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	07/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and review of pertinent facility documents, 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 clean and sanitary manner to prevent microbial growth. This deficient practice was evidenced by the following:On 7/16/25 at 9:50 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and the Regional Food Service Director (RFSD). The following was observed:1. Condensation on the outside of the ice machine on the top of lid and when opened an unidentified yellow substance was observed on the inside cover.2. Duct tape on the left and right corner above the ice machine lid and what appeared to be a white bonding material applied to the front lower left side.The surveyor interviewed the FSD who stated the machine was last cleaned on 7/8/25 but could not identify the yellow substance or explain why it was on the ice machine. The FSD explained that the duct tape was applied to prevent the sides of the ice machine from falling off and that the white substance was applied to cover up damage to the ice machine.3. Greasy, brown-appearing substance on the inner surface of the oven.The surveyor interviewed the FSD who stated that the oven should kept clean and should not have any substances in the inside of the oven.4. 5 (five) out of 5 (five) heads of wilted and partially decomposed lettuce in a clear plastic bag in the walk-in refrigerator number 1 (one).The surveyor interviewed the FSD who stated that the lettuce should have been discarded since it was spoiled. The FSD discarded the lettuce at the time of finding. The surveyor asked the FSD why the lettuce was kept in the refrigerator in the deteriorated condition. The FSD stated that produce is checked when the food is prepped and not daily.5. An opened and exposed to air a 10 lb. (pound) box of sausage which was not labeled and dated with an opened or used-by date, in walk-in refrigerator number 2 (two).6. A 5 (five) lb. container of cottage cheese which was not labeled and dated with an opened or used-by date, in the walk-in refrigerator number 2.The surveyor interviewed the FSD who stated that the box of sausage should be covered and labeled with an opened/used-by dates. The FSD stated that it was important to ensure that food is used before the used-by date and to prevent serving decayed food.On 7/21/25 at 10:08 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and the Regional Food Service Director (RFSD). The following was observed:7. 2 (two) out of 3 (three) heads of celery that were wilted and yellow in appearance, stored in walk-in refrigerator number 1.8. Four (4) out of 10 (ten) cucumbers had visible signs of spoilage with white, furry-appearing patches throughout the cucumbers & cucumber juice had leaked into the box in walk-in refrigerator number 1.Both the FSD and RFSD agreed that the celery and cucumbers should not had been in the refrigerator since they were spoiled. The FSD stated that produce should have been checked during meal prep and spoiled items are discarded.A review of the Tuesday special cleaning, schedule, indicated the following:During week 3, three cooks were tasked with cleaning the ice machine inside and outside.During weeks 1, 3 and 4, three cooks were assigned to clean and organize the fridge and freezer in the morning.On 7/24/25 at 11:50 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON), Regional Resource Registered Nurse (RRRN), and survey team, acknowledged the ice machine and oven should be cleaned and maintained per facility (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policy, prepped items should be labeled and have a used-by date, and spoiled foods should be promptly discarded.A review of the facility's policy dated 2/16/25 and titled Ice Machine Sanitation Policy, indicated that the kitchen staff will spray inside of the bin and lid with sanitizing solution and wipe the bin and lid with clean disposable kitchen wipe in steps number 7 (seven) and eight (8).A review of an undated facility's policy, titled Ice Machine Maintenance, indicated that the machine should be emptied and fully sanitized monthly and that the machine inside rim should be inspected with a white single use paper towel weekly to ensure no residue. The 2025 ice machine cleaning log indicated that the ice machine was cleaned on July 8, 2025.A review of the facility's policy dated 2/16/24 and titled Equipment Cleaning Policy indicated that conventional and convection ovens should be cleaned inside and outside with soap and water after each use and an oven-grill cleaner or degreaser should be used for heavy carbon build up.A review of the facility's protocol dated 11/12/19 and titled Labeling and Dating System Protocol, indicated that cottage cheese should be used by one week from the opened date; beef, pork, poultry should be used within 3 days after opening.NJAC 8:39-17.2(g)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation performed on 7/18/25, the surveyor observed three (3) nurses administer medications to five (5) residents. There were 30 opportunities, and three (3) errors were observed which calculated to a medication administration error rate of 10 %. This deficient practice was identified for one (2) of five (5) residents, (Resident #16 and Resident #56), that were administered medications by one (1) of three (3) nurses. The deficient practice was evidenced as follows:1. On 07/18/2025 at 08:50 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) prepare five medications for Resident #56, for medication pass observation. One of the medications was aspirin 81 mg (milligram) tablet; give one tablet once daily related to prophylactic (used to prevent disease) measures. LPN #1 removed from a bulk stock bottle, labeled aspirin 81 mg enteric coated (coating to ensure the medication is released and absorbed in the small intestines) tablets, and place it in a medicine cup (error #1). Another medication LPN #1 prepared for Resident # 56 was multi-vitamin with minerals. Once again LPN #1 chose a bulk stock bottle. She chose a plain multi-vitamins bottle and poured out one tablet (error #2), then proceeded to add the additional medications into the medicine cup.On 07/18/2025 at 09:00 AM, the surveyor stopped LPN #1 just before she was about to administer Resident #56's medication, and both returned to the nursing cart. Together LPN #1 and the surveyor reviewed the medication orders for Resident #56. LPN #1 acknowledged the order for aspirin was for chewable tablet not enteric coated. A further review of the physician orders revealed the order was for multi-vitamins with minerals not the bottle of plain multivitamin she had originally chosen. LPN #1 acknowledged she had chosen the wrong aspirin and wrong multivitamins.2. On 7/18/2025 at 9:48 AM, the surveyor observed LPN #2 prepare six medications for Resident #16, for medication pass observation. One of the medications was aspirin 325mg tablet; give one tablet once daily for DVT (deep vein thrombosis, or blood clot) prophylaxis. LPN #1 removed from a bulk stock bottle labeled, aspirin 81 mg enteric coated tablets, and place it in a medicine cup (error #3). Then proceeded to pour the remaining medications for Resident #16.On 7/18/2025 at 10:15 AM, the surveyor stopped LPN #2 just before she was about to administer Resident # 16's medication and returned to the nursing cart. Together LPN #2 and the surveyor reviewed the medication orders for Resident #16. LPN #1 acknowledged the order for aspirin was for 325 mg tablet, not the 81 mg enteric coated tablet. LPN #2 acknowledged she had chosen the wrong aspirin strength.On 07/18/2025 at 01:24 PM, the survey team met with facility Administration. The Director of Nursing (DON) stated the nurse should have clarified the order to ensure what was poured matched what the physician ordered. A review of the facility's Medication Administration policy dated implemented 9/1/24 reflected the following: 10. Ensure that the six rights of medication administration are followed:a. right residentb. right drugc. right dosaged. right routee. right timef. right documentation11. Review MAR to identify medication to be administered.12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.NJAC 8:39-11.2(b); 27.1(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) follow the prescriber's orders and accepted professional standards and principles by administering the incorrect medication and dosage for 1 of 4 (Resident #24) residents reviewed for Medication Administration; b.) follow the prescriber's orders and accepted professional standards and principles by administering medications past the required time frame for 2 of 4 (Resident #7 & #24) residents reviewed for Medication Administration, and c.) follow the prescriber's orders and accepted professional standards and principles by administering an unprescribed medication to a resident for 1 of 4 (Resident #59) residents reviewed for Medication Administration and evidenced by the following:A.) On 07/17/2025 at 10:45 AM, during the Resident Counsel Meeting, Resident #24 that they had concerns regarding late insulin. On 7/18/2025 at 8:46 AM, the surveyor conducted a follow-up interview with Resident #24, who stated that during a weekend in August 2024, at approximately 10:15 PM, they received 24 units of Novolog but were supposed to receive 24 units of Novolin N and 3 or 5 units of Novolog (based on blood sugar levels) at bedtime instead. The resident stated that he/she recognized that the color of the insulin pen was different, which prompted them to question the nurse. Resident #24 stated that he/she felt dizzy and could not see straight. The resident further stated that they had checked their blood glucose levels using their own glucometer (a medical device used to determine blood glucose levels), but could not recall the exact reading, but based on the presenting symptoms they knew that their blood sugar was dropping. Resident #24 added that he/she drank orange juice and were given glucose gel, and started to feel better about 20 minutes later. The resident further stated that now, if they are unfamiliar with their the nurse, they will administer the insulin themselves. A review of the admission Record Face (admission summary) reflected that Resident #24 was admitted to the facility with a diagnosis that included, but was not limited to: diabetes mellitus (DM) (elevated blood glucose levels). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 4/11/2025, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident received insulin. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 7/19/2024, that the resident has diabetes mellitus. Interventions included: Diabetes medication as ordered by the doctor. A review of the Order Recap Report (ORR), included the following physician orders (PO):A PO, dated 6/28/2024, for Novolin N (intermediate-acting insulin that starts to work one (1) – 3 hours after injection, peak between 4 and 12 hours and can last for up to 24 hours.), inject 24 units subcutaneously (under the skin) at bedtime. A PO, dated 2/20/2024, for Novolog (a rapid-acting insulin, starts to work 15 – 30 minutes after injection, peaks in about one (1) hour and lasts for 2 to 4 hours.) flexpen, inject as per sliding scale: if 101-150 =3 units; 151 – 200 = 5 units; 201 – 250 = 7 units; 251 – 300 = 9 units; 301 – 400 =11 units, subcutaneously before meals and at bedtime. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #24's Medication Administration Audit Report for July 1-24, 2025, revealed the Novolog for diabetes was administered past the required time frame as follows: - Scheduled Date 7/1/2025 at 21:00 PM; Administration Time 22:24 PM- Scheduled Date 7/4/2025 at 11:30 AM; Administration Time 12:32 PM - Scheduled Date 7/5/2025 at 16:30 PM; Administration Time 19:30 PM- Scheduled Date 7/6/2025 at 7:30 AM; Administration Time 9:17 AM- Scheduled Date 7/6/2025 at 11:30 AM; Administration Time 12:44 PM- Scheduled Date 7/7/2025 at 16:30 PM; Administration Time 19:12 PM- Scheduled Date 7/7/2025 at 21:00 PM; Administered Time 22:40 PM- Scheduled Date 7/9/2025 at 16:30 PM; Administered Time 21:49 PM- Scheduled Date 7/11/2025 at 16:30 PM; Administered Time 17:34 PM- Scheduled Date 7/13/2025 at 11:30 AM; Administration Time 12:53 PM- Scheduled Date 7/13/2025 at 16:30 PM; Administered Time 20:10 PM- Scheduled Date 7/13/2025 at 21:00 PM; Administered Time 00:37 AM - Scheduled Date 7/15/2025 at 16:30 PM; Administered Time 18:29 PM A review of Resident #24's Medication Administration Audit Report for July 1-24, 2025 revealed the Novolin N Suspension for diabetes was administered past the required time frame as follows: - Scheduled Date 7/6/2025 at 7:30 AM; Administration Time 9:17 AM- Scheduled Date 7/8/2025 at 7:30 AM; Administration Time 8:45 AM- Scheduled Date 7/12/2025 at 7:30 AM; Administration Time 8:34 AM- Scheduled Date 7/1/2025 at 21:00 PM; Administration Time 22:24 PM - Scheduled Date 7/7/2025 at 21:00 PM; Administration Time 22:40 PM- Scheduled Date 7/13/2025 at 21:00 PM; Administration Time 00:37 AM A review of the Medication Administration Record (MAR) for August 2024 revealed that on 8/9/2024 there was no documentation to indicate that the Novolin N and Novolog was administered according to physician orders at 9 PM. In addition, on the same date and time, there was no documentation of Resident #24's blood sugar. A review of the progress notes included a nurse's note (NN), dated 8/9/2024 at 7:00 PM, that included: Medication error noted from primary nurse [nurse's initials], nurse states she gave Novolog instead of Novolin. Continued to monitor patient throughout shift. No change in patients [sic] baseline or any issues with blood glucose levels. NP (nurse practitioner) notified and pt (patient) monitored for glucose levels. Further review of the progress notes included a nurse practitioner's note dated 8/13/2024 at 10:01 AM, which included, .over wkend (weekend), nurse accidentally gave more short acting units of insulin, glucose and oj (orange juice) given, uneventful, has happened prior . The surveyor was unable to located a progress note by Licensed Practical Nurse (LPN) #1 that administered the incorrect medication and dose. A review of the facility provided Incident Report dated 8/9/2024 at 6:00 PM, included the following narrative: Nursing Description: UM (unit manager) was informed of med (medication) error by primary nurse 3-11 shift on 8/9/24. Resident description: states nurse administered wrong medication (insulin) and wrong dose. On 7/18/2025 at 10:13 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM #2), who stated that scheduled medications should be given within one hour before or after the scheduled time, and anything beyond that would be considered late. On 7/18/2025 at 12:04 PM, the surveyor telephoned LPN #1, but there was no answer. A message (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was left on the voicemail; however, the surveyor did not get a return call. On 7/18/2025 at 12:39 PM, the survey team interviewed the Interim Director of Nursing (IDON), in the presence of the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional Director of Operations (RDO), indicated that insulin is considered late after one hour following the prescribed time. When asked if it was acceptable that insulin be administered 2 hours late the IDON responded, No. The surveyors further inquired that if insulin was 2 hours past the administration time should it have been given at which the IDON stated that it should not have been given and the physician should have been notified. On 7/21/2025 at 11:24 AM, the survey team interviewed the facilities' Pharmacy Consultant (PC), who identified that a significant medication error would include administering the wrong dosage and insulin to a resident. When asked if insulin was a high risk medication the PC agreed and further confirmed that Novolin N and Novolog were not interchangeable and should be administered according to physician orders. When asked of the medication administration expectation for nurses, the PC stated that they should be following the rights of medication: right patient, medication, time, dose, and route. On 7/22/2025 at 12:15 PM, the surveyor telephoned LPN #2, who was assigned to Resident #24 on 8/9/2024, but there was no answer. A message was left on the voicemail; however, the surveyor did not get a return call. On 7/21/2025 at 9:50 AM, the surveyor interviewed the Medical Director (MD), who stated that medications should be administered as prescribed. He further stated that when the nurse is administering medications, they should ensure that they follow the five rights: right resident, right dose, right medication, right time, and right route. On 7/22/2025, at 2:00 PM, the surveyor interviewed the Regional Director of Nursing (RDON), who stated that insulin is a high-risk medication and that she expects nurses to administer it according to the physician's orders. On 7/24/2025 at 9:52 AM, the surveyor attempted to interview the Nurse Practitioner (NP) who wrote the progress note dated 8/13/2024 at 10:01 AM. The NP stated that the incident occurred over a year ago, she doesn't know how to access the medical record. The interview was terminated when the NP stated, I don't have time for this and used profanity directed towards the surveyors upon exiting. A review the facility policy titled, Timely Administration of Insulin dated 9/1/2024 revealed that, It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident to prevent adverse effects on a resident's condition. The policy further revealed, 1. All insulin will be administered in accordance with physician's orders. and lastly, 4. Insulin administration will be coordinated with meal times and bedtime snacks unless otherwise specified in the physician order. A review the facility policy titled, Medication Administration dated 9/1/2024 revealed [.] 10. Ensure that the six rights of medication administration are followed: a. Right resident; b. Right drug; c. Right dosage; d. Right route; e. Right time; f. Right documentation; 11. Review MAR to identify medication to be administered; 12. Compare medication source (bubble pack, vial, etc) with [Medication Administration Packet] to verify resident name, medication name, form, dose, route, and time: [.]b. Administer within 60 minutes prior to or after scheduled time otherwise ordered by physician [.] 21. Sign MAR after administered. For those medications requiring vital signs, record vital signs on to the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MAR [.]. A review the facility policy titled, Documentation in Medical Record, dated 10/1/2024, revealed that: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The further revealed: [.]4. Principles of documentation include, but are not limited to: [.]b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care [.]. A review the facility policy titled, Medication Error, dated 9/1/2024, revealed that: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. The policy further revealed: [.] 4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescribers order. Examples include, but not limited to: i. Incorrect dose, route of administration, dosage form, time of administration; [.] iii. Incorrect medication; 7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right medication, dose, route, and time administration; b. Right resident and right documentation [.]. B.) During an interview with another surveyor on 07/21/2025 at 10:00 AM, Resident #7 confirmed that they receive insulin. A review Resident # 7's diagnosis located in the Electronic Medical Record (EMR) include but are not limited to Type 2 Diabetes Mellitus (the body's inability to use insulin properly, leading to high blood sugar levels) and Orthopedic Aftercare Following Surgical Amputation. A review of Resident #7's physician's orders revealed the following orders but not limited to:Insulin (a hormone produced by the pancreas that regulates blood sugar levels) Lispro (1 Unit Dial) Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Lispro)Inject 10 unit subcutaneously before meals for DM. and Inject 12 unit subcutaneously before meals for DM Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 20 unit subcutaneously one time a day for DM Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject as per sliding scale: if 200 - 249 = 2 units; 250 - 299 = 6 units; 300 - 349 = 8 units If greater than 400 give 12 units than notify MD; 400+ = 12 units, subcutaneously three times a day for DM A review of Resident #7's Medication Administration Audit Report for July 1-24, 2025 revealed the Insulin Lispro (10 units) for diabetes was administered past the required time frame as follows: - Scheduled Date 7/1/2025 at 7:30 AM; Administration Time 9:43 AM- Scheduled Date 7/1/2025 at 11:30 AM; Administration Time 15:07 PM- Scheduled Date 7/4/2025 at 16:30 PM; Administration Time 17:55 PM- Scheduled Date 7/12/2025 at 7:30 AM; Administration Time 11:43 AM- Scheduled Date 7/12/2025 at 11:30 AM; Administration Time 13:14 PM- Scheduled Date 7/12/2025 at 16:30 PM; Administration Time 18:09 PM- Scheduled Date 7/15/2025 at 7:30 AM; Administration Time 8:32 AM A review of Resident #7's Medication Administration Audit Report for July 1-24, 2025 revealed revealed the Insulin Glargine for diabetes was administered past the required time frame as follows:- Scheduled Date 7/1/2025 at 8:00 AM; Administration Time 9:43 AM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #7's Medication Administration Audit Report for July 1-24, 2025 revealed revealed the Humalog for diabetes was administered past the required time frame as follows:- Scheduled Date 7/1/2025 at 8:00 AM; Administration Time 11:59 AM- Scheduled Date 7/1/2025 at 11:30 AM; Administration Time 15:07 PM- Scheduled Date 7/3/2025 at 8:00 AM; Administration Time 12:23 PM- Scheduled Date 7/4/2025 at 16:00 PM; Administration Time 17:55 PM- Scheduled Date 7/12/2025 at 7:30 AM; Administration Time 11:42 AM- Scheduled Date 7/12/2025 at 11:30 AM; Administration Time 13:14 PM- Scheduled Date 7/12/2025 at 16:30 PM; Administration Time 18:08 PM- Scheduled Date 7/15/2025 at 7:30 AM; Administration Time 8:31 AM A review of Resident #7's Medication Administration Audit Report for July 1-24, 2025 revealed the Insulin Lispro (12 units) for diabetes was administered past the required time frame as follows:- Scheduled Date 7/4/2025 at 16:30 PM; Administration Time 17:55 PM- Scheduled Date 7/12/2025 at 7:30 AM; Administration Time 11:43 AM- Scheduled Date 7/12/2025 at 11:30 AM; Administration Time 13:14 PM- Scheduled Date 7/12/2025 at 16:30 PM; Administration Time 18:09 PM- Scheduled Date 7/15/2025 at 7:30 AM; Administration Time 8:32 AM During an interview with another surveyor on 7/18/2025 at 10:13 AM, LPN/UM #2 stated that scheduled medications should be given within one hour before or after the scheduled time, and anything beyond that would be considered late. During an interview with the survey team on 7/18/2025 at 12:39 PM, the IDON, in the presence of the LNHA, DON, and RDO, indicated that insulin is considered late after one hour following the prescribed time. When asked if it was acceptable that insulin be administered 2 hours late the IDON responded, No. The surveyors further inquired that if insulin was 2 hours past the administration time should it have been given at which the IDON stated that it should not have been given and the physician should have been notified. A review the facility policy titled, Timely Administration of Insulin dated 9/1/2024 revealed that, It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident to prevent adverse effects on a resident's condition. The policy further revealed, 1. All insulins will be administered in accordance with physician's orders. and lastly, 4. Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order. A review the facility policy titled, Medication Administration dated 9/1/2024 revealed [.] 10. Ensure that the six rights of medication administration are followed: a. Right resident; b. Right drug; c. Right dosage; d. Right route; e. Right time; f. Right documentation; 11. Review MAR to identify medication to be administered; 12. Compare medication source (bubble pack, vial, etc) with [Medication Administration Packet] to verify resident name, medication name, form, dose, route, and time: [.]b. Administer within 60 minutes prior to or after scheduled time otherwise ordered by physician [.]. A review the facility policy titled, Medication Error, dated 9/1/2024, revealed that: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. The policy further revealed: [.] 4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: i. Incorrect dose, route of administration, dosage form, time of administration; [.] iii. Incorrect medication; 7. To prevent medication errors and ensure safe medication administration, nurses should verify the following (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information: a. Right medication, dose, route, and time administration; b. Right resident and right documentation [.]. C). On 07/17/2025 at 10:45 AM, during the Resident Counsel Meeting, Resident #59 reported that they had received the medication, Baclofen (a medication used to treat muscle spasms), that was not prescribed to them.A review of the admission Record Face reflected that Resident #59 was admitted to the facility with a diagnosis that included, but was not limited to: DM, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke). A review of the resident's quarterly MDS, dated [DATE], included the resident had a BIMS score of 15 out of 15, which indicated the resident's cognition was intact. The surveyor reviewed Resident #59 ORR and did not locate an order for Baclofen. The surveyor was unable to locate a progress note by the nurse that administered the incorrect medication following the incident A review of the progress notes included a NN, dated 6/28/2025 at 10:30 AM, that included: Nurse administered Baclofen to resident which was not ordered for this resident [.] During an interview with another surveyor on 7/18/2025 at 10:13 AM, LPN/UM #1 confirmed the incident in which Resident #59 received an unprescribed medication. LPN/UM #1 stated that on 6/28/2025 an agency nurse administered 20mg of Baclofen to Resident #59 and that the resident realized the error upon taking the medication and informed the nurse of situation. LPN/UM #1 stated that the agency nurse is on the do-not-return list and has not been back in the building. During an interview with another surveyor on 7/18/2025 at 1:06 PM, the IDON, in the presence of the DON, LNHA, and RDO, confirmed that a giving a medication to a resident without a physician's order would be considered a medication error. During an interview with the survey team on 7/21/2025 at 11:24 AM, the facility PC stated that the medication administration expectation for the nurses was that that they should be following the rights of medication: right patient, medication, time, dose, and route. During an interview with the survey team on 7/22/2025 at 9:50 AM, the MD stated that medications should be administered as prescribed and administered according to the rights of medications: right patient, medication, time, dose, and route. A review the facility policy titled, Medication Administration dated 9/1/2024 revealed [.] 12. Compare medication source (bubble pack, vial, etc) with [Medication Administration Packet] to verify resident name, medication name, form, dose, route, and time: [.]b. Administer within 60 minutes prior to or after scheduled time otherwise ordered by physician [.] A review the facility policy titled, Medication Error, dated 9/1/2024, revealed that: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. The policy further revealed: [.] 4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accordance with the prescribers order. Examples include, but not limited to: i. Incorrect dose, route of administration, dosage form, time of administration; [.] iii. Incorrect medication; 7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right medication, dose, route, and time administration; b. Right resident and right documentation [.]. A review the facility policy titled, Medication Administration dated 9/1/2024 revealed [.] 10. Ensure that the six rights of medication administration are followed: a. Right resident; b. Right drug; c. Right dosage; d. Right route; e. Right time; f. Right documentation; 11. Review MAR to identify medication to be administered; 12. Compare medication source (bubble pack, vial, etc) with [Medication Administration Packet] to verify resident name, medication name, form, dose, route, and time: [.]b. Administer within 60 minutes prior to or after scheduled time otherwise ordered by physician [.]. A review the facility policy titled, Documentation in Medical Record, dated 10/1/2024, revealed that: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The further revealed: [.]4. Principles of documentation include, but are not limited to: [.]b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care [.]. N.J.A.C. 8.39-29.2 (d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, interview, and review of facility policy, it was determined that the facility failed to a) appropriately dispose of medication in accordance with currently accepted professional standards and b) ensure medications were stored securely at all times. This deficient practice was identified for 3 of 3 nurses observed during the Medication Administration task. The deficient practice was evidenced by the following: 1. On 7/18/25 at 8:50 AM, during medication pass observation on first floor West, Licensed Practical Nurse #1 (LPN #1) poured one tablet of aspirin 81 mg and one tablet of multi-vitamin tablet for Resident #56. After review of the resident's Medication Administration Record (MAR) it was determined the nurse had poured the incorrect medication. The nurse then took the medicine cup and disposed of it in the small trash container attached to the medication cart. When asked how should medications be disposed of if they are not being administered? LPN #2 responded in the drug disposal solution (a solution used to dissolve medications). When asked why she disposed of the unused medication in the trash she responded because they were over the counter medications they could be thrown away. LPN #1 then proceeded to retrieve the medications with a gloved hand from the trash and disposed of the medication in the drug disposal solution located on her nursing cart. 2. On 7/18/25 at 9:48 AM, during medication pass observation on the second floor, the surveyor observed LPN #2 pour five medications and liquid protein for Resident #16's morning medications. After pouring the liquid protein LPN #2 set the liquid protein bulk bottle on the top of the medication cart, collected the other medications, locked her cart and proceeded to walk into the resident's room to administer the medication. The surveyor stopped LPN #2 just before entering the room and losing eyesight of the medication cart. There were no patients or other staff in the hallway. When asked if she should have left the liquid protein on top of the cart she replied no, all medicines should be locked in the medication cart when not in use. 3. On 7/18/25 at 10:30 AM, during medication pass observation on the second floor, the surveyor observed LPN #3 prepare nine medications for Resident #63's morning medications. One of the medications was acetaminophen XS (extra strength) 500 mg tablet and another was a probiotic (used to balance or improve bacteria in the gut) saccharomyces boulardi capsules. LPN #3 after preparing the medications left the probiotic and the acetaminophen on the top of the medication cart and attempted to enter the resident's room before being stopped by the surveyor. The cart remained in eyesight, and there were no other residents or staff in the immediate area. When asked where medication should be stored when not in use, LPN #3 responded locked in the cart, and acknowledged she should not have left the medications on top of the cart.On 7/18/25 at 1:24 PM the survey team met with the facility administration to address their concerns. The Director of Nursing (DON) stated medications must always be secured, and no medications should be left on the top of a medication cart, it was a safety concern. The Licensed Nursing Home Administrator confirmed the DON's response. A review of the facility's Medication Storage policy dated implemented 8/1/2024 revealed. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) . During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. NJAC 8:39-29.4(h)(i)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to maintain a homelike environment that was clean, safe, and sanitary. This deficient practice was identified for 1 of 3 floors (1st floor).This deficient practice was evidenced by the following:On 07/17/2025 at 9:19 AM, the surveyor observed light brown splattered debris on the wall near a resident's bed in room [ROOM NUMBER] A. On 07/17/2025 at 9:30 AM, the surveyor inspected the 1st floor shower room and observed a shower chair inside the shower stall with a hospital gown, towel, and wet blanket placed on top of the chair. In addition, loose particles of trash were visible inside of the drain.On 07/22/2025 at 12:09 PM, during an interview with the surveyor, the Housekeeping Director (HD) said that housekeeping staff clean resident rooms and shower areas daily, with additional cleanings conducted as needed when unsanitary conditions are reported. The HD also noted that spills are discouraged in resident rooms due to infection control concerns and to help maintain a homelike environment.On 07/22/2025 at 2:39 PM, during an interview with the surveyor, the Interim Director of Nursing said that splattered debris should never be present on residents' walls, as it would compromise sanitation and the homelike environment.On 07/22/2025 at 2:42 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator said that shower areas are expected to be thoroughly cleaned and sanitized after each use to maintain hygiene, prevent infection, and provide a safe environment for residents.A review of the facility's dated policy 09/01/2024, titled, Safe and Homelike Environment, revealed, Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.N.J.A.C. 8:39-31.3(a)Top of Form

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review it was determined that the facility failed to maintain documentation and ensure that a complete and thorough investigation was conducted for residents involving medication errors. This deficient practice was identified for 2 of 4 Residents (Resident #24 & 59) reviewed for medication administration and was evidenced by the following:1.) On 07/17/2025 at 10:45 AM, during the Resident Counsel Meeting, Resident #24 that they had concerns regarding late insulin. A review of the admission Record Face (admission summary) reflected that Resident #24 was admitted to the facility with a diagnosis that included, but was not limited to: diabetes mellitus (DM) (elevated blood glucose levels). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 4/11/2025, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident received insulin. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 7/19/2024, that the resident has diabetes mellitus. Interventions included: Diabetes medication as ordered by the doctor. A review of the Order Recap Report (ORR), included the following physician orders (PO): A PO, dated 6/28/2024, for Novolin N (intermediate-acting insulin that starts to work one (1) – three (3) hours after injection, peak between 4 and 12 hours and can last for up to 24 hours.), inject 24 units subcutaneously (under the skin) at bedtime. A PO, dated 2/20/2024, for Novolog (a rapid-acting insulin, starts to work 15 – 30 minutes after injection, peaked in about one (1) hour and lasts for two (2) to four (4) hours) flexpen, inject as per sliding scale: if 101-150 =3 units; 151 – 200 = 5 units; 201 – 250 = 7 units; 251 – 300 = 9 units; 301 – 400 =11 units, subcutaneously before meals and at bedtime. A PO, dated 2/20/2024, for Novolog (a rapid-acting insulin, starts to work 15 – 30 minutes after injection, peaked in about one (1) hour and lasts for two (2) to four (4) hours) flexpen, inject as per sliding scale: if 101-150 =3 units; 151 – 200 = 5 units; 201 – 250 = 7 units; 251 – 300 = 9 units; 301 – 400 =11 units, subcutaneously before meals and at bedtime. A review of the MAR for August 2024 revealed that on 8/9/2024 there was no documentation to indicate that the Novolin N and Novolog was administered according to physician orders at 9 PM. In addition, on the same date and time, there was no documentation of Resident #24's blood sugar. A review of the progress notes included a nurse's note (NN), dated 8/9/2024 at 7:00 PM, that included: Medication error noted from primary nurse [nurse's initials], nurse states she gave Novolog instead of Novolin. Continued to monitor patient throughout shift. No change in patients [sic] baseline or any issues with blood glucose levels. NP (nurse practitioner) notified and pt (patient) monitored for glucose levels. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes included a nurse practitioner's note dated 8/13/2024 at 10:01 AM, which included, .over wkend (weekend), nurse accidentally gave more short acting units of insulin, glucose and oj (orange juice) given, uneventful, has happened prior . The surveyor was unable to located a progress note by Licensed Practical Nurse (LPN) #1 that administered the incorrect medication and dose. A review of the facility provided Incident Report dated 8/9/2024 at 6:00 PM, included the following narrative: Nursing Description: UM (unit manager) was informed of med (medication) error by primary nurse 3-11 shift on 8/9/24. Resident description: states nurse administered wrong medication (insulin) and wrong dose. Upon further review of the incident report, it was found to be lacking in several key details, including the name of the medication administered, the time it was administered, the dosage administered, and the name of the nurse who administered the incorrect medication. There were no written statements obtained. On 7/22/2025 at 2:09 PM, the surveyor interviewed the Regional Director of Nursing (RDON), who confirmed that all contents of the incident report had been provided to the surveyor and that she was unable to provide any further details of the incident. She further stated that the incident report should have included all pertinent information, and a thorough investigation should have been conducted. A review of the facility's Incidents and Accidents, undated policy revealed, It is the policy of this facility to utilize [name of software] Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents.12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions.15. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or administrator. 2). On 07/17/2025 at 10:45 AM, during the Resident Counsel Meeting, Resident #59 that they had received the medication, Baclofen (a medication used to treat muscle spasms), that was not prescribed to them. A review of the admission Record Face reflected that Resident #59 was admitted to the facility with a diagnosis that included, but was not limited to: DM, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke). A review of the resident's quarterly MDS, dated [DATE], included the resident had a BIMS score of 15 out of 15, which indicated the resident's cognition was intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed Resident #59's ORR and did not locate an order for Baclofen. A review of the progress notes included a NN, dated 6/28/2025 at 10:30 AM, that included: Nurse administered Baclofen to resident which was not ordered for this resident [.] resident A&O (alert and oriented) x3 and able to make own decisions [.].Upon review of the facility's provided Incident Report identified as #571 Med Error (wrong resident) Date 06/28/2025 00:01, the nursing description identified that: 11-7 nurse administered Baclofen 20mg which was not ordered for this resident. The incident report further identified Resident #59's mental status as oriented to person, oriented to time, oriented to place, oriented to situation. The facility did not provide a progress note or written statement by the nurse that administered the incorrect medication following the incident recounting the time, dosage, or situation involving the event. In addition, the facility did not provide a written statement from Resident #59 regarding the incident. During an interview with another surveyor on 7/18/2025 at 1:06 PM, the IDON confirmed that giving a medication to a resident without a physician's order would be considered a medication error and that it would be investigated. The IDON stated that a complete and thorough investigation included, but not limited to, nursing statement, resident statement if alert and oriented, summary and conclusion on the investigation and initiate a Quality Assurance and Performance Improvement (QAPI). Upon discussing the incident regarding Resident #59 medication error, the IDON confirmed that the resident statement was not obtained and a Quality Assurance and Performance Improvement was not put into place following the incident for administering unprescribed medication/rights of medication administration. When asked if that would be important, the IDON stated yes because it should not be a repeated error that increased the potential for harm to the residents. On 7/21/2025 at 11:24 AM, the survey team interviewed the facilities' Pharmacy Consultant (PC), who identified that a significant medication error would include administering the wrong medication to a resident. When asked of the medication administration expectation for nurses, the PC stated that they should be following the rights of medication: right patient, medication, time, dose, and route. The PC confirmed that she was not made aware of any medication errors regarding resident's being administered unprescribed medications. A review of the facility policy titled, Incidents and Accidents, dated 9/1/2024, indicated that: It is the policy of this facility for staff to utilize [name redacted] to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Under the section titled, Policy and Explanation, indicated that: the purpose of the incident report can include: [.] conducting root cause analysis to ascertain causative/contributing factors as part of the QAPI to avoid further occurrences. NJAC 8:39-4.1(a)(5)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Number of residents sampled: 25Number of residents cited: 1Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to follow hold parameters for the administration of a blood pressure medication in accordance with professional standards of practice. This deficient practice was identified for 1 of 25 residents (Resident #76) reviewed for standards of practice and was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 7/17/25 at 8:54 AM, the surveyor observed Resident #76 in bed. The resident stated they were a dialysis patient and went to the dialysis center three times a week.On 7/17/2025 at 1:05 PM, the surveyor reviewed the medical record for Resident #76.A review of the admission Record reflected the resident was admitted to the facility with diagnoses which included end stage renal disease and hypotension (low blood pressure).A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 6/9/2025, reflected a brief interview for mental status (BIMS) score of 13 out of 15, which indicated an intact cognition. A further review reflected the resident received dialysis treatments.A review of the individualized person-centered care plan reflected a focus area initiated 2/20/2025, for hemodialysis related to end stage renal failure. Interventions included giving medications according to physician orders and monitoring the resident for elevated blood pressure.A review of the Order Summary Report (OSR) included a physician's order dated 4/22/2025, for Droxidopa Oral Capsule 200 MG (Droxidopa), give 1 capsule by mouth three times a day every Tuesday, Thursday, Saturday, and Sunday for neurogenic orthostatic hypotension (a condition where a person's blood pressure drops suddenly and significantly when they stand up, due to a dysfunction of the nervous system). Hold for SBP (systolic blood pressure) (the pressure in the arteries when the heart beats and pumps blood) greater than 140. Must be swallowed whole, do not crush, chew, or open. Should be dosed upon rising in the morning, at midday, and late afternoon at least 3 hours prior to bedtime to reduce potential for supine hypotension during sleep.A review of the corresponding May 2025 Medication Administration Record (MAR) revealed the resident received Droxidopa when the SBP was above 140 and should not have been administered on the following schedules and dates:9:00 AM; 5/10/20251:00 PM; 5/11/2025A review of the corresponding June 2025 MAR revealed the resident received Droxidopa when the SBP was above 140 and should not have been administered on the following schedules and dates:9:00 AM; 6/14/2025, 6/17/2025, 6/24/202513:00 PM;6/14/2025, 6/17/2025, 6/24/202517:00 PM; 6/1/2025, 6/3/2025A review of the corresponding July 2025 MAR revealed the resident received Droxidopa when the SBP was above 140 and should not have been administered on the following schedules and dates:9:00 AM; 7/1/2025, 7/8/2025, 7/13/2025, 7/15/202513:00 PM; 7/1/2025, 7/8/2025, 7/12/2025, 7/13/202517:00 PM; 7/1/2025, 7/19/2025On 7/21/2025 at 9:45 AM, during an interview with the surveyor, the Licensed Practical Nurse/ Unit Manager (LPN/UM #1) and the surveyor reviewed the resident's MARs and confirmed the nurses were not following the physician's hold order parameters for Droxidopa on multiple dates.On 7/21/2025 at 11:42 AM, during an interview with the survey team, the Pharmacy Consultant (PC) stated that Droxidopa is indicated for orthostatic (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypotension. The PC further stated that the adverse reaction for the medication if given beyond the SBP parameter of 140 was elevated blood pressure. On 7/22/2025 at 1:11 PM, during an interview with the survey team, the Regional Nurse (RG) stated that the nurses need to follow the parameters for medications as ordered by the physician. The RG further stated that not following parameters for Droxidopa would be considered a medication error.A review of the facility-provided policy titled Medication Administration date implemented 9/1/2024, included under Policy: Medications are administered by licensed nurses . as ordered by the physician and in accordance with professional standards of practice . N.J.A.C. 8:39 - 11.2 (b); 27.1 (a)

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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. Number of residents sampled: 6Number of residents cited: 2Complaint NJ #00174809Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide appropriate incontinence care for residents who were dependent on staff for Activities of Daily Living. This deficient practice was identified for 1 unsampled resident (Resident #34) and 1 sampled resident (Resident #67) out of 6 residents observed during incontinence rounds on 1 of 2 nursing units and was evidenced by the following:1. On 7/21/2025 at 8:54 AM, the surveyor performed incontinence rounds with Licensed Practical Nurse/ Unit Manager (LPN/UM) #1 and observed Resident #34 in bed. LPN/UM #1 exposed the resident's green incontinence brief from the front and stated that the resident was wet. LPN/UM #1 proceeded to close the brief. The surveyor noticed that the edge of the incontinence brief appeared layered. The surveyor asked LPN/UM #1 to expose the back of the incontinence brief. The surveyor observed a wet blue incontinence brief inside the wet green incontinence brief. The surveyor asked LPN/UM #1 if applying 2 briefs on the resident was appropriate. LPN/UM #1 stated that it was not right and that they will find out who did it and provide education to the staff.The surveyor reviewed the medical record of Resident #34.A review of the resident's admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; congestive heart failure and type 2 diabetes mellitus.A review of the resident's most current quarterly Minimum Data Set (MDS), an assessment tool dated 6/29/25, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated severely impaired cognition. The MDS further assessed that the resident was dependent on staff assistance for toileting hygiene and that the resident was always incontinent of bowel and bladder.A review of the resident's Individualized Care Plan (ICP) included a problem area revised on 4/13/2023, that the resident had incontinence of urine and bowel and required incontinence checks as needed. 2. On 7/21/2025 at 9:08 AM, during the incontinence rounds with LPN/UM #1, the surveyor observed Resident #67 in bed. LPN/UM #1 exposed the resident's white incontinence brief from the front. The brief was soaked. LPN/UM #1 proceeded to close the incontinence brief when the surveyor asked them to expose the back of the brief. The bedsheet was noted wet in the area beneath the resident's buttocks. When the resident's brief was exposed at the back, the surveyor noted a soaked green incontinence brief inside the white brief. The surveyor asked LPN/UM #1 if applying 2 briefs on the resident was appropriate. LPN/UM #1 stated that it was not right and that they will find out who did it and provide education to the staff. The surveyor reviewed the medical record of Resident #67.A review of the resident's admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; acute respiratory failure and type 2 diabetes mellitus.A review of the resident's most current quarterly Minimum Data Set (MDS), an assessment tool dated 5/19/25, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS further assessed that the resident was dependent on staff assistance for toileting hygiene and that the resident was always incontinent of bladder and frequently incontinent of bowel.A review of the resident's Individualized Care Plan (ICP) included a problem area revised on 7/8/2025, that the resident had toileting and mobility deficit related to impaired balance and respiratory failure. The care plan did not include specific interventions addressing the resident's incontinence. On 7/22/2025 at 9:42 AM, during a tour of the storage room with the unit secretary, the surveyor confirmed the following sizes of incontinence briefs based on color: large (blue), extra-large (yellow/ tan), 2-extra large (green), bariatric (white). On 7/22/2025 at 1:11 PM, during an interview with the survey team, the Regional Nurse (RN) stated that applying double incontinence brief on residents was not acceptable.A review of facility-provided policy titled Incontinence Care date implemented on 9/1/2024, included under Policy Explanation and Compliance Guidelines: 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. N.J.A.C. 8:39 - 27.1 (a); 27.2 (h)

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	07/24/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 1 day reviewed during the period of 02/02/2025 to 02/08/2025. Based on interview and review of Nurse Staffing Report sheets, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 1 of 6 days reviewed. This deficient practice was evidenced by the following:A review of the Nurse Staffing Reports completed by the facility for the week of 02/02/2025 through 02/08/2025, revealed the facility had no RN coverage for all shifts on 02/08/2025. During an interview with the surveyor on 07/21/2025 at 12:04 PM, the Licensed Nursing Home Administrator reviewed the Nurse Staffing Reports and confirmed that there there was not a registered nurse in the building for 8 consecutive hours on 02/08/2025. A review of a facility provided policy titled Nursing Services and Sufficient Staff, implemented 9/1/14, indicated, It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. NJAC 8:39-25.2(h)

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	07/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, the facility failed to ensure that food brought to residents by family and other visitors were stored, handled, and consumed in a safe and sanitary manner. This deficient practice was identified for 2 of 2 residents (Resident # 1 and Resident # 20) who had personal refrigerators in their bedrooms.The deficient practice was evidenced by the following: On 07/16/2025 at 12:33 PM, the surveyor observed that Resident # 20's personal refrigerator, located in bedroom [ROOM NUMBER]B, was missing temperature log entries for the 4th, 5th, 6th, 8th, and 11th of the month. The log also lacked documentation of the current month, year, and the location of the refrigerator. Additionally, there was no thermometer inside of the refrigerator. The refrigerator contained an open 28-ounce black container of ham, an open 4-ounce container of orange juice, a 5-ounce lidded container filled with an unidentified white food product, and an open 5-gram container of whipped butter spread. None of the items were labeled with open dates or use-by dates.On 07/17/2025 at 9:40 AM, the surveyor observed that Resident # 1's personal refrigerator, located in bedroom [ROOM NUMBER]A, was missing temperature log entries for the 4th, 5th, 6th, 8th, and 11th of the month. The log also lacked documentation of the current month, year, and the location of the refrigerator. Ice buildup and black debris were also noted inside the refrigerator's ice box.On 07/17/2025 at 9:45 AM, the surveyor observed that Resident #20's personal refrigerator, located in bedroom [ROOM NUMBER]B, was missing temperature log entries for the 4th, 5th, 6th, 8th, and 11th of the month. The log also lacked documentation of the current month, year, and the location of the refrigerator. Additionally, there was no thermometer inside of the refrigerator. The refrigerator contained an open 28-ounce black container of ham, an open 4-ounce container of orange juice, a 5-ounce lidded container filled with an unidentified white food product, and an open 5-gram container of whipped butter spread. None of the items were labeled with open dates or use-by dates.07/22/2025 at 12:09 PM, during an interview with the surveyor, the Housekeeping Director (HD) said that housekeeping staff perform daily checks of residents' personal refrigerators and thermometers to ensure temperatures remain within acceptable ranges. Temperature logs must be fully completed, no blanks are permitted, and any opened food items that are not properly labeled are discarded. 07/22/2025 at 2:00 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator said that housekeeping staff are responsible for ensuring refrigerator temperatures remain within a safe range and that all food is properly labeled and dated, with any expired, unlabeled, or spoiled items discarded immediately to reduce the risk of foodborne illness. A review of the facility's dated policy 10/01/2024, titled, Resident Refrigerators, revealed, It is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators. A thermometer shall remain in the refrigerator. Nursing/Housekeeping staff shall clean the refrigerator weekly and discard any foods that are out of compliance. Nursing staff clean up spills as needed or refer to housekeeping staff. Foods shall be in covered containers or securely wrapped.A review of the facility's dated policy 05/2023, titled, Foods Brought by Family/Visitors, revealed, Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date. Nursing staff will discard perishable foods on or before the use by date. NJAC 8:39-17.2(g)

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	07/24/2025

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Complete Care at Ocean Grove LLC	160 S Main St Ocean Grove, NJ 07756

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Number of residents sampled: 25Number of residents cited: 0REPEAT DEFICIENCYBased on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) handle trash and soiled linen appropriately for two housekeeping staff during cleaning of residents' rooms and b.) follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for 1 housekeeping staff during handling of soiled laundry, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was evidenced by the following:Reference: Laundry workers should wear appropriate personal protective equipment (e.g.,gloves and protective garments) while sorting soiled fabrics and textiles.https://www.cdc.gov/infection-control/media/pdfs/guideline-environmental-h.pdf Reference: CDC recommendations for Hand Hygiene: Updated February 27, 2024https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html#cdc_clinical_safety_best_practices_recor 1. On 7/16/2025 at 10:26 AM, during the initial tour of the facility, the surveyor observed a cleaning cart outside Resident #100 and Resident #66's room. There were also 2 tied plastic bags on the floor outside the residents' room. One plastic bag contained trash, and the other bag contained soiled linen. A blue disposable glove was noted on the floor beside the bags. Inside the room near the doorway, there were 2 more untied plastic bags with trash and a blue disposable glove on the floor. No cautionary sign was noted inside or outside the room. Housekeeper (HSK) #1 was noted cleaning the room.On 7/16/2025 at 10:50 AM, the surveyor observed a cleaning cart outside Resident #61's room. One plastic bag containing trash was observed on the floor by the doorway. A yellow cautionary sign was noted beside the cart. HSK #2 was noted cleaning the room. On 7/21/2025 at 10:30 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated that trash and soiled laundry need to go to clear plastic bags and to the the soiled utility room at once. The IP further stated that the plastic bags should not be on the floor. On 7/22/2025 at 1:11 PM, during an interview with the survey team, the Regional Nurse (RN) was asked how trash and soiled laundry should be handled in the units. The RN stated that they are put in plastic bags and transported to the soiled utility room. The RN further stated that they should not be on the floor. A review of the facility-provided policy titled Routine Cleaning and Disinfection date implemented 9/1/2024, included under Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.2. On 7/18/2025 at 9:23 AM, during the tour of laundry facilities, the surveyor observed housekeeping staff (HSK) #3 in the washing area, put on yellow washable gown without tying it at the back. HSK #3 was also observed to load soiled laundry to the washing machine from the soiled linen cart with ungloved hands. After loading the soiled laundry to the washer, HSK #3 was observed to wash their hands in the sink for 5 seconds. The surveyor asked HSK #3 if they should have worn gloves when touching soiled laundry. HSK #3 pointed to the trash can containing used gloves and stated they used gloves. The surveyor told HSK #3 that they were observed touching soiled laundry with bare hands and not using gloves while loading the washer. The surveyor further asked HSK #3 how long they should have washed their hands after touching soiled laundry. HSK #3 stated that they should have washed their hands for 20 seconds and that they were sorry. On 7/21/2025 at 10:30 AM, during an interview with the surveyor, the IP stated that HSK #3 should have worn gloves when they touched the dirty laundry and should have washed their hands for 20 seconds. A review of the facility-provided policy titled Laundry date implemented 9/1/2024, did not specify the PPE to be used by staff when handling soiled laundry. The policy did not also specify how housekeeping staff would wash their hands when handling soiled laundry. NJAC 8:39-19.4(a); 21.1 (h)