STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Shorrock	75 Old Toms River Road Brick, NJ 08723

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 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** Based on record review and interview, the facility failed to protect the resident's right to be free from physical abuse by another resident for three of five residents (Resident (R) R64, R129 and R106) reviewed for abuse out of 44 sampled residents. This had the potential for continued abuse to the residents.Findings include: 1. Review of R24's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was readmitted to the facility on [DATE] with diagnoses of mood disorder due to known physiological condition, anxiety, and depression. Review of R24's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25 and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident's cognition was severely impaired.Review of R24's Care Plan dated 05/15/25 and located in the EMR under the Care Plan tab revealed, I am animated when I speak and can be very passionate. I use my arms/hands when I am talking for emphasis. I can become argumentative with other residents at times. Interventions included, Monitor for triggers and warning signs of agitation. Direct me away from other residents if I begin to escalate, Monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication violence/aggression towards staff/others. etc.)2. Review of R129's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia, adjustment disorder, and anxiety disorder.Review of R129's annual MDS with an ARD of 09/11/25 and located in the EMR under the MDS tab revealed a BIMS score of eight out of 15, which indicated the resident's cognition was severely impaired. Review of the Incident Report dated 09/10/25 at 10:00 PM provided by the facility revealed staff alerted by yelling from R129 towards R24. Immediately went to residents and separated them. As R24 was immediately being separated, R24's hand made contact with R129's shoulder.Review of R24 and R129 Nurse's Note dated September 2025 revealed no documentation related to the incident that occurred on 09/10/25. During an interview on 01/07/26 at 3:05 PM, Licensed Practical Nurse (LPN)4 revealed on 09/10/25, he/she was supervising, and LPN7 reported to him/her that he/she saw R24 and R129 yelling at each other. R129 said that R24 was trying to go into his/her room, and R24 pushed him/her to try and get access to his/her room. She said LPN7 heard the incident, interviewed and separated them. R129 was brought into his/her room and R24 was brought to the nurse's station. 3. Review of R64's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia, Alzheimer's, major depressive disorder, and anxiety disorder.Review of R64's quarterly MDS with an ARD of 10/02/25 and located in the EMR under the MDS tab revealed a BIMS score of two out of 15, which indicated the resident's cognition was severely impaired. Review of the Incident Report dated 10/01/25 at 8:15 PM provided by the facility revealed, Notified by staff nurse that [R24] had a verbal altercation with another resident and when staff redirected R24 away from the resident R24's hand came in contact with R64.Review of R24's Nurse's Note dated 10/01/25 at 7:15 PM and located in the EMR under the Notes written by LPN6 revealed, alleged resident to resident abuse at nurse's station. During an interview on 01/07/26 at (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:05 PM, LPN4 revealed on 10/01/25, R24 was agitated with another resident but it was not R64. There was a verbal exchange between R24 and that other resident. He/she went over to intervene, took R24 and redirected her/him away, as he/she went to walk away, R24 swatted and hit R64 on the shoulder. They were separated and R64 was assessed.4. Review of R106's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, delusional disorder, dementia, major depressive disorder, and anxiety disorder.Review of R106's annual MDS with an ARD of 10/03/25 and located in the EMR under the MDS tab revealed a BIMS score of one out of 15, which indicated the resident's cognition was severely impaired. Review of the Incident Report dated 10/04/25 at 9:00 AM provided by the facility revealed, While in hall in view of staff, [R24] came in contact with [R106's] side of head.Review of R106's Nurse's Note dated 10/04/25 at 6:52 PM and located in the EMR under the Notes written by LPN8 revealed, resident to resident aggressive behavior. During an interview on 01/08/26 at 11:35 AM, LPN5 stated he/she was assigned to R106 on 10/04/25 who was sitting in her/his wheelchair in the hallway when R24 came up from behind and swiped/mushed in his/her in the face with his/her hand. LPN5 said there was no verbal exchange between them, and it really startled R106. During an interview on 01/08/25 at 5:12 PM, the Administrator, who was the abuse coordinator, stated they did not substantiate that abuse occurred in any of the three incidents. He/she stated they felt it was more incidental and did not feel R24 was intending to hit other residents. NJAC 8:39-4.1(a)(5)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility staff failed to report an allegation of physical abuse for one resident (Resident (R)105 against R177) of five residents reviewed for abuse immediately to the State Agency (SA). This had the potential to delay an investigation to determine whether abuse occurred or not.Findings include:Review of R105's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE].Review of R105's EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/25, indicated a Brief Interview for Mental Status (BIMS) score of two out of 15 which revealed the resident was severely cognitively impaired. R105's diagnoses included coronary artery disease, non-Alzheimer's dementia, and anxiety disorder.Review of R177's admission MDS with an ARD 2/04/25 revealed an admission date of 1/28/25 and a BIMS score of four out of 15 indicating severe cognitive impairment. R107's diagnoses included anxiety disorder, bipolar disorder and schizophrenia. The MDS indicated that resident received an antipsychotic and antidepressant medication.Review of the EMR located under the census tab revealed R177 was discharged from the facility on 03/15/25.Review of an email sent to the facility dated 04/03/25, provided by the Administrator indicated that R177 had a physical altercation on 03/13/25, with R105 at which time R105 struck R177 and attempted to remove R177's pants.During an interview on 1/08/25 at 11:23 AM, the Administrator stated that the facility did not report the allegation of physical abuse to the SA.During an interview on 1/08/25 at 1:00 PM, the CM stated that after he/she became aware of the incident reported to him/her by the Unit Manager (UM)/Licensed Practical Nurse (LPN)2, the CM spoke to the Director of Nurses (DON) and the Administrator regarding what was reported. During an interview on 1/08/25 at 1:13 PM, the Administrator stated that at the time the allegation was made there was a nurse that witnessed there was no contact made between the residents. Review of the facility's policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revised 10/01/25 revealed, .facility will report all alleged violations and all substantiated incidents to the state agency. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to thoroughly investigate resident to resident abuse for four of five residents (Resident (R)129, R64, R106 and R177) reviewed for abuse out of 44 sampled residents. This had the potential for continued abuse to the residents.Findings include:1. Review of R24's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was readmitted to the facility on [DATE], with diagnoses of mood disorder due to known physiological condition, anxiety, and depression. Review of R24's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/25, and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident's cognition was severely impaired.Review of R24's Care Plan dated 05/15/25, and located in the EMR under the Care Plan tab revealed, I am animated when I speak and can be very passionate. I use my arms/hands when I am talking for emphasis. I can become argumentative with other residents at times. Interventions included, Monitor for triggers and warning signs of agitation. Direct me away from other residents if I begin to escalate, Monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication violence/aggression towards staff/others. etc.)2. Review of R129's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia, adjustment disorder, and anxiety disorder.Review of R129's annual MDS with an ARD of 09/11/25 and located in the EMR under the MDS tab revealed a BIMS score of eight out of 15, which indicated the resident's cognition was severely impaired. Review of the undated Investigational Summary and Conclusion provided by the facility, revealed on 09/10/25 at 10:00 PM, R24 was being escorted by his/her nurse on the unit as he/she passed R129, R24's hand made contact with R129's shoulder. Further review revealed that following a thorough investigation, the facility has determined that there is no evidence to suggest abuse occurred as evidenced by the following: Assigned nurse was present at the time and was escorting R24 towards the common area. While leading R24, he/she incidentally made contact with R129's shoulder. Both residents were calm and cooperative with no signs of aggressive behavior at the time. This event has been classified as isolated. Both residents were interviewed with no recall of the incident. Further review revealed no resident interviews or body audits were completed for other residents on the unit. Review of staff statements revealed there was no specific information about what specifically occurred, other than contact made or an incident was reported. There was no way of knowing what contact meant and staff did not specify what specifically was reported to them. 3. Review of R64's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE], with diagnoses of dementia, Alzheimer's disease, major depressive disorder, and anxiety disorder.Review of R64's quarterly MDS with an ARD of 10/02/25, and located in the EMR under the MDS tab revealed a BIMS score of two out of 15, which indicated the resident's cognition was severely impaired. Review of the undated Investigational Summary and Conclusion provided by the facility, revealed on 10/01/25, staff responded to a verbal altercation between two residents (R24 and R64), immediately redirected and while moving away R24 made contact with R64. No injuries noted. Further review revealed that after a thorough investigation conducted by the facility, the facility has concluded that the event was not premeditated with both residents with no memory of the event shortly after. While at the nurse's station R24 became verbally agitated speaking with her hands; staff immediately intervened, when moving R64, R24 made contact with R64. Skin and pain assessments immediately completed with no new findings. Further review revealed no resident interviews or body audits were completed for other residents on the unit. Review of staff statements revealed there was no specific information about what specifically occurred, other than contact made or an incident was reported. There was no way of knowing what contact meant and staff did not specify what was specifically (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was reported to them.4. Review of R106's Face Sheet located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease, delusional disorder, dementia, major depressive disorder, and anxiety disorder.Review of R106's annual MDS with an ARD of 10/03/25, and located in the EMR under the MDS tab revealed a BIMS score of one out of 15, which indicated the resident's cognition was severely impaired. Review of the undated Investigational Summary and Conclusion provided by the facility, revealed on 10/04/25, while in the hall in view of staff, R24 came in contact with the side of R106's head. Immediately separated. Skin and pain assessments without injury. Further review revealed, after a thorough investigation conducted by the facility, the facility has concluded that the event was not premeditated with both residents with no memory of the event shortly after. R24 and R106 passing each other in the hallway when they became agitated. R24 made contact with R106 with no noted injuries or reported pain. Residents immediately separated and R24 placed on one to one (1:1) monitoring. Further review revealed no resident interviews or body audits were completed for other residents on the unit.Review of staff statements revealed there was no specific information about what specifically occurred, other than contact made or an incident was reported. There was no way of knowing what contact meant and staff did not specify what was specifically reported to them. The staff who were the only persons to witness the incident were not interviewed and did not provide a written statement. During an interview on 01/08/25 at 5:12 PM the Administrator, who was the abuse coordinator, stated he felt the investigations were thorough. He/she stated the person who witnessed the incident would need to write a more colorful statement and that staff who the incident was reported to only needed to write that an incident was reported to them. He/she was unable to state why all the investigations used the word contact and did not go into detail about what happened. He/she stated he/she did not know why the nurse who witnessed the 10/04/25, incident was not interviewed and asked to provide a statement. He/she stated that they did not interview any other residents since many residents on the unit had low BIMS score. 5. Review of R177's EMR located under the MDS tab revealed an admission MDS with an ARD of 02/04/25, revealed an admission date of 1/28/25, and a BIMS score of four out of 15 indicating a severe cognitive impairment.Review of the EMR located under the census tab revealed R177 was discharged from the facility on 03/15/25.Review of R105's EMR located under the MDS tab revealed a quarterly MDS with an ARD of 10/24/25, with an admission date of 12/03/24, and a BIMS score of two out of 15 indicating a severe cognitive impairment.Review of an email sent to the facility on [DATE], provided by the Administrator indicated that R177 had a physical altercation on 03/13/25, with R105 at which time R105 struck R177 and attempted to remove R177's pants.During an interview on 01/08/25 at 11:23 AM, the Administrator stated that the facility did not investigate the allegation made by the Case Manager (CM) because the nurse that witnessed the incident stated that at the time of the alleged incident there was no contact made between the two residents. The Administrator also stated that the nurse wrote a statement indicating the only thing that was discussed with the CM was discharge plans and a fall.During an interview on 01/08/25 at 1:00PM, the CM stated that after he/she became aware of the incident reported to him/her by the Unit Manager (UM)/Licensed Practical Nurse (LPN)2, the CM spoke to the Director of Nurses (DON) and the Administrator regarding what was reported.Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 10/14/25, indicated, . It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation.Investigation of Alleged Abuse, Neglect and Exploitation: An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. The policy requires that an immediate investigation be initiated upon suspicion or report of abuse, neglect, or exploitation, and that the facility will take steps to protect residents from physical and psychosocial harm, including preventing further abuse during and after the investigation. NJAC 8:39-9.4(f)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure three of three residents and their resident representatives (Resident (R)18, R20 and R158) reviewed for emergent hospital transfer out of a total sample of 44 residents were provided with a written bed hold policy and transfer notice. This failure had the potential to affect the resident and their resident representative (RR) by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. This had the potential to affect all residents who resided at the facility in the event they were transferred out of the facility. Findings include:1.Review of R20's admission Record located under the Resident tab in the electronic medical record (EMR) revealed admitted to the facility on [DATE]. Review of R20's Progress notes dated 01/04/26 revealed R20 was transferred to the hospital due to Gastrointestinal (GI) bleed and returned to the facility on [DATE]Review of R20's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/08/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R20 was cognitively intact.2.Review of R158's admission Record under the Resident tab in the EMR revealed admitted on [DATE]. Review of R158's Census located under the Census tab in the EMR revealed on 12/07/25, Hospital Leave Unpaid and on 12/11/25, returned to the facility.Review of R158's EMR located under the MDS tab revealed the quarterly MDS with an ARD of 12/05/25, revealed a BIMS score of 13 out of 15 indicating cognitively intact.Review of R158's Progress Note dated 12/07/25, located under the Resident tab of the EMR revealed R158 complained of shortness of breath (SOB). New order received to send to hospital for evaluation and treatment. Ambulance in to transport resident. Review of Transfer/Bed Hold notice prior to Hospitalization or Therapeutic Leave provided by the facility for R20 and R158 revealed that the document did not include the appeal process as indicated in the facility's policy.3. Review of R18's admission Record located in the Profile tab of the EMR revealed admission to the facility on [DATE], and was discharged to the hospital on [DATE]. Review of R18's quarterly MDS under the MDS tab of the EMR, with an ARD of 12/26/25, revealed a BIMS score of 13 out of 15, which indicated the resident's cognition was not impaired. Review of Transfer/Bed Hold notice prior to Hospitalization or Therapeutic Leave dated 07/19/25 and 08/21/25, provided by the facility revealed it did not include the appeal process on the form. During an interview on 01/07/26 at 2:41 PM, the Administrator stated the facility has been providing the residents and the RR with a written transfer and discharge notice. The Administrator stated he/she was aware of the facility's policy that the transfer notice should include the appeal information to residents and the RR.During an interview on 01/08/26 at 3:15 PM, the Social Service Director (SSD) stated the Transfer/Bed Hold notice prior to Hospitalization or Therapeutic Leave form was sent to the resident and RR. The SSD confirmed that the form did not include the required information for appeal. He/she stated that he/she was unaware that the appeal information was required.Review of the facility's policy titled Transfer and Discharge (including Against Medical Advise (AMA) dated 03/10/25 indicated, .3. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided.d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. f. Information on how to obtain an appeal form. g. Information on obtaining assistance in completing and submitting the appeal hearing request. NJAC 8:39-4.1(a)(31)(32)NJAC 8:39-5.1(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to develop a comprehensive care plan that addressed the use of an indwelling urinary catheter for one of three residents (R)166) reviewed for urinary catheter in the sample of 44 residents. This failure had the potential to result in improper catheter care or maintenance. Findings include:Review of R166's admission Record located in the electronic medical record (EMR) in the Profile tab revealed admitted on [DATE] and re-admitted on [DATE].Review of R166's 5-Day Modification Minimum Data Set (MDS) under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/16/2, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating R166 was moderately cognitively impaired. Further review of the MDS revealed a diagnosis of Obstructive Uropathy and the use of an indwelling urinary catheterReview of the Treatment Administration Record (TAR) dated February 2025, in the EMR under the Reports tab revealed that R166's indwelling urinary catheter was inserted on 02/15/25. Review of R166's undated comprehensive Care Plan located in the EMR under the Care Plan tab revealed the indwelling foley catheter was not addressed as a focus area in the care plan. Interview on 01/08/26 at 10:47AM, the Director of Nursing (DON) stated that an indwelling urinary catheter should be care planned. Interview on 01/08/26 at 10:15AM, the Licensed Practical Nurse (LPN)/Nurse Manager (NM)1 stated that the care plan needs to be updated to reflect the indwelling urinary catheter. Interview on 01/08/26 at 10:35AM, the Infection Preventionist (IP) stated that the care plan needs to be updated to reflect the foley catheter. Review of the facility's policy titled Comprehensive Care Plan revision date 03/01/25 revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, .to meet a resident's medical, nursing.and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. NJAC 8:39-11.2(e) thru(i)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to administer oxygen therapy as ordered for one Resident (R) 169 of 44 sampled residents. The facility failed to provide oxygen therapy according to physician orders, has the potential to contribute to the risk of respiratory failure.Findings include:Review of R169's face sheet, located under the Census tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE], with diagnoses that included congestive heart failure, atrial fibrillation, and pulmonary embolism. Observation of R169 on 01/06/26 at 10:46 AM, revealed the resident received oxygen therapy from a concentrator via nasal cannula (NC). The concentrator was set to 3.5 liters per minute (LPM). Review of R169's physician orders located under the Orders tab of the EMR revealed an order dated 12/29/25, that read, Oxygen at 2LPM via NC Continuous every shift.Subsequent observations on 01/07/26 at 10:49 AM and 3:47 PM revealed the concentrator was set at 3.5 LPM. Interview on 01/07/26 at 4:53 PM, Licensed Practical Nurse (LPN)6 confirmed that the concentrator was set to 3.5 LPM and that the order was for 2 LPM. During an interview on 01/08/26 at 5:14 PM, the Director of Nursing (DON) confirmed that he/she expects staff to follow physician orders. He/she added that there are times when nurses use their discretion in attempts to titrate a resident whose oxygen saturation is low before they contact a physician for updated orders but admitted that that process should be done over a few hours not days. Review of the facility's policy titled, Oxygen Administration dated 09/01/24 stated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences.Policy Explanation and Compliance Guidelines:1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.12. Staff shall notify the physician of any changes in the resident's condition, including.oxygen concentrations, or evidence of complications associated with the use of oxygen. NJAC 8:39-27.1(a)