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	02/19/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview, record review, and facility policy review the facility failed to ensure the Notice of Medicare Non-Coverage (NOMNC) included the required information of the name of the QIO (Quality Improvement Organization) and the TTY (teletypewriters) a special telecommunications equipment for the deaf or hard of hearing for three of three residents (Resident (R) 23, R188, and R189.) This failure could prevent a Medicare beneficiary with hearing impairment from being able to file an appeal in a timely manner. Findings include: Review of the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS (Centers for Medicare and Medicaid)-10123 revealed the notice must include .Bullet # 4 Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type. Review of R23's NOMNC revealed it did not contain the name of the Medicare QIO or the TTY as required. R23 was admitted on [DATE] for therapy. He was discharged home with his wife on 01/31/24. His last covered day (LCD) of therapy was 01/30/24. Review of R188's NOMNC with a LCD of 08/10/23, was issued by phone on 08/08/23 to the daughter who handled all of R188's business. The NOMNC did not include the name of the QIO or the TTY number to file an expedited appeal. Resident 188 remained in the facility for long-term care. Review of R189's NOMNC with a LCD of10/13/23, was issued on 10/11/23. The NOMNC did not include the name of the QIO or the TTY phone number to call for an expedited appeal. The resident remained in the facility for long-term care During an interview on 2/14/24 at 11:40 AM with the Director of Social Services (DSS) she stated she was not aware the name of the QIO or TTY number had to be included on the NOMNC. Review of the facility policy, Beneficiary Notice Policy and Procedure dated 2022 revealed, .The NOMNC informs beneficiaries of the right to an expedited review by a Quality Improvement Organization. NJAC 8:39-5.1(a)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 40902 Based on record review, interview and policy review, the facility failed to ensure residents were free from physical abuse for four of six residents reviewed for resident-to-resident abuse (Resident (R) 136, R18, R27 and R139). Findings Include: 1. Review of R27's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia in other diseases classified elsewhere severe, and anxiety disorder. Review of R27's quarterly Minimum Data Set (MDS) assessment under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 12/11/23, revealed a Brief Interview for Mental Status (BIMS), score of 02 out of 15 which indicated severe cognitive impairment. Review of R27's Care Plan, located under the Care Plan tab of the EMR and dated 05/07/23, revealed The resident had impaired cognitive function or impaired thought related to dementia. Impaired decision making and unable to concentrate. Interventions in place were to ask yes or no questions, use resident's preferred name, face the resident when speaking and make eye contact, reduce any distractions, and keep the residents routine consistent. Further review revealed the resident was an elopement and wandered risk due to impaired safety awareness and wandering aimlessly. Interventions in place were identify patterns of wandering, monitor location, wander guard, and provide structured activities. Review of R18's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis, and morbid obesity. Review of R18's quarterly Minimum Data Set (MDS) assessment under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 12/25/23, revealed a Brief Interview for Mental Status (BIMS), score of 15 out of 15 which indicated no cognitive impairment. Review of R18's Care Plan, located under the Care Plan tab of the EMR and dated 06/26/23, revealed The resident was at risk for potential impairment to skin integrity related to fragile skin. Review of a Nurse's Note, in the EMR, written by Registered Nurse (RN) 3 and dated 04/13/23 at 2:09 PM indicated, R18called me in to her room to tell me while had been sleeping, R27 entered her room, took her fly swatter, and began hitting her with it. R18 asked R27 why she did it and she stated, because you are fat. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/24 at 9:30 AM R18 said there was one incident when R27 came into her room and hit her on the arm with a fly swatter. R18 said it happened years ago and she did not think R27 meant to hit her. She said, I think she was trying to wake me up. There was no injury, and it did not hurt. She said she honestly had forgotten about the incident since it was a long time ago. She has not had any other issues with R27. An attempted call on 02/14/24 at 9:30 AM to Certified Nurse Aide (CNA) 3 was unsuccessful and a voice message was left requesting a return call. A return call was not received by the end of the survey. During an interview on 02/14/24 at 9:33 AM RN3 stated the facility completed abuse training annually, and in-services related to abuse throughout the year. She said staff were expected to report any concern to the Director of Nursing (DON) and ensure the resident was safe. She said R27 had advanced dementia and wandered about the facility freely. She said she vaguely remembered the incident that occurred in April 2023 with R18. She did remember that when the incident occurred it was when the staff were attempting a gradual dose reduction (GDR) of her psychotropic medication but R27's behaviors increased and the resumed the medication at the original does. She said that R27 does have on a wander guard and staff supervise throughout the day and there hasn't been another incident with another resident. During an interview on 02/15/24 at 11:23 AM the DON stated the facility completed abuse training quarterly or if there were any new concerns. Staff were expected to notify her, and she would notify the Administrator. She said she was the abuse coordinator. She said she did not remember the 04/13/23 incident between R27 and R18 off hand She could not remember if R27 was able to say why but R27 wore a wander guard and was supervised by staff throughout the day. She said there has not been another incident. During an interview on 02/15/24 at 12:30 PM the Regional Administrator stated his expectation was that residents would be free from abuse. Review of the facilities policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 01/2023, revealed, all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 2. Review of R136's undated Admission Record, located in the Profile section of the EMR, revealed R136 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD) and diabetes mellitus. Review of R136's annual MDS assessment with an ARD of 01/26/23, located in the MDS tab of the EMR, revealed R136 scored 15 of 15 on the BIMS which indicated the resident was cognitively intact. Review of R136's nursing notes, provided by the facility, revealed a note written by Registered Nurse (RN)2 on 03/13/23 at 6:46 PM, which specified, Another resident came into [R136's] room thinking he was in his own room. [R136] told the Resident to, Get out of my room. When he did not listen, [R136] attempted to push the wheelchair out of her room. At that time [R136] was kicked in the right lower leg by the Resident. Family and MD were notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R139's undated Admission Record, located in the Profile section of the EMR revealed R77 was admitted to the facility on [DATE] and had a diagnosis of dementia. Review of R139's quarterly MDS assessment with an ARD of 01/18/23, located in the MDS tab of the EMR, revealed R139 scored nine of 15 on the BIMS which indicated the resident was moderately cognitively impaired. Review of R139's nursing notes, provided by the facility, revealed a note written by RN2 on 03/13/23 at 6:32 PM, which specified, Behavior Note: [R139] entered into another resident's room thinking it was his own room. Became adamant about being in his own room. The other resident attempted to push him out of the room. At this time [R139] kicked the other Resident in the leg. [R139] is now on 1/2 hour behavior checks. During an interview on 02/14/24 at 3:05 PM, RN2 stated she did not recall much about the 03/13/23 incident between R136 and R139. RN2 stated she recalled hearing R136 yelling get out, get out, get out. RN2 stated she responded and found R139 in R136's room and she redirected R139 out of the room. RN2 stated she reported the incident to the DON and did not recall if R136 was injured. Review of the facility's investigation of the 03/13/23 resident-to-resident altercation between R136 and R139 completed by the DON and dated 03/14/23 revealed, On the evening of 03/13/23 at around 4:30 PM, [R139] wheeled himself to the entrance of [R136's] room. [R136] was laying [sic] in bed and got out of bed when [R139] appeared at the entrance of her room. [R136] told [R139] to get out of her room to which [R139] responded this is my room. [R136] and [R139] continued to exchange words. [R136] then attempted to push [R139's] wheelchair out of the doorway and reportedly kicked [R136's] right medial ankle. The two residents were separated. A skin check was immediately performed and a small purpuric area [a rash of purple spots on the skin caused by internal bleeding from small blood vessels] was noted approximately the size of dime on [R136's] right lower leg. During an interview on 02/14/24 at 3:25 PM, the DON stated the facility investigated the 03/13/23 resident to resident altercation between R136 and R139. The DON stated the facility's investigation determined on 03/13/23 as R136 was attempting to remove R139 from her room when R139 kicked R136 in the right lower leg. The DON explained R136 experienced a small, reddened area on her right lower leg as a result of being kicked by R139. During an interview on 02/15/24 at 12:40 PM, the facility's Regional Administrator (RADM) stated it was the facility's expectation for residents to be safe and have an abuse free environment. NJAC 8:39-4.1(a)5 NJAC 8:39-33.2(c)12

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40902 Based on record review, interview and policy review, the facility failed to report resident to resident incident and injury of an unknown origin timely to the state survey agency for three of six incidents reviewed for abuse (Resident (R) R18, and R27). Refer to F600 Findings Include: 1. Review of a Nurse's Note, in the electronic medical record (EMR), written by Registered Nurse (RN) 3 and dated 04/13/23 at 2:09 PM indicated, R18 called me in to her room and stated while she had been sleeping and R27 entered her room, took her fly swatter, and began hitting her with it. R18 asked R27 why she did it and she stated, because you are fat. During an interview on 02/14/24 at 9:33 AM, RN3 stated she became aware of the incident on 04/13/23 at 2:09 PM and reported it to the Director of Nursing (DON). Review of the facility's Investigation Summary revealed the incident occurred on 04/13/23 around 2:30 PM. However, the incident was not reported to New Jersey Department of Health (NJDOH) until 04/14/23 at 12:25 PM. 2. Review of a Nurse's Note, in the EMR, written by Licensed Practical Nurse (LPN) 6 and dated 07/18/23 at 1:46 PM indicated, R27 was found with a bruise to the left wrist measuring about two inches long and one inch wide. R27 stated That a guy grabbed her a statement was received from CNA. The family and nurse practitioner (NP) was made aware. During an interview on 02/14/24 at 12:57 PM LPN 6 stated she became aware of the bruise on R27 wrist on 07/18/23 at 1:46 PM and reported it to the DON and former Administrator. Review of the facility's Reportable Event Record revealed the incident occurred on 07/18/23 at 12:00 PM. However, the incident was not reported to New Jersey Department of Health (NJDOH) until 07/21/23 at 1:02 PM. 3. Review of a Nurse's Note, in the EMR, written byLPN2 and dated 09/14/23 at 8:45 AM indicated, noted during rounds at 7:30am that R27 has a bruised right finger 2nd digit, a small bruise near right elbow and an abrasion on right elbow. Active range of motion to right finger, no complaints of pain or discomfort and no acute distress noted. Review of the facility Accident/Incident Report, dated 09/14/23 at 7:00 AM, revealed R27 had a bruised finer and a scraped elbow and small bruise on the side of elbow. Further review revealed this was not reported to New Jersey Department of Health. During an interview on 02/14/24 at 12:57 PM LPN6 stated she became aware of R27's finger after LPN2 reported it to her at 11:00 AM when LPN2 documented it in progress notes. She reported it to the DON, but she was unsure if it was reported to the state or investigated. LPN6 stated they were never able to determine how the injuries occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/15/24 at 11:23 AM the DON stated the facility had 24 hours if there was no significant injury, and she was not aware abuse must be reported within two hours of the facility becoming aware. But she agreed they all should have been reported timely. During an interview on 02/15/24 at 12:30 PM the Regional Administrator stated he expected that all incidents be reported within the required 2 hours. Review of the facilities policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 01/2023, revealed, all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility, the local state ombudsman; the resident's representative; adult protective services (where state law provides jurisdiction in long-term care); law enforcement officials; the resident's attending physician; and the facility medical director Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. NJAC 8:39-9.4(f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40902 Based on record review, interview and policy review, the facility failed to investigate injuries of an unknown origin for one of six residents reviewed for abuse (Resident R27). Findings Include: Review of a Nurse's Note, in the EMR, written by Licensed Practical Nurse (LPN) 6 and dated 07/18/23 at 1:46 PM indicated, R27 was found with a bruise to the left wrist measuring about 2 inches long and 1 inch wide. R27 stated That a guy grabbed her a statement was received from CNA. The family and nurse practitioner (NP) was made aware. During an interview on 02/14/24 at 12:57 PM LPN 6 stated she became aware of the bruise on R27 wrist on 07/18/23 at 1:46 PM and reported it to the DON and former Administrator. Review of the facility's Reportable Event Record revealed the incident occurred on 07/18/23 at 12:00 PM. Further review revealed no skin audit for R27, or any other residents were completed, and no residents were interviewed. Review of a Nurse's Note, in the EMR, written by LPN2 and dated 09/14/23 at 8:45 AM indicated, during rounds at 7:30AM R27 has a bruised right finger 2nd digit, a small bruise near right elbow and an abrasion on right elbow. Active range of motion to right finger, no complaints of pain or discomfort and no acute distress noted. During an interview on 02/14/24 at 12:57 PM, LPN6 stated reported it to the DON when she became aware of R27's bruised finger, but she was unsure it if was investigated. LPN6 stated they were never able to determine how the injuries occurred. Review of the facility's Accident/Incident Report, dated 09/14/23 at 7:00 AM revealed R27 had a bruised finger and a scraped elbow and small bruise on the side of elbow. Further review revealed a statement by the staff who observed the bruise was taken but there was no additional staff or resident statements or additional body audits. Also, staff did not review the camera footage at the time the bruises were identified. During an interview on 02/15/24 at 11:23 AM the DON stated she was the abuse coordinator. The DON stated if there was an injury of an unknown origin staff would complete an incident report, get statements, and review the video feed at the time around the occurrence. They would look at documentation for 24 hours for injury of unknown origin. She said she was not sure why there was no skin assessment completed for the bruise discovered on R27 wrist on 07/21/23 but there should have been. She said they were just learning their new EMR system, and they did not know what they were doing and where to document. She also said they should have talked with other residents and completed additional body audits. She could not remember the injuries found on R27 on 09/14/23 and she was unsure why it was not investigated but agreed that it should have been. During an interview on 02/15/24 at 12:30 PM the Regional Administrator stated he expected that all incidents to be thoroughly investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facilities policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 01/2023, revealed, all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. All allegations are thoroughly investigated. The administrator initiates investigations. The individual conducting the investigation as a minimum, reviews the documentation and evidence; reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents; interviews the person(s) reporting the incident; interviews any witnesses to the incident; interviews the resident (as medically appropriate) or the resident's representative; interviews the resident's attending physician as needed to determine the resident's condition; interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interviews the resident's roommate, family members, and visitors; interviews other residents to whom the accused employee provides care or services; reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly. The following guidelines are used when conducting interviews: Each interview is conducted separately and in a private location. The purpose and confidentiality of the interview is explained thoroughly to each person involved in the interview process. NJAC 8:39-9.4(f)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on staff interview, medical record review and policy review, the facility staff failed to complete a baseline care plan within 48 hours of admission for one of 39 residents in the survey sample (Resident (R)72). Findings include: Review of the undated Admission Record under the Profile tab in the electronic medical record (EMR) revealed R72 was admitted to the facility on [DATE] with the diagnosis of diabetes mellitus, spinal stenosis, and quadriplegia. Review of R72's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/23 coded the resident of having a Brief Interview for Mental Status (BIMS) score of 12 out of a possible score of 15. This represents R72 was moderately cognitive impaired. Review of R72's EMR revealed the resident did not have a base line care plan developed within 48 hours of admission to the facility. R72 was admitted on [DATE]. However, a base line care plan was developed but it had a completion date of 11/29/23. Interviewed the Director of Nursing (DON) on 02/15/24 at 11:00 AM. The DON stated, The nurses have to do a base line care plan within 48 hours of admission. Interviewed registered nurse (RN)6 on 02/15/24 at 1:24 PM. PM. RN6 reviewed the EMR and stated, No, I didn't do it within 48 hours. Review of the facility policy Baseline Care Plan dated 10/02/23 revealed, .The baseline care plan will be . developed within 48 hours of a resident's admission . NJAC 8:39-11.1 NJAC 8:39-11.2

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on interview, observation, record review, and facility policy review, the facility failed to provide two (Resident (R) 21 and R51) of three dependent residents reviewed for Activities of Daily Living (ADLs) with showers twice a week as scheduled in a total sample of 25. Findings include: Review of the facility's "Bath, Shower/Tub policy, dated 03/2023, indicated, in pertinent part, "The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. 1. Review of R21's undated Admission Record, located in the Profile section of the electronic medical record (EMR), revealed R21 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, chronic obstructive pulmonary disease (COPD), hemiplegia, and diabetes mellitus. Review of R21's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/05/24, located in the EMR found under the MDS tab, revealed R21 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated she was cognitively intact. The MDS also indicated R21 had not rejected care and had functional limitation in range of motion on one side of her upper and lower extremities. Review of R21's comprehensive Care Plan, dated 02/06/24, located in the EMR under the Care Plan tab identified that R21 had an ADL self-care performance deficit related to immobility, decreased physical mobility, cerebral vascular accident (CVA) with right sided weakness, hemiplegia, and diabetic neuropathy. A care plan Intervention/Task. indicated, Bathing/Showering: Provide a sponge bath when a full bath cannot be tolerated. Review of R21's undated Shower Schedule, documented her shower days were on Mondays and Thursdays during the 7:00 AM to 3:00 PM shift. Review of R21's January and February 2024 Documentation Survey Report indicated no shower was provided on 01/01/24 (Monday), 01/22/24 (Monday), 01/29/24 (Monday), 02/01/24 (Thursday), 02/05/24 (Monday), and 02/12/24 (Monday). Interview on 02/12/24 at 1:05 PM, R21 stated she needed staff assistance with showers, but staff did not always provide her showers as scheduled. R21 stated she was scheduled to receive two showers per week on Monday and Thursday. R21 explained she had not yet received her scheduled shower today (Monday, 02/12/24). R21 explained staff being able to provide her scheduled showers depended on how many staff were working on her shower days. Interview on 02/13/24 at 12:10 PM, R21 stated she did not receive her shower as scheduled on Monday (02/12/24). During an interview on 02/15/24 at 12:50 PM, R21 stated she still had not received a shower this week. R21 stated she preferred to receive a shower because it made her feel better than a bed bath. (continued on next page)

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	315365	A. Building B. Wing	02/19/2024

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R51's undated Admission Record, located in the Profile section of the EMR, revealed R51 was admitted to the facility on [DATE] with diagnoses of cerebral infarction and hemiplegia. Review of R51's significant change MDS with an ARD of 02/05/24, located in the EMR found under the MDS tab, revealed R51 had a BIMS score of 13 out of 15, which indicated he was cognitively intact. The MDS also indicated R51 had not rejected care and had functional limitation in range of motion on one side of her upper and lower extremities. Review of R51's comprehensive Care Plan, dated 02/06/24, located in the EMR under the Care Plan tab indicated, The resident has a potential for ADL self-care performance deficit r/t [related to] Activity Intolerance, Disease Process CVA [cerebral vascular accident], Hemiplegia, Limited Mobility, Stroke, neuropathic changes to leg and skin. Review of R51's undated Shower Schedule, documented his shower days were on Mondays and Thursdays during the 7:00 AM to 3:00 PM shift. During an interview on 02/12/24 at 11:20 AM, R51 stated needed staff assistance with showers, but he did not always receive his scheduled showers. R51 stated he was supposed to get showers two times per week and sometimes only received a shower one day or no days for a week. R51 stated he wanted at least two showers per week, as scheduled. Stated staff will provide a bed bath if not able to provide his shower, but he would prefer to receive his two showers per week as scheduled. Review of R51's January and February 2024 Documentation Survey Report indicated no shower was provided on 01/01/24 (Monday), 01/18/24 (Thursday), 01/22/24 (Monday), 01/29/24 (Monday), and 02/01/24 (Monday). During an interview on 02/15/24 at 9:25 AM, CNA8, who was caring for R21 and R51 stated the residents readily accept their scheduled showers twice a week. CNA8 stated when there were only two nursing assistants working the hallway, she may not be able to provide all of the scheduled resident showers. CNA8 stated if she was unable to provide a resident with a scheduled shower, she would provide the resident with a bed bath. CNA8 checked the shower schedule and confirmed R21 and R51's scheduled shower days were on Monday and Thursday. During an interview on 02/15/24 at 12:15 PM, LPN5 stated R21 and R51 was scheduled to receive showers on Monday and Thursday, and they readily accepted their showers. LPN5 reviewed R21 and R51's shower documentation and confirmed it reflected the resident's showers were not always being provided twice a week as scheduled. LPN5 stated the nurse aides were expected to document completed showers and if a resident refused their shower. During an interview on 02/15/24 at 12:25 PM, the DON stated the expectation was residents would receive their showers as scheduled. The DON stated she was aware there were times when residents were not receiving their showers as scheduled twice a week. The DON explained when staff were unable to provide a resident with their scheduled shower the resident was to receive a good bed bath. NJAC 8:39-4.1(a)22 NJAC 8:39-27.2(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, record review, and staff interview, the facility staff failed to ensure the facility was free of a medication error rate of five percent or greater for two of five residents in the medication administration observation (Resident (R)22 and R6. Resident (R)22 had a physician order for acetaminophen to treat mild pain and R6 had a physician order for spironolactone to treat edema. Findings include: Review of R22's undated Admission Record located under the Profile tab in the electronic medical record (EMR) revealed R22 was admitted to the facility on [DATE] with the diagnosis of diabetes mellitus, bipolar disease, and schizophrenia. Review of R22's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/23 revealed R22 had a Brief for Mental Status (BIMS) score was nine out of a possible 15. This represents R22 was moderately cognitive impaired. During the Medication Administration Observation on 02/14/24 at 8:25 AM, Licensed Practical Nurse (LPN)7 was observed administrating one acetaminophen 500 milligram (mg) tablet by mouth to R22. Review of the Physician Orders under the Orders tab in the EMR revealed a physician order for R22, dated 10/12/23, to administrator acetaminophen 500 mg give two tablets by mouth in the morning for pain. Interview with the Director of Nursing (DON) on 02/15/24 at 11:00 AM revealed, All medications are to be given as ordered by the doctor. Interview with LPN7 on 02/15/24 at 4:00 PM revealed I thought I gave two tablets. But if you saw me give one then I probably did. Interview with LPN5 on 02/15/24 at 4:30 PM revealed She [nurse] is to give the resident what the doctor orders for them to have. 2. Review of R6's undated Admission Record located under the Profile tab in the EMR revealed R6 was admitted to the facility on [DATE] with the diagnosis of hypertension, and congestive heart failure. Review of R6's admission MDS with an (ARD) of 01/11/24 revealed R6 had a BIMS score was 13 out of a possible 15. This represents R6 was cognitively intact. During the Medication Administration Observation on 02/14/24 at 8:56 AM, Registered Nurse (RN)5 was observed to be holding spironolactone 25 mg. RN5 stated, His blood pressure is 91/53 and he [R6] has orders to hold this medication when the blood pressure is that low. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician Orders under the Orders tab in the EMR revealed a physician order for R6, dated 01/04/24, for R6 to be administrated spironolactone 25 mg give one tablet by mouth in the morning for edema. There were no parameters to hold this medication and not administer to R6. Interview with the DON on 02/15/24 at 11:00 AM revealed, The nurse is to call the doctor if they feel the blood pressure is too low to give the medication the doctor has ordered. The medications are to be given as ordered by the physician. Interview with RN6 on 0215/24 at 1:25 PM revealed R6 doesn't have parameter for the spironolactone to be held. RN5 was unavailable to be interviewed on 02/15/24 prior to the exit conference. NJAC 8:39-29.2(d)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on interview, record review, and facility policy review, the facility failed to ensure medical records were readily accessible for one (Resident (R)137) of 25 sampled residents whose medical records were reviewed in a total sample of 25. Findings include: Review of the facility's policy titled, Medical Record retention Policy and Procedure, dated 2023, indicated, The purpose of this policy is to ensure the Complete Care at Ocean Grove (the Facility) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and other currently or potentially working for the Facility (Associates) comply with applicable rules regarding the maintenance of medical records, as required by state and federal law. Policy It is the policy of the Facility to maintain medical records for the period required by law. Procedure 1. Retention of Medical Records A. The Facility shall maintain residents' medical records pursuant to applicable State law for a period of [AGE] year. Review of R137's admission assessment, provided electronically by the facility, revealed R137 was admitted to the facility on [DATE] with diagnoses which included hypertension, diabetes, and dementia. Review of the facility's current electronic medical record (EMR) system on [DATE] at 9:30 AM revealed there was no information for R137 in the system. During an interview on [DATE] at 10:00 AM, the Director of Nursing (DON) confirmed R137's EMR was not accessible in the facility's current medical records system. The DON explained when R137 resided at the facility it was owned by a different company which used a different EMR system. A request was made for the DON to provide R137's medical record, including the resident's [DATE] wound treatment report, to the survey team. The DON stated she would see what medical record information was available to provide for R137's stay at the facility. During an interview on [DATE] at 12:15 PM, the facility's Registered Nurse Consultant (RNC) was informed the survey team had not received R137's medical record information. At this time, a written request was provided to the RNC for the facility to provide copies of R137's June, July, and [DATE] physician's orders, treatment records, medication administration records, progress notes, physician progress notes, and documentation from the resident's [DATE], wound center visit, and the resident's Minimum Data Set (MDS) assessment and care plan prior to [DATE]. The RNC stated she would contact the company who previously owned the facility and request R137's medical records. During an interview on [DATE] at 4:30 PM, the Administrator was informed the survey team still had not been provided with R137's medical record information that was requested earlier in the day. The Administrator stated the staff would continue to work on obtaining R137's medical record information during the evening. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 7:50 AM, the Administrator stated the facility was unable to obtain R137's medical record information. At this time, the survey team provided the Administrator with a written list of information the survey team was requesting to obtain from R137's medical record which included; admission assessment, was pressure ulcer to right foot facility acquired or community acquired, orders for dressing changes to the right foot along with all wound care notes from the time pressure to the was addressed, physician progress notes, treatment administration records (TARs) if this is where dressing changes were documented by the nurses, MDS assessments including annual and quarterly and significant changes, care plans from the resident's admission to when the resident expired with all revisions, documentation of how and when maggots were noted in the pressure wound to the resident's foot, all documentation of why R137 was sent to the hospital in [DATE] and hospital record for emergency room visit and hospital admission. During an interview on [DATE] at 9:02 AM, the Administrator stated the facility was still unable to obtain the information requested from R137's medical record. The Administrator stated the facility thought they would be able to provide the requested information to the survey team within an hour. During an interview on [DATE] at 10:15 AM, the facility's Regional Administrator stated the facility was still unable to obtain R137's medical record information. The Regional Administrator stated the facility was working with IT (Information Technology) department to gain access to R137's medical record. During an interview on [DATE] at 11:14 AM, the facility's Administrator stated the facility gained access to R137's medical record and he would send the information to the survey team's Team Coordinator (TC) via secure email. However, when the survey TC attempted to open the information via secure email, she was unable to access R137's medical record information contained in the emails. During an interview on [DATE] at 1:53 PM, the facility's Regional Administrator provided the survey team with a computer tablet. The Regional Administrator stated the computer tablet contained over 1800 pages of R137's medical record in a portable document format (pdf). The survey team's review of the information on the computer tablet revealed R137's wound treatment consultation of [DATE], wound treatment records, wound care notes, and care plans during the resident's entire facility stay could not be found in the information provided. During an interview on [DATE] at 3:55 PM, the Regional Administrator stated Complete Care took over the facility on [DATE]. The Regional Administrator explained a pdf file format was the only format R137's medical record information could be made accessible for the survey team to review at this time and separate copies of the resident's medical record information could not be made. During an interview [DATE] at 3:30 PM, family member (F)137 stated she went with R137 to the resident's wound care appointment on [DATE] and during this appointment maggots were found in the resident's foot wound. F137 stated she had a copy of the resident's [DATE] wound care report which specified maggots were found in the resident's foot wound and the facility should have a copy of this report in the resident's medical records as well. The family member stated R137 expired at the facility on [DATE]. NJAC 8:,d+[DATE].2(d)(k)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on observation, interview, record review, and facility policy review the facility failed to ensure one hospitality aide (HA1) donned a N-95 face mask and eye protection when entering resident (Resident (R) 77) room and was positive for COVID-19. The facility failed to ensure one certified nursing assistant (CNA9) doffed his personal protective equipment (PPE) inside R186's room before exiting her room. A licensed practical nurse (LPN 4) failed to wear gloves when cleaning a glucometer prior to a finger stick for R44. These failures could lead to residents being exposed to COVID-19 and blood borne pathogens. Findings include: 1. Observation on 02/13/24 at 8:44 AM of HA1 donning her PPE to enter R77's room revealed she entered the room wearing a gown, gloves, and a surgical mask. R77 was positive for COVID-19 and the HA1 did not put on a N-95 mask or eye protection. When HA1 exited the room at 8:55 AM she had on the surgical mask and no other PPE. An interview was done at that time and HA1 stated she did not know she had to wear an N-95 and eye protection. Interview with the Director of Nursing (DON) on 02/14/24 at 1:15 PM revealed she expected staff to wear the correct PPE when entering a COVID positive room or any room of a resident that was on isolation precautions. 2. Review of the undated Admission Record under the Profile tab in the electronic medical record (EMR) revealed Resident (R)186 admitted to the facility on [DATE] with the diagnosis of diabetes mellitus, and infection to the internal right hip prosthesis. Review of the CCARESJ - Nursing Comprehensive Assessment - Admit/Readmit/Annual/Sig Change - V10 dated 02/09/24 revealed R186 was oriented to person, place, time and situation. On 02/14/24 at 8:50 AM, CNA9 was observed coming out of R186's room and then doffing the gown once outside of the resident's door. R186 was in strict contact precautions due to having Methicillin Susceptible Staphylococcus Aureus (MSSA) in a wound. During an interview on 02/14/24 at 9:25 AM, CNA9 stated, I should not have done that, but I was rushing to get the resident what she needed. Interview with Registered Nurse (RN)6 on 02/15/24 at 1:25 PM,RN6 stated, CNA9 was to doff the gown before he left the resident's room and not out in the hallway. Interview with the Director of Nursing (DON) on 02/15/24 at 11:00 AM the, DON confirmed the staff are to doff their gown tight before leaving the resident's room and not in the hallway. Review of the undated Donning and Doffing PPE [personal protective equipment] instructional sheet stated, . Before leaving room, remove gown and gloves slowly in sequence to prevent self-contamination. Discard in isolation bin inside the patient's room . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the undated Admission Record under the Profile tab in the EMR revealed R44 admitted to the facility on [DATE] with the diagnosis of diabetes mellitus. Review of R44's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/23 coded R44 as having a Brief Interview for Mental Status (BIMS) score of 13 out of a score of 15. This represents R44 was cognitively intact. An observation was made on 02/14/24 at 11:37 AM after R44's insulin administration was completed by Licensed Practical Nurse (LPN)4 . LPN4 returned to the medication cart with the used glucometer in his hand and began cleaning the glucometer with a Sani Cloth with Bleach wipe. LPN4 did not wear gloves while cleaning the glucometer. Interview with LPN4 on 02/14/24 at 11:46 AM revealed I never thought about wearing gloves when cleaning the glucometer. Interview with LPN5 on 02/14/24 at 11:52 AM revealed The process is to put down a clean barrier, put on gloves and clean the glucometer . Interviewed the director of nursing (DON) on 02/15/24 at 11:00 AM. The DON stated, My expectation is that the nurses use gloves when cleaning the glucometer. 28306 NJAC 8:39-19.4(a)(b)(l)