Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315365	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Ocean Grove LLC	160 S Main St Ocean Grove, NJ 07756

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50913 Complaint #: NJ00173104 Based on interviews and record review, as well as a review of pertinent facility documents on 06/27/24 and 06/28/24, it was determined that the facility failed to administer the medications in accordance with the acceptable standard of nursing practice and follow the facility policy on Administering Medications for 2 of 4 sampled residents (Residents#1 and #2), reviewed for medication administrations. This deficient practice was evidenced by the following: 1. According to the ADMISSION RECORD (AR), Resident #1 was admitted with diagnoses including but not limited to Hypertension and Pain. A review of the Minimum Data Set (MDS), an assessment tool dated 04/18/24, revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, indicating that Resident #1 had intact cognition and required assistance with Activity of Daily Living (ADLs). A review of Resident #1's Medication Review Report (MRR) revealed an order for the following: On 4/11/24, Clonidine Tablet 0.1 milligram (mg), give 1 tablet by mouth every 8 hours for Hypertension. On 4/25/24, Gabapentin Oral Tablet, give 400 mg by mouth every 8 hours for Nerve Pain. A review of Resident #1's Medication Administration Report (MAR) for 4/2024 confirmed the medications were scheduled and to be administered as follows: Clonidine Tablet 0.1 mg and Gabapentin Oral Tablet at 6:00 a.m., 2:00 p.m., and 10:00 p.m. A review of Resident #1's Medication Admin Audit Report (MAAR) from 4/1/24 to 4/30/24 indicated that the aforementioned medications were not administered according to the scheduled time. The medications were administered as follows: Clonidine Tablet 0.1 mg was scheduled to be administered at 6:00 a.m., however, it was administered as follows: (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/17/24 at 8:03 a.m. 4/18/24 at 7:45 a.m. 4/19/24 at 8:10 a.m. 4/20/24 at 8:15 a.m. 4/21/24 at 7:51 a.m. 4/22/24 at 7:51 a.m. 4/23/24 at 8:03 a.m. 4/24/24 at 8:07 a.m. 4/25/24 at 8:35 a.m. Clonidine Tablet 0.1 mg was scheduled to be administered at 2:00 p.m., however, it was administered on 4/30/24 at 4:14 p.m. Gabapentin Oral Tablet, give 400 mg by mouth was scheduled to be administered at 6:00 a.m., however, it was administered as follows: 4/17/24 at 8:03 a.m. 4/18/24 at 7:45 a.m. 4/19/24 at 8:11 a.m. 4/20/24 at 8:16 a.m. 4/21/24 at 7:51 a.m. 4/22/24 at 7:52 a.m. 4/23/24 at 8:04 a.m. 4/24/24 at 8:08 a.m. Gabapentin Oral Tablet, give 400 mg by mouth was scheduled to be administered at 2:00 p.m., however, it was administered on 4/30/24 at 4:15 p.m. A review of Resident #1's progress notes (PN) from 4/1/24 to 4/30/24, there was no indication in the PN that the Resident's Primary Care Physician (PCP) was notified that the aforementioned medications were not administered according to the scheduled time. In addition, there was no documented evidence of harm to the Resident from the late administration of medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. According to the AR, Resident #2 was admitted with diagnoses including but not limited to Hypertension and Dermatitis. A review of the MDS dated [DATE], revealed that Resident #2 had a BIMS score of 14, indicating that Resident #2 had intact cognition and required assistance with ADLs. A review of Resident #2's CP, initiated on 5/1/23 and revised on 9/24/23 indicated that Resident #2 had Hypertension. Intervention included but were not limited to give anti-hypertensive as ordered. A review of Resident #2's Order Summary Report (OSR), dated 3/1/24, revealed an order for Cozaar Tablet 25 mg, give 1 tablet by mouth two times a day for Hypertension and Hydroxyzine Tablet 25 mg, give 1 tablet by mouth three times a day for Itching. A review of Resident #2's MAR for the month of 6/2024 confirmed the abovementioned medications were scheduled and to be administered as follows: Cozaar Tablet 25 mg, give 1 tablet by mouth to be administered at 9:00 a.m. and 5:00 p.m. Hydroxyzine Tablet 25 mg, give 1 tablet by mouth to be administered at 9:00 a.m., 1:00 p.m., and 5:00 p.m. A review of Resident #2's MAAR indicated that the abovementioned medications were not administered according to the scheduled time. The medications were administered as follows: Cozaar Tablet 25 mg, was schedule to be administered at 9:00 a.m., however, it was administered as follows: 6/1/24 at 1:45 p.m. 6/2/24 at 11:45 a.m. 6/3/24 at 1:04 p.m. 6/4/24 at 11:39 a.m. 6/6/24 at 11:26 a.m. 6/7/24 at 11:25 a.m. 6/8/24 at 3:10 p.m. 6/11/24 at 12:56 p.m. 6/12/24 at 10:59 a.m. 6/15/24 at 1:08 p.m. 6/18/24 at 11:48 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/23/24 at 10:49 a.m. 6/26/24 at 1:24 p.m. 6/27/24 at 2:38 p.m. Cozaar Tablet 25 mg, was schedule to be administered at 5:00 p.m., however, it was administered as follows: 6/1/24 at 7:21 p.m. 6/3/24 at 9:10 p.m. 6/4/24 at 7:36 p.m. 6/5/24 at 9:02 p.m. 6/6/24 at 11:01 p.m. 6/9/24 at 7:45 p.m. 6/10/24 at 10:38 p.m. 6/11/24 at 11:55 p.m. 6/16/24 at 8:55 p.m. 6/18/24 at 10:19 p.m. Hydroxyzine Tablet 25 mg, give 1 tablet by mouth was schedule to be administered at 9:00 a.m. and 1:00 p.m., however, it was administered follows: 6/1/24 9:00 a.m. given at 1:45 p.m. and the 1:00 p.m. dose at 1:47 p.m. 6/2/24 9:00 a.m. given at 11:42 a.m. and the 1:00 p.m. dose at 2:58 p.m. 6/3/24 9:00 a.m. given at 1:03 p.m. and the 1:00 p.m. dose at 1:03 p.m. 6/4/24 9:00 a.m. given at 11:39 a.m. 6/6/24 9:00 a.m. given at 11:26 a.m. 6/7/24 9:00 a.m. given at 11:25 a.m. 6/8/24 9:00 a.m. and the 1:00 p.m. were given at 3:10 p.m. 6/10/24 1:00 p.m. given at 2:33 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/11/24 9:00 a.m. and the 1:00 p.m. given at 12:56 p.m. 6/15/24 9:00 a.m. and the 1:00 p.m. given at 1:08 p.m. 6/16/24 9:00 a.m. and the 1:00 p.m. given at 12:48 p.m. 6/18/24 9:00 a.m. given at 11:48 a.m. 6/23/24 1:00 p.m. given at 2:56 p.m. 6/26/24 9:00 a.m. given at 1:24 p.m. and the 1:00 p.m. given at 1:24 p.m. 6/27/24 9:00 a.m. given at 2:28 p.m. and the 1:00 p.m. given at 2:37 p.m. A review of Resident #2's PN from 6/1/24 to 6/27/24, there was no indication in the PN that the Resident's PCP was notified that the aforementioned medications were not administered according to the scheduled time. In addition, there was no documented evidence of harm to the Resident from the late administration of medications. During an interview with the Registered Nurse (RN #1) on 6/27/24 at 12:06 p.m., the RN stated that the nurses were to administer the medications according to the schedule, one hour before and one hour after. RN #1 further stated that if the medications were not administered on scheduled time, the nurse was to notify the Doctor and document in the residents' medical records (MR) for continuity of care and to avoid errors. During an interview with the 3rd floor Unit Manager/RN (UM/RN #2) on 6/27/24 at 12:47 p.m., the UM/RN#2 stated that the nurses were expected to administer the medications according to the schedule, one hour before and one hour after. The UM/RN #2 further stated that if the medications were not administered on scheduled time, the nurse was to notify the doctor and document in the residents' (MR). The UM/RN explained that if not documented means it didn't happen, the Doctor was not notified. A review of the facility's policy titled Medication Administrations, dated on 10/2022, revealed Medications shall be administered in a safe and timely manner, and as prescribed .2. Medications must be administered in accordance with the orders, including any required time frame. 3. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified .11. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication will document in medication administration record . NJAC 8:39-29.2 (d)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50913 C #: NJ00173104 and NJ00171706 Based on interviews, medical record review, and review of other pertinent facility documents on 6/27/24 and 6/28/24, it was determined that the facility staff failed to consistently document in the Documentation Survey Report (DSR) the Activities of Daily Living (ADL) status and care provided to the resident according to the facility policy and protocol for 2 of 4 residents (Resident #1 and Resident #3) reviewed for documentation. This deficient practice was evidenced by the following: 1. According to the ADMISSION RECORD (AR), Resident #1 was admitted with diagnoses including but not limited to Muscle Weakness and Encounter for Orthopedic Aftercare Following Surgical Amputation. A review of the Minimum Data Set (MDS), an assessment tool dated 4/18/24, revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, indicating that Resident #1 had intact cognition and required assistance with ADLs. Resident #1's Care Plan (CP) initiated on 4/12/24 and revised on 4/29/24 indicated that Resident #1 had a self-care, toileting and mobility performance deficit related to impaired balance musculoskeletal impairment. The form DSR (ADL Record), dated 4/2024 for completion of ADL under Intervention/Task did not indicate that the rolling left and right, turned and repositioned, and toileting were provided to the Resident on the following dates and time: Rolling Left and Right and Turned and Repositioned, During 7:00 a.m. to 3:00 p.m. shift, on 4/13/24 to 4/30/24. During 3:00 p.m. to 11:00 p.m. shift, on 4/14/24 to 4/26/24, 4/29/24 and 4/30/24. During 11:00 p.m. to 7:00 a.m. shift, on 4/14/24 to 4/17/24, 4/21/24 to 4/23/24, 4/29/24, and 4/30/24. Toileting: During 7:00 a.m. to 3:00 p.m. shift, on 4/21/24 to 4/30/24 During 3:00 p.m. to 11:00 p.m. shift, on 4/21/24 to 4/25/24, 4/27/24, 4/29/24, and 4/30/24. During 11:00 p.m. to 7:00 a.m. shift, on 4/21/24, 4/23/24, 4/29/24, and 4/30/24. 2. According to the AR, Resident #3 was admitted with diagnoses that included but were not limited to: Parkinsonism, Alzheimer's Disease, and Dementia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS, dated [DATE] indicated that Resident #3 was rarely/never understood, indicating severe impairment in cognition and required total assistance from staff with ADLs. Resident #3's CP initiated on 5/1/24 indicated that Resident #3 had limited physical mobility related to contractures and Parkinson's Disease. Interventions included but not limited to: Providing supportive care, assistance with mobility as needed, and document assistance as needed. Review of Resident #3's DSR and PN for the months of 5/2024 and 6/2024, there were no indication that the care was provided on the following dates and shifts which was not according to their policy. The form DSR, dated 6/2024 for completion of ADL under Intervention/Task did not indicate that the bed mobility, turned and repositioned, and toileting were provided to the Resident on the following dates and time: Bed Mobility, Turned and Repositioned, and Toileting: During 7:00 a.m. to 3:00 p.m. shift, on 5/2/24, 5/3/24, 5/9/24, 5/15/24 to 5/28/24, 5/30/24, 5/31/24, 6/01/24 to 6/4/24, and 6/6/24 to 6/13/24. During 3:00 p.m. to 11:00 p.m. shift, on 5/1/24 to 5/4/24, 5/6/24 to 5/9/24, 5/16/24 to 5/31/24, 6/01/24 to 6/4/24, 6/6/24, 6/11/24, and 6/13/24. During 11:00 p.m. to 7:00 a.m. shift, on 5/1/24 to 5/9/24, 5/16/24 to 5/31/24, and 6/1/4 to 6/11/24. During an interview with the surveyor on 6/28/23 at 11:44 AM, the Certified Nursing Assistants (CNA #1), who took care of Resident #3, stated that CNAs are responsible for documenting the ADL care provided into the Point of Care (POC), a mobile-enabled app that runs on wall-mounted kiosks or mobile devices that enables care staff to document activities of daily living at or near the point of care to help improve accuracy and timeliness of documentation, at the end of the shift. CNA #1 explained that the ADLs provided to the residents had to be documented in POC to communicate to other staff that the care was done. During an interview with the surveyors on 6/28/24 at 12:47 P.M., the Unit Manager/Registered Nurse (UM/RN#1), stated that CNAs were responsible for documenting the ADL care provided into the POC. The UM/RN further stated that the CNAs need to document in the DSR even if the care was not provided due to refusal. He explained that the documentation must be completed in the residents' DSR by the end of each shift to show that the care was provided to the residents. Review of the facility policy titled Charting and Documentation, dated 1/2022, reflected POLICY Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record .c. Treatment or services performed . NJAC: 8:39-35.2 (d)(6)