potential for pressure ulcer development r/t decreased mobility/functional ability, inc. of B +B, anemia (low hemoglobin level, carries oxygen in the blood) and a goal that the resident will have intact skin, free of redness, blisters or discoloration by/through review date, Interventions included teaching resident/family the importance of changing positions for prevention of pressure ulcers and encouraging small frequent position changes. A second entry, dated 07/01/23 and revised 09/18/23, included a focus that the resident was incontinent of bladder with a goal that the resident will be free of skin breakdown secondary to incontinence through the review date. Interventions included barrier cream to skin every shift and PRN (as needed), monitoring redness or skin breakdown during toileting/incontinence care, and providing discreet and prompt incontinence care to promote resident's dignity.</p> <p>On 05/20/24 at 09:50 AM, the surveyor asked the LPN/UM to accompany her into Resident #30's room. The surveyor asked the LPN/UM if she smelled anything. The LPN/UM stated that she smelled urine. The surveyor asked if it were a strong scent and the LPN/UM stated, Yes. The LPN/UM then pulled back the resident's linens with the resident's permission, and the LPN/UM stated that she saw two briefs, and was unsure if it were a third brief, or a brief liner (used for added absorbency). The LPN/UM stated, This should not be, and that the resident was not properly changed. The LPN/UM further stated that the first brief, liner vs. second brief, and first chux were soaked through. The LPN/UM stated that staff were not allowed to double brief because it could cause skin breakdown. The LPN/UM explained that either the staff did not want to change the resident often, or thought that he/she was a heavy wetter which was not appropriate and was not protocol.</p> <p>On 05/20/24 at 09:58 AM, the LPN/UM and the surveyor entered Resident #23's room with the resident's permission. The resident was washing his/her upper body at that time. The LPN/UM stated that she observed the resident wore two briefs and soaked through the inner brief and outer chux. The LPN/UM stated that this was not acceptable and could lead to skin breakdown.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/20/24 at 10:03 AM during an interview with the LPN/UM, she stated that last night on the 11 PM to 7 AM shift there were three (3) aides for 42 residents, or 14 residents per aide. She stated that residents should have been checked every two hours to see if they needed incontinence care and as needed. The LPN/UM stated that it did not seem that the residents were checked every two hours and she further stated she was surprised by the findings.</p> <p>On 05/20/24 at 10:10 AM, in a follow-up interview with the LPN/UM, she stated that she would not have expected one aide to tell another aide to double brief. The LPN/UM stated it was night time and there was no reason why residents did not get proper care.</p> <p>On 05/20/24 at 10:17 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated she was assigned to Residents #12, #23 and #30. The LPN stated that Resident #30 was a heavy wetter. The LPN explained that residents should be checked to see if they need incontinence care every two hours if the ratios were good. The LPN stated that she would not expect to see double briefing because it was not proper and would lead to skin breakdown. The surveyor asked what it meant if Resident #30 was triple briefed and only the inner brief were wet and the chux that were beneath the resident were soaked through and the LPN stated that it meant that they did not change the resident's chux, only their brief, and skin breakdown could result. The LPN stated that the aides may have done that to minimize the frequency of changes.</p> <p>On 05/20/24 at 10:28 AM, the surveyor interviewed CNA #2 who stated that when two briefs, liners, and multiple chux were used, the resident's skin could not breathe and may breakdown. CNA #2 explained that the facility had small, medium, and large briefs that were mint green, blue, and yellow/tan. The surveyor asked what it meant if the resident wore two or three different size briefs at once and CNA #2 stated that it would not be appropriate to put different sizes on at once because the skin could not breathe. CNA #2 stated that some agency aides double brief, but long-term aides should know better.</p> <p>On 05/20/24 at 10:36 AM, the surveyor asked the LPN/UM to show her the supply room where incontinence products such as briefs and liners were stored. The surveyor asked the LPN/UM to show her a liner, as she previously stated that Resident #30 may have worn a liner in addition to two briefs, rather than three briefs at once. The LPN/UM stated that there were no liners on the cart, only large briefs which were yellow/tan.</p> <p>On 05/21/24 at 9:53 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she began working at the facility in October of 2023. The DON stated aides should round every two hours and that double or triple briefing was never acceptable for a number of reasons, such as dignity. The DON stated that there were no reason to double brief and if the resident was on a diuretic (water pill) then the resident needed to be changed more frequently, not double briefed. The DON stated it was poor practice to double brief and she hoped that it was not the standard at the facility. The DON stated that there were enough aides to round every two hours at night unless there was a last minute call out or no show and that all the residents were in bed, so care should be number one at night.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/21/24 at 10:16 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that his expectation was for their to be constant rounding on all shifts. The LNHA stated that residents should be checked and changed as needed and was not sure if it were every one or two hours. LNHA stated that if double or triple briefing were noted, then he would check with both staff and the resident to identify if there were a resident preference or not. The LNHA stated that if an aide did it, a severe education was done.</p> <p>On 05/22/24 at 9:45 AM, the Director of Nursing provided the surveyor with an undated staff in-service titled, Incontinence Care which revealed the following: Double diapering is not allowed, resident's are to be rounded and checked on every 2 (two) hours or as needed, double diapering can be uncomfortable to the resident and can potentially cause skin impairment.</p> <p>Review of the facility policy, Activities of Daily Living (ADLs), Supporting (Updated 01/2023) revealed the following:</p> <p>Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).</p> <p>Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: .elimination (toileting);</p> <p>NJAC 8:39-27.1(a), 27.2(h)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>41260</p> <p>Complaint # NJ167481, NJ169584</p> <p>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) ensure that an air mattress was accurately set according to the resident's weight, and b.) thoroughly investigate a facility acquired pressure ulcer.</p> <p>This deficient practice was identified for 2 of 3 residents (Resident #131 and #182) reviewed for pressure ulcers and was evidenced by the following:</p> <p>1.) On 05/17/24 at 10:15 AM, the surveyor observed Resident #182 lying in bed asleep. The resident had an air mattress which was set to 280 lbs. (pounds).</p> <p>On 05/20/24 at 9:46 AM, the surveyor observed Resident #182 lying in bed asleep and the resident's air mattress was set to 280 lbs.</p> <p>On 05/21/24 at 9:30 AM, the survey observed Resident #182 lying in bed awake and the resident's air mattress was set to 280 lbs. When asked about the air mattress, the resident stated he/she thought the mattress was not set correctly because he/she could feel a dimple in the mattress on his/her backside. The resident further stated that he/she had a wound, but believed it was healing.</p> <p>According to the Admission Record, Resident #182 was admitted with diagnoses which included, but were not limited to, pressure ulcer of unspecified site, muscle wasting and atrophy, dysphagia (difficulty swallowing), and unspecified severe protein-calorie malnutrition.</p> <p>Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/29/24, included the resident had a Brief Interview for Mental Status score of 13, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident weighed 97 lbs. and had a Stage III pressure ulcer present on admission.</p> <p>Review of the Care Plan, revised 03/28/24, included, the resident has pressure ulcer sacrum, with an intervention to, monitor placement and proper functioning of air loss mattress.</p> <p>Review of the Order Summary Report, as of 05/21/24, included an active physician's order to, monitor alternating airloss mattress for proper placement and functioning, with a start date of 03/30/24.</p> <p>Review of the Wound Consult, dated 05/14/24, revealed the resident had a Stage IV pressure ulcer to the sacrum measuring 3.8 x 2.7 x 0.2 centimeters. Further review of the consult included, the pressure ulcer is to be offloaded using low air loss mattress.</p> <p>Review of the resident's weights, listed in the electronic medical record, revealed the resident weighed 85 lbs. on 05/16/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the surveyor on 05/21/24 at 9:43 AM, the Certified Nursing Assistant (CNA) stated that the nurse was responsible for making sure the air mattress was set to the resident's weight. The CNA further stated that it was important to make sure the air mattress was set correctly to prevent worsening of the wound.</p> <p>During an interview with the surveyor on 05/21/24 at 9:50 AM, the Licensed Practical Nurse (LPN) stated that when a resident needed an air mattress, the nurse would obtain a physician's order for the nurse to check the mattress every shift to ensure the correct weight was set. The LPN further stated that if the air mattress was set to the wrong weight, it could impede healing or worsen the wound.</p> <p>During an interview with the surveyor on 05/21/24 at 10:04 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated the nurses were responsible for checking that the air mattresses were set to the correct weight of the resident. The LPN/UM further stated that the resident's weight determined the pressure of the air mattress and that it was important to ensure it was set correctly to help heal the wound.</p> <p>During an interview with the surveyor on 05/21/24 at 10:16 AM, the Director of Nursing (DON) stated that the nurses were responsible for making sure the weight setting on the air mattress matched the resident's current weight. The DON further stated that the resident's weight determines the appropriateness of the mattress.</p> <p>During a follow-up interview with the surveyor on 05/21/24 at 10:56 AM, the surveyor informed the DON of the incorrect weight setting on Resident #182's air mattress. The DON stated that the nurses should have been monitoring the resident's weight and set the mattress to the correct weight.</p> <p>Review of the facility's Support Surfaces Guidelines policy, updated 01/2024, included, Redistributing support surfaces are to promote comfort for all bed-or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction, and, Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed.</p> <p>2.) The surveyor reviewed the closed record for Resident #131.</p> <p>According to the Admission Record, Resident #131 was admitted with diagnoses which included, but were not limited to, zoster without complications, herpesviral infection, muscle weakness, and dysphagia (difficulty swallowing).</p> <p>Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 08/17/23, included the resident had a Brief Interview for Mental Status score of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed the resident was at risk of developing pressure ulcers/injuries.</p> <p>Review of the admission Progress Note, dated 08/11/23, included comprehensive skin assessment done, and did not indicate that the resident had any pressure ulcers.</p> <p>Review of the admission Nursing Comprehensive Assessment, dated 08/11/23, included a skin assessment, and did not indicate that the resident had any pressure ulcers.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care Plan, initiated on 08/15/23, included, [Resident #131] has potential for pressure ulcer development r/t [related to] decreased mobility/functional ability.</p> <p>Review of the Wound Consult, dated 08/17/23, revealed, Patient c/o [complained of] itching to buttock area. Turned to left side and observed discoloration to right gluteal fold. Further review of the Wound Consult indicated the resident had a deep tissue pressure ulcer to the right gluteal fold measuring 5.0 x 1.0 centimeters and the date of origin was identified as 08/17/23.</p> <p>On 05/17/24, the surveyor requested all incident reports for Resident #131, which the facility was unable to provide.</p> <p>During an interview with the surveyor on 05/21/24 at 9:43 AM, the Certified Nursing Assistant (CNA) stated that if a resident had a new pressure ulcer, she would report it to the nurse and fill out a statement to give the Unit Manager (UM). The CNA further stated that it was important for the facility to investigate facility acquired pressure ulcers to prevent reoccurrence.</p> <p>During an interview with the surveyor on 05/21/24 at 9:50 AM, the Licensed Practical Nurse (LPN) stated that if a resident had a new pressure ulcer, the nurse would notify the supervisor and complete an incident report and obtain statements from the primary nurse and CNAs. The LPN further stated that it was important for the facility to investigate facility acquired pressure ulcers to determine if the wound was preventable or unavoidable.</p> <p>During an interview with the surveyor on 05/21/24 at 10:04 AM, the LPN/UM stated if a resident had a new pressure ulcer, the nurse would complete an incident report and obtain statements from the nurses and CNAs going back 48 hours. The LPN/UM further stated that it was important for the facility to investigate facility acquired pressure ulcers to determine the cause and to develop interventions to promote wound healing or prevent further pressure ulcer development.</p> <p>During an interview with the surveyor on 05/21/24 at 10:16 AM, the Director of Nursing (DON) stated if a resident had a new pressure ulcer, the nurse would complete an incident report and obtain statements from the CNAs. The DON further stated that completed incident reports are given to the DON and that it was important to investigate facility acquired pressure ulcers to determine how the wound was obtained and implement new interventions.</p> <p>During an interview with the surveyor on 05/21/24 at 10:50 AM, the Licensed Nursing Home Administrator verified that the facility did not have any incident reports for Resident #131.</p> <p>During a follow-up interview with the surveyor on 05/21/24 at 10:56 AM, the surveyor informed the DON of the missing incident report for Resident #131. The DON stated that when the wound was discovered, the nurse should have completed an incident report for the facility acquired pressure ulcer.</p> <p>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.).</p> <p>NJAC 8:39-27.1(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>43936</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident receiving enteral feeding received appropriate care and services to prevent complications of enteral feeding, specifically by having the enteral feeding pump running while disconnected resulting in nutritional formula dripping onto the floor, failing to replace the irrigation syringe every twenty-four hours, and failing to clean nutritional formula residue off of the pole supporting the enteral feeding pump.</p> <p>This deficient practice was identified for 1 of 1 resident (Resident #22) investigated for tube feeding and was evidenced by the following:</p> <p>According to the Admission Record, Resident #22 had a diagnosis which included, but was not limited to, Unspecified Severe Protein-Calorie Malnutrition.</p> <p>A review of Resident #22's physician's orders located in the Electronic Medical Record (EMR) revealed an order for Enteral Feed four times a day for prevention of clogging use 225mL (Milliliters) water for flush. Further, the EMR revealed an order that revealed, Enteral Feed in the evening TwoCal HN: Administer continuous via Pump at 35ML per hour for a total volume of 630ml to provide 1,260 kcal/day. Start at 4pm, down when TV [Total Volume] infused. AND every shift Document TV infused daily once feeding completed. The order became active on 04/10/2024.</p> <p>A review of Resident #22's Care Plan located in the EMR revealed a focus that, Res [Resident] is on tube feed via PEG d/t [due to] failure to thrive and low PO [per os; by mouth] intake/poor appetite H/o [History of] sig [significant] wt [weight] fluctuations. The focus was initiated on 04/23/2023.</p> <p>On 05/15/2024 at 11:19 AM, Surveyor #1 observed Resident #22 in bed. At that time, the surveyor observed that the enteral feeding pump was running and the tubing was disconnected from the resident and instead, wrapped around the enteral feeding pump with nutritional formula dripping on the floor.</p> <p>On the same date at 11:46 AM in the presence of Surveyor #1, the Licensed Practical Nurse/Unit Manager (LPN/UM) observed the enteral feeding tube disconnected from the resident and dripping on the floor. At that time, the LPN/UM confirmed the enteral feeding tube should have been connected to Resident #22.</p> <p>On 05/20/2024 at 12:09 PM, Surveyor #2 observed residual formula dried on the base of the pole that held the enteral feeding pump. The surveyor also observed an irrigation syringe (needleless syringe used to infuse fluids into an indwelling tube connected to the resident) on the bedside table. The date on the irrigation syringe package revealed a handwritten date of 5/19/24 indicating when the irrigation syringe was opened.</p> <p>On 05/21/2024 at 08:42 AM, while in Resident #22's room, Surveyor #2 observed the same irrigation syringe located on the bedside table. Again, the date on the irrigation syringe package revealed a handwritten date of 5/19/24 indicating when the irrigation syringe was opened.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On the same date at 09:02 AM, during an interview with Surveyor #2, the Licensed Practical Nurse said the irrigation syringes are to be changed every twenty-four hours.</p> <p>On the same date at 12:43 PM, during an interview with Surveyor #2, the [NAME] President of Clinical Services (VPCS) replied, Daily when the surveyor asked when should the syringe be replaced. Secondly, the VPCS replied, No, when Surveyor #2 asked if nutritional formula should ever be running while disconnected from the resident.</p> <p>A review of the facility provided policy titled, Enteral Nutrition updated 1/2024 revealed under Policy Statement that, Adequate nutritional support through enteral feeding will be provided to residents as ordered.</p> <p>NJAC 8:39-27.1</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547</p> <p>Complaint #: NJ 169584, 169666, 169916, 167481, and 170088</p> <p>Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure there was sufficient nursing staff on a 24-hour basis in accordance with the facility assessment to a.) maintain the required minimum direct care staff-to resident ratios as mandated by the State of New Jersey, b.) provide appropriate incontinence care to dependent residents (Resident #12, #23 and #30), c.) provide residents with scheduled showers (Resident #45), and d.) prevent the increase of falls for (Resident #9, #56, #232, #233, #234, #235, #236, #237, #238, #241 and #242).</p> <p>This deficient practice was identified for 6 of 6 residents and 9 of 9 closed records reviewed, affected all residents on 2 of 2 units, and was evidenced by the following:</p> <p>Refer to F677</p> <p>1.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, Compliance with N.J.S. A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift.</p> <p>One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>1. For the week of Complaint staffing from 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows:</p> <p>-09/10/23 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-09/11/23 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-09/12/23 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs.</p> <p>-09/13/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.</p> <p>-09/15/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-09/16//23 had 6 CNAs for 87 residents on the day shift, required at least 11 CNAs.</p> <p>2. For the 2 weeks of Complaint staffing from 12/24/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <p>-12/24/23 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs.</p> <p>-12/25/23 had 6 CNAs for 87 residents on the day shift, required at least 11 CNAs.</p> <p>-12/26/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.</p> <p>-12/27/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.</p> <p>-12/28/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.</p> <p>-12/29/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs.</p> <p>-12/30/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs.</p> <p>-12/31/23 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs.</p> <p>-01/01/24 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs.</p> <p>-01/02/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs.</p> <p>-01/03/24 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs.</p> <p>-01/04/24 had 7 CNAs for 94 residents on the day shift, required at least 12 CNAs.</p> <p>-01/05/24 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs.</p> <p>-01/06/24 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs.</p> <p>3. For the 2 weeks of staffing prior to survey from 04/28/2024 to 05/11/2024, the facility was deficient in CNA staffing for residents on 9 of 14-day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows:</p> <p>-04/28/24 had 6 CNAs for 76 residents on the day shift, required at least 9 CNAs.</p> <p>-05/01/24 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs.</p> <p>-05/03/24 had 7 CNAs for 76 residents on the day shift, required at least 10 CNAs.</p> <p>-05/04/24 had 8 CNAs for 78 residents on the day shift, required at least 10 CNAs.</p> <p>-05/05/24 had 8 CNAs for 82 residents on the day shift, required at least 10 CNAs.</p> <p>-05/06/24 had 8 CNAs for 82 residents on the day shift, required at least 10 CNAs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-05/08/24 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs.</p> <p>-05/10/24 had 7 CNAs for 82 residents on the day shift, required at least 10 CNAs.</p> <p>-05/10/24 had 4 CNAs to 10 total staff on the evening shift, required at least 5 CNAs.</p> <p>-05/11/24 had 7 CNAs for 79 residents on the day shift, required at least 10 CNAs.</p> <p>On 5/21/24 at 12:05 PM, the surveyor interviewed the facility Staffing Coordinator (SC) regarding staffing. The SC was able to verbalize the regulation regarding CNA to resident staffing ratios. The SC stated the facility did its best to follow the regulation.</p> <p>On 05/22/24 at 09:10 AM, the surveyor interviewed the Director of Nursing (DON) and the Registered Nurse/Vice President of Clinical Services (RN/VPCS) regarding staffing. The DON stated that the facility attempted to follow the CNA staffing guidelines. The DON stated that the facility scheduled staffing in accordance with the guidelines. The RN/VPCS stated the facility tried its best to recover from call outs.</p> <p>2.) On 05/20/24 at 9:17 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated the unit census was 42 residents with six (6) aides and three (3) nurses.</p> <p>On 05/20/24 at 9:23 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated that she was assigned to nine (9) residents that morning. CNA #1 stated that seven (7) of the 9 residents that she was assigned to were incontinent. CNA #1 further stated that she still had four (4) incontinent residents still left to do.</p> <p>At that time, CNA #1 entered Resident #23's room and requested permission to provide incontinence care to the resident in the presence of the surveyor. The resident who was lying in bed agreed. When interviewed at that time, Resident #23 stated that he/she was changed a couple of hours ago. When CNA #1 pulled back the linens that covered the resident and unfastened the resident's brief, a second brief was noted beneath it that was soiled, but had not soaked through to the outer brief or onto the multiple chux (disposable, absorbent, incontinence pads) that were placed beneath the resident. When the surveyor asked CNA #1 why the resident wore two briefs instead of one, she stated, Either the resident was a heavy wetter or they were short staffed. The surveyor asked if any other residents that she had already changed wore double briefs this morning. CNA #1 stated, yes, Resident #9 and Resident #24. The surveyor asked CNA #1 if she placed two briefs on Resident #9 and Resident #24 when she changed them and she stated, Another aide on the day shift told me to double brief, so I did. CNA #1 stated that when she last worked at the facility, date unknown, she observed residents that wore two briefs. CNA #1 stated on that date, they were very short staffed and there were only two aides for the whole floor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/20/24 at 9:36 AM, CNA #1 entered Resident #30's room and requested permission to provide incontinence care to the resident in the presence of the surveyor. The resident who was lying in bed agreed. The resident was not able to state when they were last changed. When CNA #1 pulled back the linens that covered the resident, three briefs were noted. CNA #1 stated that the resident wet through the first brief and the other two outer briefs were dry. When CNA #1 assisted the resident to turn onto their right side, there were multiple chux noted beneath the resident. CNA #1 stated that the chux that was directly beneath the resident was soaked through with urine. When asked how it was possible for the two outer briefs to be dry, yet the chux was soaked through, CNA #1 stated, The resident was not properly cared for or changed every two hours. CNA #1 explained that the night shift aides started AM care at 05:00 AM. CNA #1 further stated that when residents wore more than one brief and multiple chux, it could lead to skin break down.</p> <p>On 05/20/24 at 09:44 AM, CNA #1 entered Resident #12's room and requested to provide incontinence care to the resident in the presence of the surveyor. The resident who was lying in bed agreed. When interviewed at that time, the resident stated that he/she was last changed at 05:00 AM, and was not normally changed again until 10:30 AM. The resident wore two briefs, a blue brief that was a size large according to CNA #1 and a yellow/tan brief that was a size extra large. CNA #1 stated that the resident had soaked through the blue brief. CNA #1 then proceeded to change the resident at that time at the resident's request.</p> <p>On 05/20/24 at 09:50 AM, the surveyor asked the LPN/UM to accompany her into Resident #30's room. The surveyor asked the LPN/UM if she smelled anything. LPN/UM stated that she smelled urine. The surveyor asked if it were a strong scent and the LPN/UM stated, Yes. LPN/UM then pulled back the resident's linens with resident permission, and LPN/UM stated that she saw two briefs, and was unsure if it were a third brief, or a brief liner (used for added absorbency). LPN/UM stated, This should not be. LPN/UM stated the resident was not properly changed. LPN/UM state that staff were not allowed to double brief because it could cause skin breakdown. LPN/UM stated that either they did not want to change the resident often, or thought that he/she was a heavy wetter which was not appropriate and was not protocol.</p> <p>On 05/20/24 at 09:58 AM, the LPN/UM and the surveyor entered Resident #23's room with resident permission. The resident was washing their upper body at that time. LPN/UM stated that she observed the resident wore two briefs and soaked through the inner brief and outer chux. LPN/UM stated that this was not acceptable and could lead to skin breakdown.</p> <p>On 05/20/24 at 10:03 AM, during an interview with the LPN/UM, she stated that last night on the 11 PM to 7 AM shift there were 3 aides for 42 residents, or 14 residents per aide. She stated that residents should be checked every two hours to see if they need incontinence care and as needed. LPN/UM stated that it did not seem that the residents were checked every two hours and she further stated she was surprised by the findings.</p> <p>On 05/20/24 at 10:10 AM, in a later interview with the LPN/UM, she stated that she would not have expected one aide to tell another aide to double brief. LPN/UM stated it was night time and there was no reason why residents did not get proper care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/20/24 at 10:17 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated she was assigned to Residents #12, #23 and #30. LPN #1 stated that Resident #30 was a heavy wetter. LPN #4 stated that residents should be checked to see if they need incontinence care every two hours if the ratio were good. LPN #1 stated that she would not expect to see double briefing because it was not proper and was going to lead to skin breakdown. The surveyor asked what it meant if Resident #30 was triple briefed and only the inner brief were wet and the chux that were beneath the resident were soaked through? LPN #1 stated that it meant that they did not change the resident's chux, only their brief and skin breakdown could result. LPN #1 stated that the aides may have done that to minimize the frequency of changes.</p> <p>On 05/21/24 at 9:53 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she began working at the facility in October of 2023. The DON stated aides should round every two hours. DON stated that double or triple briefing was never acceptable for a number of reasons such as dignity #1. The DON stated that there were no reasons to double brief. If the resident was on a diuretic (water pill) then the resident needed to be changed more frequently, not double briefed. The DON stated it was poor practice to double brief and she hoped that it was not the standard here. The DON stated that there were enough aides to round every two hours at night unless there was a last minute call out or no show. Everyone was in bed and care should be number one at night.</p> <p>On 05/21/24 at 10:16 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that his expectation was for there to be constant rounding on all shifts. The LNHA stated that residents should be checked and changed as needed. The LNHA further stated that he was not sure if it were every one or two hours. The LNHA stated that if double or triple briefing were noted then he would check with both staff and the resident to identify if there were a resident preference or not. The LNHA stated that if an aide did it, a severe education was done.</p> <p>43308</p> <p>3. On 05/16/24 at 10:18 AM, the surveyor spoke with the facility's Volunteer Ombudsman (VO) who stated she was last at the facility on 5/13/24 and during her tour there were concerns with staffing. She explained there was a lack of staffing and the resident's needs were not met completely. The VO stated that Resident #45 did not receive their scheduled shower.</p> <p>On 05/16/24 at 11:16 AM, during tour the surveyor observed that Resident #45 was not in their room. A staff member informed the surveyor he/she was currently at the Resident Council meeting.</p> <p>On 05/17/24 at 10:01 AM, the surveyor observed Resident #45 in their room sitting in a wheelchair. Resident #45 stated that their scheduled shower days were Tuesday and Friday during the 3 PM to 11 PM shift. The resident stated that they did not receive a shower last Friday, 5/10/24. When asked why they did not receive their scheduled shower? The resident stated, because of low staffing they did not offer. The resident further stated but they also did not ask. Resident #45 stated the last time they received their shower was on Tuesday, 5/14/24 shower day and was scheduled for today 5/17/24. The resident stated since he/she was able to wash themselves up in the bathroom they had no concerns. Resident #45 then stated but it did happen at least once a month where he/she did not receive their shower.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/17/24 at 10:06 AM, the surveyor interviewed the LPN/UM who stated that the CNAs documented the scheduled showers in the electronic medical record (EMR). She further stated that the nurses documented if the resident refused a shower in the Progress Notes and the nurses also completed weekly skin assessments on shower days.</p> <p>A review of the shower schedule for the 2nd floor the Starlight Unit reflected Resident #45 scheduled shower days were Tuesday/Friday 3PM to 11PM.</p> <p>A review of the shower log revealed blanks on Friday, 2/23/24, Friday, 3/29/24, Friday 4/5/24, Friday, 4/12/24, Friday, 5/3/24 and Friday, 5/10/24.</p> <p>A review of the CNA assignment sheet for the 2nd floor the Starlight Unit on 5/10/24 evening shift 3PM to 11:30 PM, revealed a census of 43 with three (3) CNAs but one (1) CNA left the building, and the unit was left with two (2) CNAs. A further review indicated one (1) CNA had 22 residents and the second CNA had 21 residents. Resident #45 was 1 of 22 residents to receive care and 1 of 10 that was scheduled to receive a shower.</p> <p>On 05/20/24 at 10:14 AM, the surveyor interviewed CNA #3 who stated that the scheduled showers were on their assignment sheet, and it indicated the specific days and time for that resident. She stated that they documented in the EMR if the resident received the shower and how they assisted them; if they were independent, set up or full assist. CNA #3 stated they also informed the nurse if the shower was given or if the resident refused. CNA #3 stated that she generally had between seven (7) to nine (9) residents on the day shift. When asked was there a time that was short staffed and she was unable to provide a shower to the resident? She stated she felt she was able to provide care to residents during her shift.</p> <p>On 05/20/24 at 10:23 AM, the surveyor interviewed CNA #2 who stated that this was her second time working at the facility. She stated that both times she had 9 residents for the day shift. CNA #2 stated she felt she had enough time to provide showers and complete care to the residents.</p> <p>On 05/21/24 at 09:31 AM, the surveyor interviewed LPN #2 who stated that the CNA documented in the EMR, and the nurse could access whether a shower was completed under the task tab. She stated that if the resident refused then the nurses document in the EMR, but every week the resident had a skin assessment. LPN #2 stated that if there were blanks then it meant it was not done but that it should be at least a progress note from the nurses documenting that it was either done or refused.</p> <p>On 05/21/24 at 09:38 AM, the surveyor interviewed CNA #4 who stated that she never had 15 residents but knows there are call outs and the facility utilized agency staff. CNA #4 stated she always felt she was able to provide care to the residents as she has been an aide for a long time. She emphasized she rounded on her residents frequently. CNA #4 stated that she documented in the EMR if the resident had a shower and informed the nurse if the resident refused the shower.</p> <p>On 05/21/24 at 09:53 AM, the LPN/UM in the presence of the surveyor reviewed the EMR for the shower for Resident #45. At that time, the LPN/UM stated that it was documented on the Treatment Medication Record (TAR) as the weekly skin assessment for 5/10/24 was completed. She stated that skin assessments were done on shower days. At that time, the LPN/UM stated that she would have to review additional documentation to confirm if the resident receive a shower.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/21/24 at 09:56 AM, during an interview with the surveyor the LPN/UM stated that showers could be a challenge. She explained it was challenging due to staffing. She further explained it could be difficult for staff to provide showers to the residents when they are short staffed.</p> <p>On 05/21/24 at 10:35 AM, the surveyor interviewed the Director of Nursing (DON) who stated that showers were given twice a week. She stated that if a shower was not given on the scheduled shower day, then the practice was for the resident to receive a shower the next morning. At that time, the DON and the surveyor reviewed the shower log. The DON confirmed based on the shower log the resident did not receive a shower on 5/10/24 or the next day 5/11/24.</p> <p>On 05/22/24 at 09:40 AM, the Licensed Nursing Home Administrator (LNHA) confirmed in the presence of the DON, the Licensed Practical Nurse/Infection Preventionist (LPN/IP), the Regional Nurse and the survey team that on the scheduled shower days that were left blank, Resident #45 did not receive a shower.</p> <p>A review of the facility's Bath Shower/Tub updated 3/2024, included, to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation 1. The date and time the shower/tub was performed.</p> <p>4.) On 05/16/24 at 10:18 AM, the surveyor spoke with the facility's Volunteer Ombudsman (VO) who stated she was last at the facility on 5/13/24 and during her tour there were concerns with staffing. The VO informed the surveyor Resident #9 had a recent fall.</p> <p>On 05/16/24 at 11:03 AM, the surveyor observed Resident #9 sitting in a recliner chair wearing oxygen via nasal cannula watching tv. Resident #9 stated he/she fell over the weekend. The resident stated they had no injuries but that their right knee still hurt. The resident stated that they used the call bell, but no one came to assistance, and he/she was trying to get off the commode (portable toilet) because they were sitting so long on the commode. Resident #9 stated the facility was very short staffed and residents had to wait a long time for assistance.</p> <p>A review the Accident/Incident Report for Resident #9 revealed the resident fell on [DATE] during the 7 AM to 3 PM shift. No injuries noted.</p> <p>A review the Accident/Incident Report for December 2023 revealed the following:</p> <ul style="list-style-type: none"> - Resident #233 fell on [DATE] during the 7 AM to 3 PM Shift. - Resident #241 fell on [DATE] during the 3 PM to 11 PM Shift. - Resident #232 fell on [DATE] during the 11 PM to 7 AM Shift. - Resident #56 fell on [DATE] during the 11 PM to 7 AM Shift. - Resident #234 fell on [DATE] during the 3 PM to 11 PM Shift. - Resident #242 fell on [DATE] during the 3 PM to 11 PM Shift. - Resident #235 fell on [DATE] during the 7 AM to 3 PM Shift. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Resident #236 fell on [DATE] during the 7 AM to 3 PM Shift.</p> <p>- Resident #237 fell on [DATE] during the 11 PM to 7 AM Shift.</p> <p>-Resident #238 fell on [DATE] during the 11 PM to 7 AM Shift.</p> <p>No injuries were noted for the above falls.</p> <p>A review of the CNA staffing assignment sheet on the 12/17/23, 7 AM to 3 PM Shift there were 5 CNAs with a census of 49 on the 1st floor. The CNA assigned to Resident #233 had 9 residents.</p> <p>A review of the CNA staffing assignment sheet on the 12/18/23, 3 PM to 11 PM Shift there were 3 CNAs with a census of 49 on the 1st floor. The CNA assigned to Resident #241 had 16 residents.</p> <p>A review of the CNA staffing assignment sheet on the 12/23/23, 11 PM to 7 AM Shift there were 3 CNAs with a census of 40 on the 1st floor. The CNA assigned to Resident #232 had 16 residents.</p> <p>On 05/21/24 at 09:38 AM, the surveyor interviewed CNA #4 who stated today 5/21/24 she had 7 residents but sometimes she had 9 to 10 residents on the day shift. CNA #4 stated that she never had 15 residents but knows there are call outs and they utilize agency staff. When asked did she recall a lot of falls occurring? She stated she did not recall a lot of falls, but that there were only a few residents that fell sometimes.</p> <p>On 05/21/24 at 09:56 AM, the surveyor interviewed the LPN/UM regarding the number of falls. The LPN/UM stated that they had a lot of falls but do not believe it was related to staffing. The LPN/UM emphasized in the past week they have gotten better with the number of falls.</p> <p>On 05/21/24 at 10:41 AM, the surveyor interviewed the DON who stated that on paper staffing was sufficient based on the ratios but that they did get call outs. She stated that the call out have gotten better and they try to get enough coverage for the shifts. When asked about the number of falls the DON stated she conducted a fall tracking log and that and the number of falls have decreased. She stated there were more falls in the winter but does not think it was related to staffing.</p> <p>On 05/22/24 at 9:45 AM, the DON provided the surveyor with an undated staff in-service titled, Incontinence Care which revealed the following: Double diapering is not allowed, resident's are to be rounded and checked on every 2 (two) hours or as needed, double diapering can be uncomfortable to the resident and can potentially cause skin impairment.</p> <p>Review of the facility policy, Activities of Daily Living (ADLs), Supporting (Updated 01/2023) revealed the following:</p> <p>Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).</p> <p>Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: .elimination (toileting)</p> <p>A review of the facility's the policy, Staffing, update, did 1/2024. The policy statement indicated that the facility provides sufficient members of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the Facility Assessment.</p> <p>The facility Assessment Tool dated 08/18/2017 B.) Staffing RNs, LPNs, CNAs, PTs reflected the We provide adequate staff to meet it's resident needs, preferences and routines. This includes services of a registered nurse for a least eight (8) consecutive hours a day, 7 days a week, a designated licensed nurse to serve as a charge nurse on each tour of duty and adequate staffing on each shift to ensure that our residents' needs are met by registered and licensed nursing staff, certified/state tested assistants, and other support services that include, but not limited to, dietary, activities/recreational, social, therapy, and environmental services. The facility tries to maintain and meet the state required minimum ratios.</p> <p>We listen to reviews and provide adequate staffing based on census, acuity, and diagnoses of out resident population commensurate to their needs.</p> <p>NJAC 8:39-25.2 (a); 27.1(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>44833</p> <p>Based on observation, interview, and pertinent record review, it was determined that the facility failed to ensure the accountability of the Narcotic Shift Count logs were completed in accordance with facility policy and accurately account for and document the administration of controlled medications.</p> <p>This deficient practice was identified on 2 of 3 medication carts and was evidenced by the following:</p> <p>On 05/16/24 at 11:44 AM, during medication storage observations, the surveyor, in the presence of Licensed Practical Nurse #1 (LPN #1), observed the controlled substances inventory and count logs for the Seabreeze nursing unit's medication Cart 3. The following was observed: Narcotic Shift Count log for May 2024 was missing a nursing signature for:</p> <ul style="list-style-type: none"> -05/03/24 11 PM - 7 AM shift going off duty nurse -05/04/24 3 PM - 11 PM shift going off duty nurse -05/06/24 11 PM - 7 AM shift going off duty nurse -05/07/24 11 PM - 7 AM shift coming on duty nurse -05/07/24 7 AM - 3 PM shift going off duty nurse -05/09/24 11 PM - 7 AM shift going off duty nurse <p>At that time, LPN #1 confirmed that there should be no missing signatures for the shift change narcotic count log, and that the signature indicated that the incoming and outgoing nurses have counted and reconciled the controlled substances in the medication cart at the change of shift.</p> <p>On 05/16/24 at 12:18 PM, during medication storage observations, the surveyor, in the presence of LPN #2, observed the controlled substances inventory and count logs for the Starlight nursing unit's medication Cart 1. The following was observed: Narcotic Shift Count log for May 2024 was missing a nursing signature for:</p> <ul style="list-style-type: none"> -05/01/24 11 PM - 7 AM coming on duty and going off duty nurse -05/04/24 7 AM- 3 PM coming on duty nurse <p>At that time, LPN #2 acknowledged that there should be no missing signatures for these dates and times, and that the incoming nurse and outgoing nurse should count the narcotics and sign the log together at the change of shift.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor along with LPN #2 continued review of the logbook and the individual narcotic declining inventory logs. At that time, LPN #2 indicated to the surveyor that she had administered the ordered 9:00 AM alprazolam 0.25 milligrams (mg) (a narcotic used to treat anxiety) to Resident #44 that day and failed to sign the narcotic out on the declining inventory sheet. LPN #2 was able to show that she signed the medication out in the resident's electronic Medication Administration Record (MAR) but did not sign it out in the narcotic log.</p> <p>On 05/20/24 at 11:15 AM, the surveyor interviewed the Director of Nursing (DON) who stated that there should never be any missing signatures or documentation on the narcotic shift count log, and that the incoming and outgoing nurses should be counting the narcotics and signing the log together in real time. The DON further stated that the declining inventory log should be updated and filled out by the administering nurse at the time of dispensing an ordered narcotic to a resident and not wait to fill it out later.</p> <p>Review of the facility's Controlled Substance policy updated 3/2024 included but was not limited to: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. 4. If the count is correct, an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance . 9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.</p> <p>NJAC 8:39-29.7(c)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>33106</p> <p>Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to provide a gradual dose reduction (GDR) of psychoactive medication (mood altering drug) in the absence of targeted behaviors and obtain a psychiatric consult for the use of a psychotropic medication.</p> <p>This deficient practice was identified for 1 of 5 residents (Resident #24) reviewed for unnecessary medications and was evidenced by the following:</p> <p>According to the Admission Record, Resident #24 was admitted to the facility with diagnoses which included, but were not limited to, depression and unspecified dementia with other behavior disturbances.</p> <p>The quarterly Minimum Data Set (MDS), an assessment that facilitates care, dated 03/04/24, indicated that Resident #24 was sometimes understood, and ability was limited to making concrete request. The MDS also indicated that the resident responded to simple direct communication however able. The MDS reflected that the resident was taking psychotropic medications and was not exhibiting behaviors. The MDS also reflected that the resident had received psychotropic medications and that the physician had not documented that a GDR was clinically contraindicated or attempted.</p> <p>On 05/15/24 at 10:56 AM, the surveyor observed Resident #24 sitting in the wheelchair. The resident's call bell was observed in reach of the resident's right hand. The resident was unable to communicate with the surveyor and mumbled words. The resident was able to shake his/her head yes or no when the surveyor asked direct questions, however, the resident's speech was slurred and difficult to understand.</p> <p>On 05/17/24 at 11:20 AM, the surveyor reviewed Resident #24's electronic medical record (EMR) which revealed the following information:</p> <p>The physician orders audit report (PO), dated 03/27/23, indicated that the resident was to receive, Seroquel [antipsychotic medication] 25mg Give 1 tablet by mouth one time a day for dementia with behavioral disturbance.</p> <p>The surveyor reviewed the facility Monthly Psychotropic Review (MPR) forms dated 06/2023 through 04/2024, which indicated that the resident was on Seroquel 25mg for dementia with behavior disturbance. The forms also indicated that the resident's behaviors were identified as babbling and yelling. Upon review of the MPR forms there was no documentation that the resident had any episodes of these behaviors from 06/2023 to 04/2024.</p> <p>The surveyor could not locate documentation in the EMR that a GDR was attempted in the absence of behaviors. The surveyor could not locate documentation of the resident exhibiting any behaviors and there was no documentation that the resident was evaluated by a psychiatrist.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Pharmacy Consultant (PC) monthly review dated 03/18/2024 indicated that the antipsychotic medication Seroquel 25mg daily would continue as per the Nurse Practitioner.</p> <p>On 05/20/24 at 09:03 AM, the surveyor interviewed the Director of Nursing (DON) and requested that the DON provide any consults from the facility psychiatrist. The DON stated that Resident #24 was never seen by the facility psychiatrist and that the psychotropic medications were managed by the resident's primary care physician. The DON stated that Resident #24 had the diagnosis of encephalopathy and had been on the antipsychotic medication Seroquel for years for behaviors such as screaming out at times. The DON had no explanation as to why there was no documentation of behavior monitoring or psychotropic medication monitoring for Resident #24.</p> <p>On 05/20/24 at 09:20 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that she had been employed through the agency. The CNA stated that she provided care to Resident #24 and was not informed that the resident exhibited any behavior. The CNA stated that that the resident had not have any behaviors while she cared for her.</p> <p>On 05/20/24 at 09:24 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she was the resident's primary care nurse. The LPN explained the process of monitoring resident behaviors and stated that behaviors were monitored in the progress notes. She explained that there was not a specific area in the MAR to document behavior monitoring or psychotropic medication monitoring. She stated that the facility did not utilize behavior monitoring sheets. The LPN continued to explain that if a resident was on psychotropic medications, then the resident should be seen by the psychiatrist and that it was important for psychiatrist to examine the resident for appropriate diagnoses, reassessment, and tapering of medication usage. She also stated that the use of psychotropic medication should be documented in the residents Care Plan.</p> <p>On 05/20/24 at 09:33 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that if the resident had behaviors, they were documented in progress notes and monthly psychotic summaries. The LPN/UM stated that Resident #24 had not had any behavior issues in a while and confirmed that there was no documentation in the progress notes or monthly psychoactive notes that the resident had exhibited any behaviors such as yelling, screaming, or hallucinations. The LPN/UM could also not provide documentation of the physician's rationale for not attempting a GDR in the absence of behaviors since 06/2023. The LPN/UM then provided the surveyor with a progress note dated 11/13/23 that reflected that the facility's psychiatrist reviewed Resident #24's medications and recommended that a GDR be attempted, however the NP did not want any medication changes. The LPN/UM explained that the psychiatrist could give recommendations regarding psychotropic medication usage during psych rounds, however the resident was not being following by the psychiatrist.</p> <p>On 05/20/24 at 12:04 PM, the surveyor interviewed Resident #24's primary care physician (PCP) who indicated that he thought that Resident #24 was being followed by the psychiatrist and that the psychiatrist was writing the rationales on why a GDR was not attempted in the last year. He stated that if there was no documentation from the NPs on the rationale of why a GDR was not attempted, he stated he would have a conversation with the NP and would have to try and do better regarding documentation of rationales in the resident's medical record.</p> <p>The facility policy titled; Psychotropic Medication Use dated 01/2024 indicated that residents on psychotropic medications receive a GDR unless clinically contraindicated, in an effort to discontinue these medications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	

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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy titled; Tapering Medications and Gradual Drug Dose Reduction dated 01/2024 indicated that all medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as a gradual dose reduction. The policy indicated that the staff and practitioner would consider tapering as one approach to finding an optimal dose or determining whether continued use of a medication is benefiting the resident. The staff and practitioner would consider tapering under certain circumstances include when the underlying causes of the original target symptoms have resolved. The policy reflected that within the first year after the resident was started on a psychotropic medication the staff or practitioner shall attempt a GDR in two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year an attempt a least annually unless clinically contraindicated.</p> <p>NJAC 8:39-27.1(a)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833</p> <p>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) properly secure medications during medication administration, and b.) properly secure a resident's home supply medications.</p> <p>This deficient practice was identified for 2 of 2 nurses observed during medication administration, and 1 of 1 resident (Resident #28) reviewed for pain management, and was evidenced by the following:</p> <p>1.) On [DATE] at 8:34 AM, during medication administration observation, the surveyor observed Licensed Practical Nurse #1 (LPN #1) prepare to administer medications to Resident #21. After preparing the ordered medications including docusate sodium (a facility stock supply of over-the-counter stool softener), LPN #1 left the bottle of docusate sodium, which contained medication, on top of the locked medication cart in the hallway and proceeded into the resident's room to administer their medications. At 8:38 AM, the LPN returned to the medication cart, at that time the surveyor pointed out the bottle to the LPN. The LPN stated it was not supposed to be left out of the cart, unsecured, and that she didn't mean to, it was behind the gloves, I didn't even see it.</p> <p>On [DATE] at 9:19 AM, during medication administration observations, the surveyor observed LPN #2 prepare and administer medications to Resident #58. After having prepared the ordered medications for the resident, LPN #2 entered the resident's room, leaving the medication cart unlocked in the hallway outside the resident's room. While obtaining the resident's blood pressure prior to administering their medication, LPN #2 acknowledged to the surveyor that she had noticed the cart is unlocked. The LPN continued obtaining the resident's blood pressure and administered their medication before returning to the medication cart. At 9:59 AM, the surveyor interviewed LPN #2 who stated, she was not supposed to leave the medication cart unlocked when not attended.</p> <p>On [DATE] at 11:15 AM, the surveyor interviewed the Director of Nursing (DON) who stated when nurses walk away from the medication cart, even for a second, it should be locked, and medications, even if simply Tylenol should never be left unsecured on top of the medication cart.</p> <p>2.) On [DATE] at 11:15 AM, during initial tour of the facility, the surveyor observed Resident #28 in their room. The resident was out of bed, dressed, and sitting in a wheelchair. As the surveyor entered the resident's room, the resident was observed closing a bottle of pills, which the resident identified as a bottle of his/her own Tylenol. The resident then placed the bottle into the unlockable top drawer of their nightstand table next to the bed. The resident informed the surveyor that the facility is aware that he/she has his/her own Tylenol which is kept in the resident's room.</p> <p>On [DATE] at 12:11 PM, the surveyor observed Resident #28 in their room. The resident showed the surveyor that they have a bottle of Tylenol 650 milligram (mg) tablets as well as an albuterol inhaler (medication used to treat lung disease) in their nightstand drawer, stating the facility lets him/her have it here so I can take it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:01 AM, the surveyor interviewed LPN #2, who stated residents are not to keep medication in their room.</p> <p>On [DATE] at 11:17 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM) who stated residents who self-administer medications should first be assessed and approved by the physician to be able to self-administer. The LPN/UM added that medications, even if self-administered, should be secured, or locked in the DON's office. The LPN/UM stated that there were no residents on that nursing unit that were assessed and approved for self-administering medication or to keep medication in their room.</p> <p>On [DATE] at 11:22 AM, the surveyor and the LPN/UM proceeded to Resident #28's room. The resident was not in their room at that time, the LPN/UM opened the top drawer of the nightstand and observed an albuterol inhaler as well as a container of topical pain relief cream. The LPN/UM stated that the resident should not have that in their room, and that she would speak with the resident and secure the medications.</p> <p>On [DATE] at 11:29 AM, the surveyor interviewed the DON. She stated that resident's medication should not be kept at bedside and should be secured by nursing.</p> <p>Review of Resident #28's admission Minimum Data Set (MDS; a comprehensive assessment tool), dated [DATE], indicated the resident had a Brief Interview of Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment.</p> <p>Further review of the resident's medical record did not indicate the resident was assessed or care planned to self-administer or keep medications at their bedside.</p> <p>Review of the facility's Administering Medication policy updated ,d+[DATE] included but was not limited to: during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide.</p> <p>Review of the facility's Storage of Medication policy updated ,d+[DATE], included but was not limited to: compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.</p> <p>Review of the facility's Self-Administration of Medications policy updated ,d+[DATE] included but was not limited to: any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party . the nursing staff routinely checks self-administered medication ad removes expired, discontinued, or recalled medications.</p> <p>NJAC 8:,d+[DATE].4</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 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>33106</p> <p>Based on observation, interview, and review of facility documentation, it was determined that the facility failed to a.) label, date, and store potentially hazardous foods appropriately to prevent food borne illness and b.) maintain kitchen equipment in a manner to prevent microbial growth.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 05/15/24 at 09:52 AM, accompanied by the Licensed Nursing Home Administrator (LNHA), the surveyor made the following observations in the kitchen during the initial tour:</p> <ol style="list-style-type: none"> 1.) The surveyor observed the can opener blade, shaft, and base of the can opener had sticky brown food particles throughout. <p>The surveyor interviewed the Executive Chef (EC) at that time who stated that the can opener was usually cleaned daily, however, was not cleaned yet.</p> <ol style="list-style-type: none"> 2.) The surveyor observed a large plastic bin of dry rice with scooper left inside the bin. The EC stated that the scooper should not be left inside the bin and removed it. 3.) On a bottom shelf of a preparation table, the surveyor observed a large bin of loose onions, some of the onions were whole and were cut up some cut up, stored uncovered next to a trash can. The EC stated that the onions were usually stored in the fridge and removed the onions. 4.) The surveyor observed on a shelf a bread toaster full of crumbs and debris. 5.) On the bottom shelf of the preparation table, the surveyor observed 3 (three) 25-pound (lb.) tubs of beef base with brown debris all over the top of the lids. 6.) The surveyor observed a 10 lb. box of bacon stored in the with no open date. The plastic that covered the bacon was opened exposing the meat to air. <p>On 05/15/24 10:23 AM, the surveyor interviewed the Regional Food Service Director (RFSD) who accompanied the surveyor and observed the can opener, three 25-lbs tubs of beef base, and opened box of bacon and stated that the beef base lids should be free of debris, onions should not have been stored uncovered next to the trash can, and that bacon should have had an opening date.</p> <p>The facility undated policy titled; Equipment Cleaning) indicated that the toaster should be cleansed with soap and water after each use. The policy also indicated that the can opener shaft should be ran through the dish 3 compartment sink and the base of the can opener and holder should be cleansed with soap and water.</p> <p>The facility undated policy titled; Receiving and Storage indicated that all foods follow the first in, first out method and are dated and labeled.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility undated policy titled; Dry Food Policy indicated that dry product were to be kept in the original packaging or in a tightly covered, clearly labeled containers.</p> <p>NJAC 8:39-17.2(g)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38680</p> <p>Complaint # NJ169584</p> <p>Based on interview, record review, and review of facility documents, it was determined that the facility failed to maintain medical records that were complete by not documenting the completion of medications and treatments for 3 of 22 (Resident #19, #131, and #182) sampled residents.</p> <p>This deficient practice was evidenced by the following:</p> <p>1.) According to the Admission Record (AR), Resident #19 was admitted with diagnoses which included, but were not limited to, end stage renal disease and dependence on renal dialysis.</p> <p>Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/10/24, revealed that Resident #19 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.</p> <p>Review of Resident #19's Order Summary Report (OSR) with active orders as of 05/01/2024, revealed a physician order dated 03/04/2024 for atorvastatin calcium oral tablet give one tablet by mouth at bedtime for HLD (high cholesterol).</p> <p>Review of the May 2024 Medication Administration Record (MAR) revealed the corresponding 03/04/2024 order for atorvastatin was not signed out as completed and left bank on 05/03/2024 and 05/12/2024 at 2100.</p> <p>Review of Resident #19's OSR with active orders as of 05/01/2024, revealed a physician order dated 03/04/2024 for apixaban oral tablet 2.5mg (miligrams) give one tablet by mouth every morning and at bedtime for atrial fibrillation.</p> <p>Review of the May 2024 MAR revealed the corresponding 03/04/2024 order for apixaban. The MAR was not signed out as completed and left bank on 05/03/24 and 05/12/24 at 2100.</p> <p>Review of Resident #19's OSR with active orders as of 05/01/2024, revealed a physician order dated 03/04/2024 for colace oral capsule 100mg give 2 capsules by mouth at bedtime for constipation.</p> <p>Review of the May 2024 MAR revealed the corresponding 03/04/2024 order for colace oral capsule was not signed out as completed and left bank on 05/03/2024 and 05/12/2024 at 2100.</p> <p>Review of Resident #19's OSR with active orders as of 05/1/2024, revealed a physician order dated 03/27/2024 for gabapentin capsule 100mg give one capsule by mouth every 12 hours for nerve pain.</p> <p>Review of the May 2024 MAR revealed the corresponding 03/27/2024 order for gabapentin was not signed out as completed and left bank on 05/03/2024 and 05/12/2024 at 2100.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #19's OSR with active orders as of 05/01/2024, revealed a physician order dated 03/04/2024 for [NAME] oil oral capsule 300mg give one capsule by mouth at bedtime for a supplement.</p> <p>Review of the May 2024 MAR revealed the corresponding 03/04/2024 order for [NAME] oil was not signed out as completed and left bank on 05/03/2024 and 05/12/2024 at 2100.</p> <p>Review of Resident #19's OSR with active orders as of 05/01/2024, revealed a physician order dated 3/26/2024 for nifedical XL oral tablet extended release 24 hour 60mg give one tablet by mouth every 12 hours for hypertension.</p> <p>Review of the May 2024 MAR revealed the corresponding 03/26/2024 order for nifedical was not signed out as completed and left bank on 05/03/2024 and 05/12/2024 at 2100.</p> <p>During an interview with the surveyor on 05/21/2024 at 10:20 AM, the Licensed Practical Nurse (LPN) stated that when administering medications the nurse should document in the MAR once the medications were administered. She stated there should not be blanks in the MAR and if there is a blank, it is presumed that the medication was not given. When LPN and the surveyor reviewed the May 2024 MAR for Resident #19, she acknowledged that there were blanks in the MAR.</p> <p>During an interview on 05/21/24 at 10:52 AM, the Director of Nursing (DON) stated that nurses should document that they have administered medications in the resident MAR. She furthered that if there are blanks in the MAR it means the medication was not given.</p> <p>Review of the facility's Charting and Documentation policy, revised July 2017 and updated 01/2024 included, the following information is to be documented in the resident medical record: b. Medications administered.</p> <p>41260</p> <p>2.) According to the Admission Record, Resident #131 was admitted with diagnoses which included, but were not limited to, zoster without complications, herpesviral infection, muscle weakness, and dysphagia (difficulty swallowing).</p> <p>Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 08/17/23, included the resident had a Brief Interview for Mental Status score of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed the resident was at risk of developing pressure ulcers/injuries.</p> <p>Review of the Care Plan, initiated on 08/15/23, included, [Resident #131] has potential for pressure ulcer development r/t [related to] decreased mobility/functional ability, with an intervention to, Administer treatments as ordered and, if the resident refuses treatment . Document alternative methods.</p> <p>Review of the Wound Consult, dated 08/17/23, revealed, Patient c/o [complained of] itching to buttock area. Turned to left side and observed discoloration to right gluteal fold. Further review of the Wound Consult indicated the resident had a deep tissue pressure ulcer to the right gluteal fold measuring 5.0 x 1.0 centimeters and the date of origin was identified as 08/17/23.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the September 2023 Treatment Administration Record (TAR) included a physician's order, dated 08/24/23, for RIGHT BUTTOCK: apply skin prep to linear erythema prior to application of calazime every day and evening shift. Further review of the TAR revealed the treatment was not signed out as completed and was left blank on 09/07/23 evening shift.</p> <p>Further review of the September 2023 TAR included a physician's order, dated 09/07/23, for RIGHT BUTTOCK: cleanse with NSS [Normal Saline Solution], pat dry, apply Medihoney and cover with CDD [Clean Dry Dressing] daily and PRN [as needed] if soiled every day and evening shift for wound care. Further review of the TAR revealed the treatment was not signed out as completed and was left blank on 09/10/23 evening shift.</p> <p>Review of the October 2023 TAR included a physician's order, dated 10/05/23, for RIGHT BUTTOCK: cleanse with NSS, pat dry, apply Medihoney and cover with CDD daily and PRN if soiled every evening shift for wound care. Further review of the TAR revealed the treatment was not signed out as completed and was left blank on 10/15/23, 10/23/23, and 10/29/23.</p> <p>3.) According to the Admission Record, Resident #182 was admitted with diagnoses which included, but were not limited to, pressure ulcer of unspecified site, muscle wasting and atrophy, dysphagia (difficulty swallowing), and unspecified severe protein-calorie malnutrition.</p> <p>Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/29/24, included the resident had a Brief Interview for Mental Status score of 13, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had a Stage III pressure ulcer present on admission.</p> <p>Review of the Care Plan, revised 03/28/24, included, the resident has pressure ulcer sacrum, with an intervention to, administer treatments as ordered.</p> <p>Review of the Wound Consult, dated 05/14/24, revealed the resident had a Stage IV pressure ulcer to the sacrum measuring 3.8 x 2.7 x 0.2 centimeters.</p> <p>Review of the April 2024 TAR included a physician's order, dated 04/10/24, for, SACRAL WOUND: cleanse with NSS, pat dry. Apply medihoney to wound base followed by light Calcium AG [Alginate] cover with LARGE FOAM drsg [dressing] daily and as needed. Further review of the TAR revealed the treatment was not signed out as completed and was left blank on 04/10/24, 04/17/24, and 04/19/24.</p> <p>Further review of the April 2023 TAR included a physician's order, dated 04/23/24, for SACRAL WOUND: cleanse with NSS, pat dry. Apply medihoney to wound base following by light Calcium AG cover with LARGE FOAM drsg daily and as needed. Further review of the TAR revealed the treatment was not signed out as completed and left blank on 04/26/24 day and evening shifts.</p> <p>Further review of the April 2023 TAR included a physician's order, dated 04/26/24, for SACRAL WOUND: cleanse with NSS, pat dry. Apply collagen to wound base pack loose with saline dampened gauze cover with LARGE abd [abdominal] pad BID [twice a day] and as needed. Further review of the treatment revealed the treatment was not signed out as completed and was left blank on 04/28/24 day shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the May 2024 TAR included a physician's order, dated 04/26/24, for SACRAL WOUND: cleanse with NSS, pat dry. Apply collagen to wound base pack loose with saline dampened gauze cover with LARGE abd [abdominal] pad BID [twice a day] and as needed. Further review of the treatment revealed the treatment was not signed out as completed and was left blank on 05/04/24 evening shift, 05/10/24 evening shift, 05/14/24 day and evening shift, and 05/16/24 evening shift.</p> <p>Further review of the May 2024 TAR included a physician's order, dated 05/16/24, for SACRAL WOUND: cleanse with NSS, pat dry. Apply 1:1 mix of medihoney and collagen sprinkles, calcium alginate and cover with foam dressing daily and PRN. Further review of the TAR revealed the treatment was not signed out as completed and was left blank on 05/17/24.</p> <p>During an interview with the surveyor on 05/21/24 at 9:50 AM, the Licensed Practical Nurse (LPN) stated that nurses sign off treatments in the TAR right after the treatment was completed and that if there was a blank on the TAR, it was considered not done. The LPN further stated that it was important for nurses to document on the TAR so that staff would know the resident was taken care of and the treatment was completed as ordered.</p> <p>During an interview with the surveyor on 05/21/24 at 10:04 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that nurses sign off treatments in the TAR when the treatment was completed and that a blank on the TAR indicated that the nurse did not document the treatment. The LPN/UM further stated that it was important for nurses to document on the TAR to show that the treatment was completed.</p> <p>During an interview with the surveyor on 05/21/24 at 10:16 AM, the Director of Nursing (DON) stated that nurses sign off treatments in the TAR when the treatment was completed and that a blank on the TAR would look like the treatment wasn't completed. The DON further stated that it was important for nurses to document on the TAR to assure the treatment was complete.</p> <p>During a follow-up interview with the surveyor on 05/21/24 at 10:56 AM, the surveyor informed the DON of the blanks on the TARs for Resident #131. The DON stated the nurses should have documenting on the TAR whether the treatment was completed or not.</p> <p>Review of the facility's Charting and Documentation policy, updated 01/2024, included, The following information is to be documented in the resident medical record: . Treatments or services provided, and, Documentation in the medical record will be objective, complete, and accurate.</p> <p>NJAC 8:39-35.2 (d)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49094</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the required members were present during the quarterly Quality Assurance and Performance Improvement (QAPI) Program committee meetings.</p> <p>This deficient practice occurred during 3 of the 4 quarterly QAPI meetings reviewed and was evidenced by the following:</p> <p>On 05/21/2024 at 09:40 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the Quality Assurance Performance Improvement (QAPI) process in the facility. The surveyor reviewed the quarterly QAPI meeting sign in sheets in the presence of the LNHA. According to the quarterly sign in sheets provided by the facility, there was no Infection Preventionist (IP) in attendance at the quarterly QAPI meeting that was held on 04/18/2024. When the surveyor reviewed the sign in sheets for the quarterly meetings, the sign in sheets were missing the Director of Nursing (DON) signature indicating that the DON had not been in attendance for two of the four meetings held on 07/26/2023 and 01/22/2024.</p> <p>The LHNA confirmed with the surveyor that the IP did not sign the sign in sheet for the 04/18/2024 meeting and was not present at the meeting. The LHNA further verified that the DON did not sign the sign in sheet for the 07/26/2023 and 01/22/2024 meeting. The LHNA stated, I thought the DON was present at the 01/22/2024 meeting, but according to the attendance sheet, she was not present.</p> <p>On 05/21/2024 at 11:25 AM, during an interview with the surveyor, the IP stated, I do not believe I was at the April meeting because I was doing wound rounds at that time. The surveyor presented the 04/18/2024 sign in sheet to the IP who confirmed that she did not sign the sign in sheet as she did not attend the meeting.</p> <p>On 05/21/2024 at 11:29 AM, the surveyor interviewed the Director of Nursing (DON) who stated, I did not attend the QAPI meeting on 01/22/2024 because I had to leave early that day.</p> <p>On 05/21/2024 at 12:09 PM, a review of the facility policy and procedure for Quality Assurance and Performance Improvement (QAPI) Program, updated 11/2022 revealed the following under Authority section: 3. The administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements.</p> <p>On 05/22/2024 at 12:35 PM, a review of the facility policy and procedure for Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership, updated 11/2022 revealed the following under Policy Interpretation and Implementation: 6. The following individuals serve on the committee: a. Administrator, or a designee who is in a leadership role; b. Director of Nursing Services; c. Medical Director; d. Infection Preventionist.</p> <p>NJAC 8:39-33.1(b)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>33106</p> <p>Complaint # NJ168787</p> <p>Based on observation, interview, and review of medical records and other pertinent facility documentation, it was determined that the facility failed to a.) follow transmission-based precautions (TBP) to prevent the potential spread of infection by not utilizing personal protective equipment (PPE) for a resident on contact precautions for 1 of 1 resident (Resident #63) reviewed for TBP, b.) obtain a physician's order to include a resident's transmission-based precautions (TBP) for 1 of 3 residents (Resident #182) reviewed for pressure ulcers, c.) maintain a resident's urinary catheter bag off the floor for 1 of 1 resident (Resident #5) reviewed for urinary catheter, and d.) test residents for influenza (flu) in accordance with the Center for Disease Control and Prevention (CDC) guidelines for 5 of 5 residents (Resident #2, #8, #231, #239, and #240) reviewed.</p> <p>This deficient practice and was evidenced by the following:</p> <p>1.) According to the Admission Record, Resident #63 was admitted to the facility with the diagnoses which included but was not limited to; urinary tract infection (UTI), methicillin resistant staphylococcus Aureus (MRSA- infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics) and sepsis (happens when the body's immune system has an extreme response to an infection). The quarterly Minimum Data Set (MDS), a resident assessment tool dated 04/02/24, reflected that Resident #63 had severe cognitive deficits and maximum to dependent assistance with activities of daily living (ADLs).</p> <p>On 05/16/24 at 12:25 PM, the surveyor observed a sign on Resident #63's room which indicated that the resident was on Contact Isolation. The sign also indicated that gloves and isolation gown must be applied before entering the room.</p> <p>On 05/16/24 at 12:30 PM, the surveyor observed a staff member inside Resident #63's room providing the resident with a lunch tray. The staff member was observed not wearing any personal protective equipment (PPE) such as an isolation gown or gloves. There was a sign posted on the resident's doorway which indicated that the resident was on contact isolation and there was a PPE caddy hanging on the resident's door which contained isolation gowns and gloves. The staff member then exited the resident's room, walked down the hallway, retrieved a straw from the nurse that was at the medication cart, then went back into Resident #63's room and did not apply PPE. The staff member then exited out of the resident's room. The staff member utilized alcohol-based hand rub (ABHR) and then went into another resident's room. The staff member then exited the other resident's room, and the surveyor interviewed the staff member. She identified herself as a Certified Nursing Assistant (CNA #1) and stated that she worked at the facility through the nursing agency. She admitted to not reading the sign on the door that the resident was on contact isolation and that she should have donned (applied) an isolation gown and worn gloves while in the resident's room. CNA #1 stated that she had infection control education and that she should have worn the appropriate PPE to prevent the spread of infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The surveyor reviewed the physician's order (PO) dated 05/15/2024 which reflected a PO to maintain the resident on contact isolation precautions (used for patients with diseases caused by microorganisms (bacteria and viruses) that are spread through direct and indirect contact) related to MRSA and Vancomycin Resistant Enterococci (VRE-a bacteria resistant to the antibiotic vancomycin) of the urine.</p> <p>The surveyor reviewed Resident # 63's Medication Administration Record (MAR) which reflected a PO dated 04/18/24, to maintain contact isolation precautions for MRSA and VRE of the urine.</p> <p>The surveyor reviewed the residents Care Plan dated 04/18/24, which reflected that Resident #63 was on contact isolation precautions for MRSA and VRE of the urine.</p> <p>On 05/16/24 at 12:45 PM, the surveyor interviewed the Licensed practical Nurse Unit Manager (LPN/UM #1) who stated CNA #1 should have worn the correct PPE when entering Resident #63's room. She explained to the surveyor that contact isolation meant that a gown and gloves were to be utilized while in the resident's room and while caring for the resident because the resident had VRE of the urine. She stated that it was important to wear the PPE that was required to prevent spread of infection. She indicated that the resident was followed by Infectious Disease physician (ID) and that a culture would have to be obtained prior to the discontinuation of contact isolation.</p> <p>On 05/17/24 at 09:50 AM, the surveyor observed the environmental service (housekeeper) collecting a food tray from another employee inside Resident #63s room. Surveyor observed that the housekeeper was not wearing an isolation gown or gloves inside the resident's room while retrieving a food tray from the other employee. The housekeeper was interviewed that this time and indicated that he thought that the only time that he must wear a isolation gown and gloves was if he was performing direct patient care. The housekeeper admitted that the did not read the sign posted on the resident's door that the resident was on contact isolation and that gown and gloves were to be worn before entering the resident's room. The housekeeper then admitted that the did not know that when a resident was on contact isolation that an isolation gown and gloves were required when in contact with the resident or the resident's environment. He stated that he had infection control education but could not recall transmission-based precaution called contact isolation.</p> <p>On 05/17/24 09:52 AM, the surveyor interviewed a CNA #2 who stated that she had been employed in the facility for 3 years. The surveyor observed this CNA in the Resident #63's room not wearing an isolation gown or gloves. CNA #2 was observed giving the housekeeper Resident #63 food tray to put back on the food tray cart. The surveyor interviewed the CNA who stated that she always entered this resident's room without wearing a gown or gloves to provide meal or retrieve the residents tray after done eating because she was not providing direct resident care. She stated that she thought that she only needed to wear the isolation gown and gloves when she was providing direct resident care. She stated that she had received infection control education and that she should have read the sign completely before she entered the resident's room. Stated it would be important to follow what type of transmission-based precautions (TBP) the resident was on to prevent the spread on infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/17/24 at 10:45 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that she had been in the role of IP for 5 months. She stated that education regarding infection control and TBP was provided annually, and reeducation was provided monthly regarding handwashing and proper application and removal of PPE. She stated that review of TBP was provided to all-staff members in the facility. She stated that it was part of their annual competencies. She explained that staff were educated that Enhanced Barrier Precautions (EBP-a type of TBP) were to be provided for residents with any internal body access such as catheters, wounds, internal tubes etc. She stated that EBP are utilized to protect the residents from staff and cross contamination. The IP continued to explain that staff were educated regarding contact precautions were utilized to prevent the spread of infection from the resident and that gown and gloves were to be utilized while in the resident's room and when in contact with the resident. She stated that isolation gown and gloves must be applied prior to entrance into a resident's room. She stated that signs on the resident's door would indicate as such. She stated that staff were required to follow TBP to prevent the spread of infection.</p> <p>On 05/17/24 at 10:59 AM, the surveyor interviewed the (Director of Nursing) DON who stated that EBP meant that gloves and gown were required for any hands-on contact for a resident with a colostomy, catheter, urostomy and line that contained blood or body fluids. She explained that contact precautions were required for any resident with confirmed infection and gloves and gown were required when in contact with the resident and the resident's environment.</p> <p>The facility policy titled Isolation-Categories of Transmission-Based Precautions dated 03/06/24 indicated that Contact Precautions were implemented for resident's known or suspected to be infected with microorganism that could be transmitted by direct contact with the resident or indirect contact with the resident's environment. The policy indicated that staff and visitors were required to wear gloves and disposable gown when entering the room and prior to leaving the room to avoid touching potentially contaminated environmental surfaces or items in the resident's room.</p> <p>The facility policy titled Isolation-Categories of Transmission-Based Precautions dated 03/06/24 indicated that Contact Precautions were implemented for resident's known or suspected to be infected with microorganism that could be transmitted by direct contact with the resident or indirect contact with the resident's environment. The policy indicated that staff and visitors were required to wear gloves and disposable gown when entering the room and prior to leaving the room to avoid touching potentially contaminated environmental surfaces or items in the resident's room.</p> <p>41260</p> <p>2.) On 05/17/24 at 10:15 AM, the surveyor observed Resident #182's doorway had a sign indicating Enhanced Barrier Precautions, and that staff were required to don PPE for High-Contact Resident Care Activities.</p> <p>On 05/20/24 at 9:30 AM, the surveyor observed the Enhanced Barrier Precautions sign on Resident #182's doorway had been replaced with a sign indicating Contact Precautions, and that staff were required to don PPE prior to entering the resident's room.</p> <p>According to the Admission Record, Resident #182 was admitted with diagnoses which included, but were not limited to, pressure ulcer of unspecified site, muscle wasting and atrophy, dysphagia (difficulty swallowing), and unspecified severe protein-calorie malnutrition.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/29/24, included the resident had a Brief Interview for Mental Status score of 13, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had a Stage III pressure ulcer present on admission.</p> <p>Review of the Care Plan, revised 04/19/24, included a focus of The resident is on IV [intravenous] piperacillin [an antibiotic] r/t [related to] sacral wound, and another focus of, The resident has actual impairment to skin integrity of the sacral region. Both focuses had an active intervention of Enhanced Barrier Precautions, initiated 05/16/24.</p> <p>Further review of the Care Plan revealed at the top of the first page, Strict contact isolation for ESBL/VRE [antibiotic resistant bacteria] of sacral wound, but did not include a date of when it was initiated.</p> <p>Review of the Order Summary Report (OSR), as of 05/21/24, included an active physician's order to Maintain Enhanced barrier precautions, dated 05/16/24. Further review of the OSR revealed there was no physician's order for contact precautions.</p> <p>Review of the Wound Culture lab result, dated 05/17/24, revealed the resident's wound contained multiple organisms including Klebsiella Pneumoniae ESBL positive and VRE. Further review of the lab result included, Contact precautions indicated.</p> <p>Review of the Progress Note, dated 05/17/24, included the Infectious Disease Nurse Practitioner was notified of the culture results and a physician's order was obtained for antibiotic treatment, however, there was no indication that a physician's order for contact precautions was obtained.</p> <p>During an interview with the surveyor on 05/21/24 at 9:43 AM, the Certified Nursing Assistant (CNA #3) stated that she knows which residents are on contact precautions by the sign posted on the resident's door. The CNA further stated that it was important for staff to follow TBP to prevent the spread of infection.</p> <p>During an interview with the surveyor on 05/21/24 at 9:50 AM, the Licensed Practical Nurse (LPN #1) stated that when a resident is placed on TBP, the nurse should obtain a physician's order for the specific type of isolation. The LPN further stated that it was important for staff to follow TBP to prevent the spread of infection.</p> <p>During an interview with the surveyor on 05/21/24 at 10:04 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated that when a resident is placed on TBP, the nurse should obtain a physician's order for the specific type of isolation. The LPN further stated that it was important for staff to follow TBP to prevent the spread of infection.</p> <p>During an interview with the surveyor on 05/21/24 at 10:10 AM, the Licensed Practical Nurse/Infection Preventionist (LPN/IP) stated that nurses would know which residents were on TBP based on the residents' physician's orders. The LPN/IP further stated that it was important for staff to follow TBP to protect the residents and staff from infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the surveyor on 05/21/24 at 10:16 AM, the Director of Nursing (DON) stated that residents on TBP would have a physician's order to specify the type of isolation. The DON further stated that it would be important for staff to follow TBP to prevent the transmission of infection.</p> <p>During a follow-up interview with the surveyor on 05/21/24 at 10:56 AM, the surveyor informed the DON that Resident #182 had a physician's order for Enhanced Barrier Precautions, but the sign on the resident's doorway was for contact precautions. The DON stated that when the resident was placed on contact precautions, the nurse should have obtained a physician's order for contact precautions.</p> <p>Review of the facility's Isolation - Categories of Transmission-Based Precautions policy, updated 03/06/2020, included, Contact precautions may be implemented for residents with known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.</p> <p>44833</p> <p>3.) On 05/15/24 at 11:23 AM, during the initial tour of the facility, the surveyor observed Resident #5 in their room in bed with a CNA assisting the resident with putting on a t-shirt to finish dressing after morning care. The resident had a urinary catheter tube leading from the resident to a urine drainage bag which was observed to be hanging from the frame of the bed without being in a privacy bag and in contact with the floor.</p> <p>On 05/20/24 at 9:35 AM, the surveyor observed the resident in bed. The resident's urine drainage bag for the urinary catheter was observed to be in the privacy bag, hanging from the frame of the bed under the resident, and in contact, resting on the floor. The resident informed the surveyor that he/she had a urinary catheter since January of this year.</p> <p>Review of the Resident #5's Admission Record indicated the resident was admitted to the facility with diagnosis which included but was not limited to metabolic encephalopathy (occurs when problems with your metabolism cause brain dysfunction), alcoholic cirrhosis of the liver, congestive heart failure, and myeloid leukemia (cancer that starts in the blood-forming cells of the bone marrow).</p> <p>Review of the Quarterly Minimum Data Set (MDS) (a comprehensive assessment tool) dated 5/3/24 indicated the resident had a BIMS of 10 out of 15 reflecting moderately impaired cognition and had an indwelling urinary catheter.</p> <p>Review of the physician's Order Summary Report included an order with a start date of 4/26/24 to render Foley catheter care every shift and as needed every eight hours as needed for care, and another order dated 4/26/24 to monitor Foley catheter every shift for signs and symptoms of infection every shift.</p> <p>Review of the resident's Care Plan included, but was not limited to, a focus area for having a urinary catheter, and included interventions for enhanced barrier precautions, and to monitor and report signs and symptoms of urinary tract infections (UTI) to the physician.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/21/24 at 10:48 AM, the surveyor interviewed Certified Nurses Aid 2 (CNA #4), who stated that resident's urinary catheter drainage bags should be hanging from the bed in a privacy bag and not in contact with the floor. She stated this is for infection control purposes and a resident can obtain a UTI if it is on the floor.</p> <p>On 5/21/24 at 10:55 AM, the surveyor interviewed Licensed Practical Nurse (LPN #2) who stated that included with resident's urinary catheter care is to ensure the urine drainage bag is not on the floor at any point and being in contact with the floor could create a risk for infection.</p> <p>On 5/21/24 at 11:24 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM #2) who stated that catheter drainage bags should be in a privacy bag and not on the floor for infection control purposes.</p> <p>On 5/21/24 at 11:33 AM, the surveyor interviewed the Director of Nursing (DON), who stated urine catheter bags should be in a privacy bag, hanging from a non-movable portion of the bed, when the resident is in bed, and not in contact with the floor.</p> <p>Review of the facility's Catheter Care, Urinary policy with an updated date of 1/2024 under the section titled Infection Control, included but was not limited to: be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>43308</p> <p>4.) Reference:</p> <p>Center for Disease Control and Prevention (CDC) Influenza A: Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Facilities. The following guidance for the 2023-2024 influenza season:</p> <p>Influenza Testing - Even if it's not influenza season, influenza testing should occur when any resident has sign and symptoms of acute respiratory illness or influenza-like illness.</p> <p>Center for Disease Control and Prevention (CDC) Influenza A: Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 and Influenza Viruses are Co-circulating:</p> <p>Test any resident with symptoms of Covid-19 or influenza for both viruses.</p> <p>A review of the facility's influenza line list revealed two (2) staff members tested positive for influenza. The first staff member was the Licensed Practical Nurse/Unit Manager (LPN/UM) for the 2nd floor Starlight Unit lasted worked 10/13/23 and tested positive on 10/14/23. A further review of the facility's influenza line list revealed 5 of 5 residents (Resident #2, #8, #231, #239, and #240) were sent to the hospital and tested positive for influenza A.</p> <p>A review of the Progress Notes (PN) reflected the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #2 had a negative rapid covid swab on 10/12/23. A further review indicated on 10/15/23 the resident exhibited respiratory symptoms (ex. cough) and a low-grade temperature (temp) and was sent to the hospital. There was no evidence the resident was tested at the facility for influenza (flu) during the flu outbreak.</p> <p>-Resident #8 had a negative rapid covid swab on 10/12/23. A further review indicated on 10/16/23 the resident exhibited respiratory symptoms and a low-grade temp and was sent to the hospital. There was no evidence the resident was tested at the facility for influenza during the flu outbreak.</p> <p>-On 10/16/23 Resident #231 exhibited signs and symptoms of altered mental status, was vomiting, and was sent to the hospital. There was no evidence the resident was tested at the facility for influenza during the flu outbreak.</p> <p>-Resident #239 had a negative rapid covid swab on 10/12/23. A further review indicated on 10/14/23 the resident started exhibiting respiratory symptoms and a low-grade temp. The resident was started on Tamiflu (an antiviral medicine to treat and prevent the flu) on 10/16/23. The resident was sent to the hospital on 10/17/23. There was no evidence the resident was tested at the facility for influenza during the flu outbreak.</p> <p>-Resident #240 had a negative rapid covid swab on 10/12/23. A further review indicated on 10/19/23 the resident exhibited respiratory symptoms and was sent to the hospital. There was no evidence the resident was tested at the facility for influenza during the flu outbreak.</p> <p>On 05/17/24 at 10:46 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist who stated in the presence of the survey team that she only worked at the facility for 5 months. She stated that anything prior to her start date she did not have access to the files and was unaware. The LPN/IP stated that she provided education annually and if staff needed to be re-educated, she did that as well on anything related to infection control. When asked what was the process for discovering potential infections and outbreaks? The LPN/IP stated typically when we had norovirus (a common and very contagious infection that causes vomiting and diarrhea), we try to isolate to one wing and depending on the floor we isolate per floor. When asked what was the facility's testing policy? The LPN/IP stated they did covid swabs for employees and residents on admission.</p> <p>On 05/17/24 at 11:17 AM, the surveyor interviewed the Director of Nursing (DON) who stated that if a resident was tested for covid-19 or influenza then the nurses would document it in the progress notes.</p> <p>On 05/20/24 at 09:32 AM, the Licensed Nursing Home Administrator stated in the presence of the DON and the surveyor that the Infection Preventionist (IP) in October 2023 left to pursue another position. The LNHA confirmed that the facility was in an influenza (flu) outbreak in October 2023. He stated that the protocol was mandatory masking and isolation precaution were put into place. He further stated that the all the residents were tested for the flu. The surveyor asked when did testing start? The LNHA stated he was not sure when they started testing at the facility.</p> <p>On 05/20/24 at 09:37 AM, the DON stated in the presence if the LNHA and the surveyor that flu season started October 1st and ended in March. The DON stated she did not start until November 2023 but explained they would get guidance from their local Department of Health. She further stated that if a resident was symptomatic then they would test for both covid-19 and flu.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/20/24 at 10:26 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that there was a flu outbreak in October 2023 on the second floor. She stated that during the outbreak they provided prophylactic Tamiflu for the resident unless it was contraindicated by the physician, or if the resident refused. The LPN/UM stated that they were in an outbreak because they had a couple of residents that tested positive for the flu a few days apart. When asked if residents were tested in the facility? The LPN/UM stated they were tested in the facility of the resident exhibited signs and symptoms for covid, the flu or Respiratory syncytial virus, (RSV - a respiratory virus that infects the lungs and breathing passages). She further stated that they would document in the electronic medical record (EMR) that the resident was tested , the results, and the results would also be under the results tab.</p> <p>On 05/20/24 at 10:29 AM, the surveyor continued to interview the LPN/UM. The LPN/UM stated that she remembered Resident #231 was tested for covid, had a chest x-ray, and was placed on an antibiotic. She stated she did not recall if the resident was tested for flu at the facility but knew the resident had tested positive at the hospital. The LPN/UM stated that if it was during the flu season then they would test for the flu. She further stated that October was the beginning of the flu season so confirmed that Resident #231 would also be tested for flu when he/she was tested for covid.</p> <p>On 05/21/24 at 09:34 AM, the surveyor interviewed LPN #2 who stated that during the flu outbreak in October 2023, every staff wore mask, and they did flu swabs on the residents and if tested positive the resident was placed on isolation. LPN #2 stated the residents were also started on prophylactic Tamiflu once they received the physician order.</p> <p>On 05/21/24 at 09:44 AM, during a follow up interview the LPN/UM stated the facility's protocol for an outbreak would be to test the residents for the flu and then they would provide prophylactic Tamiflu. She stated that she was one of the staff members that tested positive, so she was not there during that week. The LPN/UM stated that only if the resident had signs and symptoms, they swabbed the resident. She then stated to her knowledge the facility did not swab the residents for the flu, and that the residents were only offered Tamiflu. The LPN/UM revealed she was unsure if the residents should be swabbed for the flu. She stated if there was a covid outbreak then all residents would get a rapid swab test but that she was not sure if all residents would get swabbed for the flu.</p> <p>On 05/21/24 at 10:26 AM, during a follow up interview the DON stated that if there was a flu outbreak, they would test the residents. She further stated that if the resident exhibited respiratory signs and symptoms then they would test for covid, flu, and RSV. At that time, the DON confirmed the facility did test the residents for covid but not for flu during the influenza outbreak. The DON stated based on the resident exhibiting signs and symptoms she would expect the residents to been tested for both covid and the flu. She stated the 5 residents were not tested at the facility but at the hospital. The DON concluded if the facility was in an outbreak, she would expect all residents to be tested .</p> <p>On 05/22/24 at 09:41 AM, the LNHA stated in the presence of the DON, the Infection Preventionist (IP), the Regional Nurse and the survey team that during the flu outbreak they provided testing and Tamiflu. He stated that the guidance the previous IP and DON received was to provide Tamiflu, the influenza vaccine and to track the symptoms of residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Brick LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Jack Martin Blvd Brick, NJ 08724	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the email provided from the local DOH guidance dated 10/16/23, included the CDC Interim guidance for Influenza Outbreak and the NJDOH [New Jersey Department of Health] also recommended that residents who become symptomatic in the affected unit should be tested and a respiratory panel must be obtained. Tamiflu must be offered to all staff on that unit and all residents. Further guidance to review the influenza management and testing guidance on the CDC.</p> <p>A review of the facility's Influenza, Prevention and Control of Seasonal policy revised 1/2019, included, Surveillance 1. The Infection Preventionist has established procedures for monitoring and reporting influenza activity in the facility.</p> <p>A review of the facility's Outbreak of Communicable Diseases policy reviewed 3/2024, included, 1. An outbreak of most communicable diseases can be defined as one of the following: a. one case of an infection that is highly communicable. c. Occurrence of three (3) or more cases of the same infection over a specific period of time and in a defined area. 4. An outbreak of influenza is defined as anything exceeding the endemic rate, or a single case if unusual for the facility. A single case of influenza is reportable to the Department of Health.</p> <p>NJAC 8:39-19.4 (m)(n), 27.1 (a)</p>