STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING ______ B. WING ______	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE LONG BRANCH, NJ 07740**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: 172281, 172455, 173605, 174208, 180147 Survey Date: 12/9/24 Census: 93 Sample: 21 + 3 Closed Records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		1/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/01/2025

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.

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: NJ Complaint # 174208 Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to serve meals in a dignified, home-like manner by using disposable containers to serve food for residents who dinned in 1 of 2 main dining rooms (NJ Exec Order 26.4b1). The deficient practice was evidenced by the following: On 12/3/24 at 12:10 PM, the surveyor observed residents in the [redacted] floor main dining room being served lunch from the on-site serving station/steam table and being plated on reusable plates and silverware. Once lunch was served to all residents present in the dining room, the surveyor observed that four (4) out of the 14 residents were served lunch on red plastic disposable plates. At that time, the surveyor	F 550	1. Corrective Action " • The (U.S. FOIA) and nurse were educated by the Food Service Director that the residents should not have received a plastic plate and that all residents in the dining room must be served all courses of the meal on non-disposable plates. 2. Identification of other residents having potential to be affected by the deficient practice " • The deficient practice has the potential to affect all residents receiving meals. 3. Measures put in place " • Staff, including, nursing and dietary, were in-serviced on dignity with	

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F 550	Continued From page 2 interviewed the Licensed Practical Nurse (LPN #1) who was present in the room, regarding the disposable plates, and LPN #1 stated that there were not enough reusable plates brought up from the kitchen to serve all the residents in the main dining room. On 12/3/24 at 12:23 PM, after completing entrée service for the resident's lunch, the U.S. FOIA (b) went to the main kitchen to obtain desserts for the residents in the second floor main dining room. The U.S. FOIA (b) returned with a tray of individually wrapped sliced cake that were plated on disposable plates. The U.S. FOIA (b) then proceeded to serve each resident in the dining room a slice of cake by placing the individually wrapped slices on the table in front of them. No staff members were observed assisting residents to remove the plastic wrap off the cake slices. On 12/5/24 at 12:24 PM, the surveyor in the presence of the contracted dietary U.S. FOIA (b)(6) observed one resident (unsampled) in the main dining room of the second floor eating lunch off of a red plastic disposable plate, while two other residents at the table were eating off of reusable plates. The surveyor at that time asked the U.S. FOIA (b) about the use of the disposable plates, and the U.S. FOIA (b) approached the U.S. FOIA (in the dining room who stated that he "ran out of regular plates" and that he "always" had disposable plates as backup because the kitchen did not provide enough plates for the meal service. On 12/5/24 at 12:35 PM, the surveyor interviewed the U.S. FOIA (b), who stated that residents should not be served on disposable plates because it was a dignity issue and the facility needed to maintain a	F 550	regards to meal service and the Facility's policy on Tray presentation. This included education on serving prepared deserts on reusable plates. 4. How facility will monitor corrective actions to ensure the deficient practice does not recur. " • The Dietary Director (or designee) will complete weekly audits for four weeks and monthly for two months. • Dietary Director will submit Audit results to the QAPI Committee monthly for three Months.	

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F 550	Continued From page 3 home-like environment. On 12/6/24 at 11:53 AM, the U.S. FOIA (b)(6) [redacted], in the presence of the survey team, acknowledged that the residents in the main dining room should have all been served in the same manner using reusable plates and silverware because it was a dignity concern with dining. On 12/9/24 at 11:02 AM, the U.S. FOIA (b)(6), in the presence of the survey team, the U.S. FOIA (b)(6) [redacted]), stated that the kitchen should have provided more than the anticipated amount of plates needed for the residents meal service, and the U.S. FOIA (b)(6) should have called the kitchen to request additional plates. A review of "Dining Service Tray Presentation" policy dated revised 10/2023, included...residents will eat their meals in a dignified home-like environment. Disposable plates, containers, utensils will not be used for meal service...the director of each account is responsible for keeping inventory and purchase non-disposables to maintain adequate supply... NJAC 8:39-17.2(e)	F 550		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		1/17/25

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F 607	Continued From page 4 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview, review of facility policy, and review of pertinent facility documents, it was determined that the facility failed to implement their NJ Ex Order 26 policy to complete reference checks on employees before their start date. The deficient practice was identified for 5 of 10 employees reviewed for new hires (Employee #3, #6, #8, #9 and Employee #10), and was evidenced by the following: A review of facility's "Abuse Policy" dated 9/1/24, included in the section titled "Screening Components" that it is the policy of this facility to screen employees and volunteers prior to working	F 607	1. The U.S. FOIA (b) (6) was in-serviced by the Administrator on ensuring Reference Checks prior to hire or documenting if unable to obtain. 2. All residents have the ability to be affected by this deficient practice. An audit was done on all current employee files to ensure reference checks were completed with no further concerns identified. 3. The Administrator provided in person	

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F 607	Continued From page 5 with residents. Screening components include 1. verification of references shall be conducted on potential employees...3. The facility will maintain documentation of proof that the screening occurred. On 12/3/24 at 12:47 PM, the surveyor requested from the U.S. FOIA (b)(6) ten newly hired employee personnel files who were hired since the facility's last standard survey who were still employed or terminated. A review of employee personnel files revealed the following: For Employee #3, Certified Nursing Assistant (CNA) with a start date of NJ Exec Order 26.4b1, there was no evidence of a reference check prior to the start of employment. For Employee #6, a Licensed Practical Nurse (LPN) with a start date of NJ Exec Order 2, there was no evidence of a reference check prior to the start of employment. For Employee #8, a CNA with a start date of NJ Exec Order 26.4, there was no evidence of a reference check prior to the start of employment. For Employee #9, a Registered Nurse (RN) with a start date of NJ Exec Order 26.4b there was no evidence of a reference check prior to the start of employment. For Employee #10, a NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4, there was no evidence of a reference check prior to the start of employment. On 12/5/25/24 at 11:57 AM, the surveyor interviewed the U.S. FOIA (b)(6)	F 607	education to Department Heads and the Human Resource Director pertaining to documents required upon hire, per policy. 4. The Human Resources Director will audit all new hire files weekly for four weeks and then Monthly for two months. The Human Resources Director will submit to the Administrator the status of all New Hire Reference Checks for the past month at Monthly QAPI meeting for three months and then at Quarterly for the next three Quarters	

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F 607	Continued From page 6 U.S. FOIA (b)(6) about the facility's screening process for new hires, and the U.S. FOIA (b)(6) stated the facility should follow their hiring policy and all new hires should have a completed reference check prior to their first day of employment. On 12/9/24 at 10:35 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6)), and survey team acknowledged the missing pre-employment checks. The U.S. FOIA (b)(6) confirmed every employee should have a criminal background and reference check prior to employment. NJAC 8:39-4.1(a)(5); 9.3(b)	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid	F 622		1/17/25

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F 622	Continued From page 7	F 622		

under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident

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F 622	Continued From page 8 needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 172455; 173605 Based on interview and review of pertinent facility documents, it was determined that the facility failed to a) ensure the New Jersey Universal Transfer Form (UTF) used to communicate with the receiving long-term care (LTC) facility where a resident was being transferred was complete and b) complete the physician discharge summary. The deficient practice was identified for 1 of 3 resident reviewed for discharge (Resident #289), and was evidenced by the following:	F 622	1. Resident affected by the deficient practice: The facility failed to ensure the New Jersey Universal Transfer form and physician discharge summary was completed for resident #289. Resident #289 was discharged from the facility NJ Exec Order 26.4b1. Individual nurse who discharged the resident was provided with individual education on the process for discharging residents to another LTC facility, including the New Jersey	

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Reference: NJ.gov: https://www.nj.gov/health/forms/hfel-7instr_1.pdf: "INSTRUCTIONS FOR COMPLETING THE NEW JERSEY UNIVERSAL TRANSFER FORM" dated August 2011, The purpose of the New Jersey Universal Transfer Form: A form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs. It conveys the patient information required under federal regulations and conveys specific facts that the physician and nurse need to begin caring for a patient. The word patient is used throughout the form but refers to resident/client or the terminology used by a specific facility or program. Complete all boxes #1 - 29.
b) A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability.
1. The Universal Transfer Form is not complete if medication information is not attached.
(c) A licensed healthcare facility or program shall send a completed, paper copy of the Universal Transfer Form with a patient when a patient is transferred.
(d) A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record...

On 12/04/24 at 10:30 AM, the surveyor reviewed the closed medical record for Resident #289.

A review of the Admission Record face sheet (an admission summary) revealed the resident was

Universal Transfer Form.

2. Identifying other residents who could be affected by the deficient practice:
Residents being discharged to another LTC facility could be affected by this deficient practice.
Discharges for December were audited and no residents were discharged from the facility to another LTC during this period.

3. Measures or systemic changes to ensure that the deficiencies will not recur:
Licensed Nurses and U.S. FOIA (b) (6) were in-serviced on the policy/process for discharging residents to another facility that includes the New Jersey Universal Transfer Form, beginning 12/4/24 by the Director of Nursing and Assistant Director of Nursing. The Clinical Management team and The Medical Records Director in-serviced on completion of Physician discharge summary for all residents discharged, beginning on 12/4/24 by the Director of Nursing and Assistant Director of Nursing.

4. Monitoring the continued effectiveness of the systemic change:
The Director of Nursing or Designee will conduct audits of discharged resident□s charts to ensure accurate completion of the New Jersey Universal transfer form and discharge summaries weekly x 4 weeks then monthly x 2 months. Results of the audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to

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F 622	Continued From page 10 admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . A review of the Progress Note (PN) dated NJ Ex Order 26.4(at 2:17 PM, indicated Resident #289 had been transferred to another [name redacted NJ Exec Orde facility closer to family member. All the resident's belongings were packed and transferred with resident in private vehicle. A review of the UTF dated NJ Ex Order 26.4(b), instructed on the top of the form "Items 1 - 29 must be completed," revealed the following: only 9 of 29 specific areas were completed (#1, #2, #3, #4, #5, #7, #9, #13, and #24) and the remaining areas were blank which included: #6 code status, #8 reason for transfer, #10 NJ Ex Order 26.4(b)(1) #11 NJ Ex Order 26.4(b)(1) needs, #12 isolation precautions, #14 NJ Ex Order 26.4(b)(1), #15 NJ Ex Ord conditions, #16 diet, NJ Ex Order 26.4(b)(1), #17 intravenous (IV) access, #18 personal items sent, #19 attached documents i.e. medical records and discharge summary but not limited to, #20 at risk alerts, i.e. NJ Ex Orde NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) precautions but not limited to, #21 mental status, #22 Preadmission Screening Resident Review (PSARR) level, #23 NJ Ex Order 26.4(b)(1) functioning, #25 bowel, #26 bladder, #27 sending facility contact, #28 form filled out by, and #29 form completed by.	F 622	ensure compliance and reassessed for further action.	

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F 622	Continued From page 11 The medical record did not include a discharge summary. On 12/5/24 at 9:00 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated if a resident was transferred, the staff completed the UTF and made copies of the record for the receiving facility which include but not limited to; the resident's discharge summary. On 12/6/24 at 11:50 AM, the U.S. FOIA (b)(6) , in the presence of the U.S. FOIA (b) and survey team, acknowledged that Resident #289's UTF was not complete and the resident's discharge summary was not completed. A review of the "Discharge Planning Process"policy dated 9/1/24, included...10. the facility will assist residents and their resident representatives in choosing an appropriate post-acute care provider (i.e. another Long-Term Care Facility SNF) that will meet the resident's needs, goals, and preferences...12. all relevant information will be provided in a discharge summary to avoid unnecessary delays in the resident's discharge or transfer, and to assist the resident in adjustment to his or her new living environment... NJAC 8:39-4.1(a)31	F 622		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		1/17/25

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	315284	A. BUILDING ______ B. WING ______	C 12/12/2024

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F 656	Continued From page 12 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656		

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F 656	Continued From page 13 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop an individualized comprehensive care plan (ICCP) for a resident with a new NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 who was receiving NJ Ex Order 26.4 care to a NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 22 residents reviewed for comprehensive care plans (Resident #189), and was evidenced by the following: On 12/3/24 at 10:40 AM, during the initial tour of the facility the surveyor observed Resident #189 out of bed sitting in a wheelchair. The resident told the surveyor that they were receiving NJ Exec Order 26. NJ Exec Order 26.4b1, showing the surveyor that the resident had NJ Ex Order 26.4(b)(1) . The surveyor reviewed the medical record for Resident #189. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted with medical diagnoses which included; NJ Exec Order 26.4b1 . A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, indicated the resident had a Brief Interview of Mental Status (BIMS) score NJ Exec Order 26.4b1 meaning the resident was NJ Exec Order 26.4b1. A review of Section NJ Ex Order 26.4(b)(1), revealed that the resident had an NJ Exec Order 26.4b1 .	F 656	1. Resident affected by deficient practice: The facility failed to develop an individualized comprehensive care plan for a resident with a new NJ Exec Order 26.4b1 who was receiving NJ Exec Order 2 care to a NJ Ex Order 26.4(b)(1) Resident #189 care plan was updated to reflect NJ Exec Order 26.4b1 related to NJ Ex Order 26.4(b 2. Identifying other residents who could be affected by the deficient practice: Residents who are admitted to the facility with a surgical site could be affected by this deficient practice. Other residents with surgical sites were audited. No other residents with surgical sites were found. 3. Measures or systemic changes to ensure that the deficient practice does not recur: U.S. FOIA (b) (6), Unit Managers, Nursing Supervisors and Licensed Nurses in-serviced on Comprehensive Care Plans to include surgical wound care by Director of Nursing. 4. Monitoring the continued effectiveness of the systemic change: Director of Nursing/designee will conduct Audits of all new admissions to ensure accurate completion of comprehensive care plans for surgical sites/wounds weekly x 4 then monthly x 2. Results of	

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F 656	Continued From page 14 A review of the Physician Order Summary included a physician's order (PO) dated NJ Exec Order 26.4b1 to cleanse the NJ Exec Order 26.4b1 , and an NJ Exec Order 26.4b1 daily. A review of the corresponding Treatment Administration Record (TAR) revealed that Resident #189 was receiving NJ Exec Order 26.4b1 A review of the ICCP did not include a NJ Exec Order 26.4b1 On 12/5/24 at 12:13 PM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding baseline/comprehensive care plans. The surveyor asked what would be included in the electronic medical record (EMR) if a resident was admitted with a NJ Exec Order 26.4b1, and the U.S. FOIA (b) stated the NJ Exec Order 26.4b1 would be noted on the admission assessment, in the physician orders, and included in the ICCP. The surveyor asked what the focus would be on the ICCP, and the U.S. FOIA (b) stated NJ Exec Order 26.4b1. The surveyor asked if a new NJ Exec Order 26.4b1 should be part of the ICCP, and the U.S. FOIA (b) confirmed yes. A review of the "Comprehensive Care Plan" policy dated 9/1/24, included it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights to meet a residents medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment...	F 656	the audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 656	Continued From page 15 NJAC 8:39-11.2(e), 27.1(a)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to a) revise an individual comprehensive care plan (ICCP) for a resident	F 657	1. 1. Residents affected by the deficient practice: Resident #55's care plan was updated	1/17/25

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F 657	Continued From page 16 with NJ Exec Order 26.4b1, and b) revise an (ICCP) for a resident after a NJ Exec. This deficient practice was identified for 2 of 2 residents reviewed for NJ Exec Ord (Resident #14 and Resident #55), and was evidenced by the following: 1. On 12/3/24 at 9:50 AM, during the initial tour of the facility, the surveyor went to see Resident #55 and was informed that the resident was NJ Exec Order 26.4b1 On 12/9/24 at 10:23 AM, the surveyor reviewed the medical record for Resident #55. The medical record indicated that the resident was readmitted back to the facility on NJ Exec Order 26.4. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, revealed the resident had a Brief Interview of Mental Status (BIMS) score of NJ Exec Order 2 meaning the resident had a moderately impaired cognition. A review of Section NJ Ex Ord, indicated that the resident was NJ Ex Order 26.4(b)(1) on staff for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b). A review of Section NJ Ex Order 26.4(Assessment, revealed the resident did not have NJ Ex Order 26.4(b) since admission/entry or reentry to the facility. A review of the Order Summary Report included a physician's order (PO) dated NJ Exec Order 26.4, to always have NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) when in bed. An additional PO dated	F 657	with NJ Exec O interventions upon readmission on 12/6/24. Resident #14 had no NJ Exec Order 26.4b1 requiring further care plan intervention. 2. Identifying other residents who could be affected by the deficient practice: All Residents who have a fall or who have an incident could be affected by this deficient practice. Current residents with a fall were audited for care plan updates with no noted issues. 3. Measures or systemic changes to ensure that the deficiencies will not recur: U.S. FOIA (b) (6), Unit Managers, Nursing Supervisors and Licensed Nurses in-serviced on the Policy for Incidents/Accidents and the process by Director of Nursing. Emphasis placed on the timing of completing the care plan with a new intervention at the time of the incident. 4. Monitoring the continued effectiveness of the systemic change: The Director of Nursing/Designee will audit five resident incident reports to ensure timely completion of CarePlan interventions weekly x 4 then monthly x 3. Results of audit will be reviewed at Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 657	Continued From page 17	F 657		

NJ Ex Order 26.4(b) indicated the resident could NJ Exec Order 26.4b1 .

A review of the post NJ Exec O assessment dated NJ Exec Order 26.4b, indicated following the resident's NJ Exec the resident was a NJ Exec Order 26.4b1

A review of the ICCP included a focus area dated NJ Ex Order 26.4(b)(, and last revised on NJ Ex Order 26.4(, that the resident was a moderate risk for NJ Exec Ord related to NJ Exec Order 26.4b1 Interventions included to; keep NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(to evaluate and treat. The care plan goals were that the resident would be free from NJ Ex Ord and the resident would be free from NJ Ex Order 26.4(b)(1). The goals were updated on NJ Ex Order 26.4(, after the surveyor inquiry.

On 12/9/24 at 12:15 PM during an interview with the U.S. FOIA (b)(6)), the surveyor asked if the ICCP should be updated with new interventions following a NJ Exec, and the U.S. FOIA (b) responded confirmed yes, that it should be updated with new interventions put in place.

2. On 12/3/24 at 11:00 AM, during the initial tour of the facility, the surveyor observed Resident #14 sleeping in a recliner chair in their bedroom.

On 12/4/24 at 12:13 PM, the surveyor observed Resident #14 lying in bed sleeping. The surveyor observed NJ Exec NJ Ex Order located on both sides of the resident's bed and the resident's bed was NJ Ex Order 2 with the call device within reach.

On 12/4/24 at 1:13 PM, the surveyor reviewed the

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F 657	Continued From page 18 medical record for Resident #14. A review of the Admission Record Face sheet reflected that the resident was admitted to the facility with diagnoses that included but not limited to; NJ Exec Order 26.4b1 A review of the most recent comprehensive MDS dated NJ Exec Order 26.4b1, indicated the resident had a BIMS score of NJ Exec Order 26.4b1, indicating a NJ Exec Order 26.4b1. A further review in Section NJ Ex Order 26.4(b)(1), reflected the resident was NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) A review of the Order Summary Report included a PO dated NJ Exec Order 26., for NJ Ex Order 26.4(b)(1) at all times when in bed. A review of the facility's incident and accident reports revealed that Resident #14 had NJ Exec Or on NJ Exec Order 26.4b1 A review of the ICCP included a focus area dated 9/12/22, that the resident was at risk for NJ Exec O related to NJ Exec Order 26.4b1 and does not always call for NJ Ex Order 26.4(b)(1) when needed, behaviors of NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and putting their self NJ Ex Order 26.4(b)(1). Interventions included but not limited to; NJ Ex Order 26.4(b)(1) in place at all times, bed NJ Ex Order 26.4(b)(	F 657		

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F 657	Continued From page 19 NJ Ex Order 26.4(b when in bed, educate resident to use NJ Ex O for items out of reach, and review information on NJ Exec Order 26.4b1 and attempt to determine the cause of the NJ Exec Orde The ICCP did not include any new interventions put into place after the NJ Exec O . During an interview with the surveyor on 12/5/24 at 11:20 AM, the U.S. FOIA (b)(6) identified that a ICCP should be updated with interventions as changes occurred, quarterly, and annually. The U.S. FOIA (b) further stated that when there was a fall, the ICCP was updated with new interventions. The U.S. FOIA (b) acknowledged that Resident #14's ICCP was not updated after the NJ Exec Order 26.4b1 A review of the facility's "Fall Prevention Program" policy dated implemented date 9/1/24, included... 6. each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 7. When any resident experiences a fall, the facility will... e. Review the resident's care plan and update as indicated... A review of the facility's "Care Plan Revisions Upon Status Change" policy dated implemented 9/1/24, included...2. Procedure for reviewing and revising the care plan when a resident experiences a status change... d. The care plan will be updated with the new or modified interventions... NJAC 8:39-27.1(a)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		1/17/25

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F 658	Continued From page 20 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: NJ Complaint # 172281 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain professional standard of practice by a) ensuring medications were administered in a timely manner in accordance with the resident's physician's order for Resident #48, and b) ensuring proper medication management by borrowing medications from one resident's supply to administer to another resident for Resident #60 and Resident #4. This deficient practice was identified for 3 of 21 residents (Resident #48, Resident #60 and Resident #4) reviewed for professional standards of practice. 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 casefinding, 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."	F 658	1. Residents affected by the deficient practice: The facility failed to maintain professional standard of practice by ensuring medications were administered in a timely manner in accordance with the resident's physicians order and ensuring proper medication management by borrowing medications from one resident supply to administer to another resident. Resident #48 had not had further cited concerns of receiving medications outside of parameters since NJ Exec Order 26.4b1. Resident #60 and Resident #4 received medication as ordered. Licensed nurse who administered medication as cited to resident #60 and #4 received individual education. 2. Identifying other residents who could be affected by the deficient practice: All residents can be affected by this practice. Residents #48, #60, and #4 were audited for medication administration outside of parameters with no further issues identified. Five other residents were audited to ensure that all medications were available with no issues identified	

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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 casefinding; 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."

1. During initial tour on 12/4/24 at 12:15 PM, the surveyor observed two nurses exiting Resident #48's bedroom. The nurse stated the resident just received their 12:00 PM medications and did not want to be bothered at this time.

The surveyor reviewed the medical record for Resident #48.

A review of the Admission Record Face sheet (an admission summary) reflected that Resident #48 was admitted to the facility with diagnoses which included, but not limited to: NJ Exec Order 26.4b1 [redacted]

A review of the most recent significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated U.S. FOIA (b)(6) [redacted], reflected the resident had a brief

F 658

3. Measures or systemic changes to ensure that the deficiencies will not recur: Licensed nurses in-serviced on the Medication Administration Policy and the process if a resident is out of their supply of medication beginning 12/5/24 by Assistant Director of Nursing.

4. Monitoring the continued effectiveness of the systemic change:

The Unit Managers/Designee will conduct an audit of medication availability and administration time parameters for five residents weekly x 4 then monthly x 2. Results of the audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.

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F 658	Continued From page 22 interview for mental status score of NJ Exec Order 26.4b1, indicating that the resident had an NJ Exec Order Further review in Section J "Health Conditions" reflected the resident received scheduled NJ Ex Order medication. A review of the Order Summary Report included a physician's order (PO) dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 May wake for administration. The Order Summary Report also included a physician's order dated NJ Exec Order 26.4b1 NJ Ex Further review of the Order Summary Report revealed an order dated NJ Exec Order 26., with a discontinued date of NJ Exec Order 2, for NJ Exec Order 26.4b1 . Hold for NJ Ex Order 26.4(b)(1) There was a new physician order dated NJ Exec Order 26 for NJ Exec Order 26.4b1 A review of the corresponding Medication Admin Audit Report revealed the NJ Ex Order 26.4(b)(1) was administered outside of the parameters (3) three times on NJ Ex Order 26, (1) one time on NJ Ex Order 26, (5) five times on NJ Ex Order 26, (2) two times on NJ Ex Order 26, (5) five times on NJ Ex Order 26.4((2) two times on NJ Ex Order 26.4 and (1) one time on NJ Ex Order 26. The NJ Ex Order 26.4(b)(1) was administered outside parameters (2) two times on NJ Ex Order 26, (1) one time on NJ Ex Order 26, (2) two times on NJ Ex Order 26 and (1) one time on NJ Ex Order 26. The NJ Ex Order 26.4(b)(1) was administered outside of	F 658		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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F 658	Continued From page 23	F 658		

NJ Exec Order 26.4b1

On 12/6/24 at 11:35 AM, the surveyor asked the U.S. FOIA (b)(6) in the presence of the survey team what were the time frames for administering medications, and the U.S. FOIA (b)(6) stated medications can be administered an hour before or after the physician order. The U.S. FOIA (b)(6) acknowledge that 9 AM medications given after 10 AM were considered late.

On 12/9/24 at 11:05 AM, the U.S. FOIA (b)(6)), in the presence of the U.S. FOIA (b)(6) in training and the survey team, stated that if the nurse is administering medications outside the parameters, they need to document the reason. The U.S. FOIA (b)(6) stated the importance of administering the medication on time was to prevent the potential of an overdose.

A review of the facility's "Medication Administration" implemented on 9/1/24, included compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time ...Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.

2. On 12/5/24 at 8:35 AM, during medication administration observations, the surveyor observed Licensed Practical Nurse #1 (LPN #1) dispensing and preparing to administer medication to Resident #60. During the process of medication administration, after showing the surveyor the medication cards ("Bingo card"

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F 658	Continued From page 24 containing individually packaged pills), one at a time, for observation, the LPN #1 dispensed one NJ Exec Order 26.4b1 into a small plastic medication cup. The LPN #1 proceeded to retrieve the second medication NJ Exec Order 26.4b1 when the LPN #1 recognized Resident #60 did not have this medication in the medication cart. The LPN #1 then stated, "I will have to borrow the medication from another resident." The LPN #1 also stated she should not be borrowing medication from another resident, but "I don't have back up medication on the medication cart." The LPN #1 further stated that back up medications were located in the medication room. LPN #1 found the NJ Exec Order 26.4b1 in Resident #68's medications. LPN #1 then dispensed the medication into the small plastic medication cup. LPN #1 administered the medications to Resident #60. On 12/5/24 at 8:50 AM, during medication administration observation, the surveyor observed LPN #1 as she prepared 15 medications for Resident #4. Included in these medications was NJ Exec Order 26.4b1 . When LPN #1 went to retrieve the medication from the resident's medication cards, LPN #1 stated Resident #4 did not have this medication in the medication cart and she would have to borrow it from another resident. LPN #1 then proceeded to borrow the NJ Exec Order 26.4b1 from Resident #82. LPN #1 then administered all NJ Exec medications to Resident #4. LPN #1 then stated, "we aren't supposed to borrow medications from another resident, but I don't	F 658		

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F 658	Continued From page 25 have backup medications on the medication cart." The surveyor reviewed the medical records for Resident's #60, #68, #4 and #82. a.) A review of the Admission Record Face sheet (an admission summary) reflected that Resident #60 was admitted to the facility with diagnoses that included, but not limited to; NJ Exec Order 26.4b1 A review of Resident #60's most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, indicated the resident had a brief interview for mental status (BIMS) score of NJ Exec Order 2 indicating the resident was NJ Exec Order 26.4b1 A review of the Order Summary Report for Resident #60 included a physician's order (PO) dated NJ Exec Order 26.4b1 b.) A review of the Admission Record Face sheet (an admission summary) reflected that Resident #68 was admitted to the facility with diagnoses which included, but not limited to; NJ Exec Order 26.4b1 A review of Resident #68's most recent annual MDS dated NJ Ex Order 26.4b, indicated the resident had a BIMS score of NJ Exec Order 26.4b1 indicating the resident had NJ Exec Order 26.4b1.	F 658		

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F 658	Continued From page 26 A review of the Order Summary Report for Resident #68 included a physician's order (PO) dated NJ Exec Order 26.4b1 c.) A review of the Admission Record Face sheet (an admission summary) reflected that Resident #4 was admitted to the facility with diagnoses which included, but not limited to; NJ Exec Order 26.4b1 A review of Resident #4's most recent quarterly MDS dated NJ Exec Order 26 indicated the resident had a BIMS score of , indicating that the resident had NJ Exec Order 26.4b1 A review of the Order Summary Report for Resident #4 included a physician's order (PO) dated NJ Exec Order 26.4b1 . d.) A review of the Admission Record Face sheet reflected that Resident #82 was admitted to the facility with diagnoses which included, but not limited to; NJ Exec Order 26.4b1 A review of Resident #82's most recent quarterly MDS dated NJ Exec Order 26.4b1 indicated the resident had a	F 658		

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F 658	Continued From page 27 BIMs score of NJ Exec Order 26.4b1, indicating the resident had NJ Exec Order 26.4b1. A review of the Order Summary Report for Resident #82 included a physician's order (PO) dated NJ Exec Order 26.4b1 On 12/5/24 at 9:08 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that when a medication was not available the nurse was to check the back up medication in the pyxis (automated medication dispensing system). The U.S. FOIA (b)(6) stated if its not in the pyxis, the nurse should call the pharmacy to see if it can be ordered STAT (immediately) and also notify the physician. The U.S. FOIA (b)(6) further stated that a nurse should never borrow a medication from another resident. On 12/5/24 at 9:15 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that the nurse should check the pyxis if they run out of a medication. The U.S. FOIA (b) also stated that if the medication was not in the pyxis, the nurse should notify the physician, get a new order if needed and follow up with the pharmacy. The U.S. FOIA (b) further stated the nurse would notify the resident and the residents representative. U.S. FOIA (b) then proceeded to state that medications should not be borrowed from one resident for another. On 12/6/24 at 11:35 AM, during an interview with the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) in training and the survey team, stated that if a nurse runs out of a medication, they are to check the pyxis	F 658		

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F 658	Continued From page 28 for back up. If there was no back up, the nurse is to notify the physician, pharmacy, and the resident. The [U.S. FOIA (b)] stated the nurse should not borrow medications from another resident. The [U.S. FOIA (b)] further stated that borrowing medications from another resident can cause that resident to run out of their medication. A review of the facility's "Medication Administration" implemented on 9/1/24, included compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time ...Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. NJAC 8:39-29.2(d)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of	F 686	1. Residents affected by the deficient	1/17/25

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F 686	Continued From page 29 pertinent facility documentation it was determined that the facility failed to provide NJ Exec Order 26.4b1 prevention and NJ Ex Order 26.4(b)(1) devices as ordered by the physician. This deficient practice was identified for 1 of 2 residents (Resident #85) reviewed for NJ Exec Order 26.4b1 and was evidenced by the following: On 12/3/24 at 11:05 AM, during the initial tour of the facility the surveyor observed Resident # 85 in the bed. Resident #85 told the surveyor they were receiving NJ Exec Order 26.4b1 but could not NJ Ex Order because of a NJ Exec Order on their NJ Exec Order 26.4b1. The surveyor asked if it had NJ Ex Order 26.4 and the resident stated, 'NJ Exec Order 26.4b1 On 12/4/24 at 11:00 AM, the surveyor observed Resident #85 in bed. The resident did not have a NJ Exec Order 26.4b1 in place. On 12/5/24 at 10:00 AM, the surveyor reviewed the medical record. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted with medical diagnoses which included but was not limited to NJ Ex Order 26.4(b)(due to NJ Exec Order 26.4b1 A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 indicating that the resident was NJ Exec Order 26.4b1. Review of Section NJ E of the MDS for NJ Ex Ord assessment	F 686	practice: Orders were discontinued for NJ Exec Order 26.4b1 and no NJ Exec Order 26.4b1 was in place per recommendation as NJ Exec Order 26.4b1 had been NJ Ex Order 26.4 as of NJ Exec Order 26.4b1 rounds and NJ Exec Order 26.4b1 rounds, NJ Exec Order 26.4b1 was NJ Ex Order 26.4(2. Identifying other residents who could be affected by the deficient practice: All residents with wounds and that are at risk for wounds Residents with wounds were audited to ensure that all orders and recommendations were carried out. No further issued identified. 3. Measures or systemic changes to ensure that the deficiencies will not recur: Unit Managers and Licensed nurses were educated on the Administration of Wound treatments by Assistant Director of Nursing. 4. Monitoring the continued effectiveness of the systemic change The Director of Nursing/designee will conduct an audit of all wound consults to ensure all orders/recommendations were followed weekly x 4 weeks then monthly x 2. Results of the audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 686	Continued From page 30 indicated the resident had a NJ Exec Order 26.4b1 and was at risk for the development of NJ Exec Order 26.4b1 A review of the Physician Order Summary (PO) revealed an order dated NJ Exec Order 26, to NJ Exec Order 26.4b1 when in bed, a PO dated NJ Exec Order 26.4b, for a NJ Exec Order 26.4b1 for the NJ Exec Order 26, a PO dated NJ Exec Order 26.4b1 to the NJ Exec O and a PO dated NJ Exec Order 26.4b1 consult. A review of the current resident care plan revealed a focus area for NJ Ex Order 26.4(b)(1) to NJ Exec Order 26.4b1. The care plan was initiated on NJ Exec Order 26.4b. Interventions included to educate resident and family of causative factors and measures to prevent NJ Ex Order 26.4(b)(1), follow facility protocols for treatment of NJ Ex Order and identify potential causative factors and eliminate/resolve where possible. A review of the NJ Exec Order 26.4b1, showed the resident had a documented NJ Exec Order 26.4b1. The resident also had a NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 consult recommended a NJ Exec Order 2 while in bed. Review of the NJ Exec Order 26.4b1 consultant note recommended to continue NJ Ex Order 26.4(b)(1) measures. On 12/5/24 at 12:28 PM, the resident was observed in bed. The resident was not on a NJ Exec and the resident did not have NJ Exec Order 26.4b1. The surveyor asked if resident had NJ Exec Order 26.4b1 while	F 686		

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F 686	Continued From page 31	F 686		

in bed and the resident stated, "No, they use NJ sometimes." The surveyor asked the resident if they were offered a NJ Exec Order 26.4b1 and the resident told the surveyor "no." The surveyor then asked the resident if the facility fitted them for a NJ Exec Order 26.4b1 and the resident stated "no." The resident pointed to their own NJ Exec Order 26.4b1 on the nightstand and said they were their NJ Exec Order.

On 12/5/24 at 1:31 PM, the surveyor interviewed the U.S. FOIA (b)(6) caring for Resident #85. The surveyor asked if the resident wore NJ Exec Order 26.4b1, and she stated, "no, we NJ Exec Order 26.4b1." The surveyor then asked the NJ Exec Orde if the resident had a NJ Exec Order 26.4b1, and the NJ Exec O stated "no."

On 12/6/24 at 12:10 PM, during an interview with the U.S. FOIA (b)(6) regarding the recommendations made by the NJ Ex Order 26.4(b)(1) consultants. The U.S. FOIA (b) stated that the recommendations were reviewed by the Unit Manager and were then carried out. The surveyor asked why the resident would need a NJ Exec Order 26.4b1 and the U.S. FOIA (b) stated to prevent NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1.

On 12/9/24 at 1:00 PM, the surveyor reviewed the policy titled, "Pressure Injury Prevention and Management", dated 9/1/24. The policy included that the facility was committed to the prevention of avoidable injuries, unless clinically unavoidable and is to provide treatment and services to heal the pressure ulcer and prevent development of additional pressure ulcers.

NJAC 8:39-27.1 (e)

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to have a resident who smoked sign the "Smoking Contract/Agreement" upon admission. This deficient practice was identified for 1 of 3 residents (Resident #82) reviewed for accidents. A review of the resident's "Smoking Contract/Agreement" provided by the facility was signed by the resident on [NJ Exec Order 26.4]. The facility could not provide a smoking contract upon admission. This deficient practice was evidenced by the following: On 12/3/24 at 10:53 AM, during the initial tour the surveyor observed Resident #82 [NJ Exec Order 26.4b1] in the hallway with [NJ Exec Order 26.4b1]. On 12/6/24 at 1:03 PM, the surveyor observed Resident #82 in their bedroom. Resident #82 stated, "I am going to eat my lunch now." The resident was not sure if they were going [NJ Ex Order 26.4] later.	F 689	1. Resident affected by deficient practice: Resident #82 had a [NJ Exec Order 26.4b1] completed on [NJ Exec Order 26.4]. 2. Identifying other residents who could be affected by the deficient practice: Residents who smoke could be affected by this deficient practice. All other residents who smoke were audited for smoking contracts and no further issues were identified. 3. Measures or systemic changes to ensure that the deficiencies will not recur: Smoking policy/process re-education provided to clinical team ([U.S. FOIA (b) (6)], Unit Managers, Nursing Supervisors, Licensed Nurses, and the [U.S. FOIA (b) (6)] in person by Director of Nursing. The Smoking Policy was reviewed in person with all residents who smoke require a smoking assessment and contract upon admission to the facility. 4. Monitoring the continued	1/17/25

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F 689	Continued From page 33 On 12/4/24 at 9:41 AM, the surveyor reviewed the medical record for Resident #82. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses including but not limited to; NJ Exec Order 26.4b1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated , reflected that the resident had a brief interview for mental status score of NJ Exec Order 26.4b1 indicating that the resident had an NJ Exec Order Further review of the MDS in Section J for "Health Conditions" reflected the resident was a NJ Ex Order 26.4(b)(1). A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ Exec Order 2, that the resident was NJ Exec Order 26.4b1. Interventions included that the facility would conduct a smoking safety evaluation on admission and as needed; educate the resident/responsible party on the facility's NJ Ex Order 26.4(b)(1) policy and the resident will sometimes ask staff to give their NJ Ex Order 26.4(b)(1) to her friends. The ICCP included a focus area dated NJ Exec Order 26, that the resident is a NJ Exec Order contract was signed and reviewed with the resident. Interventions included that the resident is assisted with NJ Ex Order 26.4(b)(1) and to notify the resident of any changes to the NJ Ex Order 26.4(b)(schedule.	F 689	effectiveness of the systemic change: The Activities Director/Designee will audit up to five smokers to ensure adherence to smoking policy and procedure have been completed weekly x 4 then monthly x 2. Results of the audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 689	Continued From page 34	F 689		

A review of the NJ Ex Order 26.4(b)(1) Assessment, located in the electronic medical record (eMR) revealed the most recent NJ Ex Order 26.4(b)(assessment was completed on NJ Exec Order 26.4b The NJ Ex Order 26.4(b)(1 Assessment indicated that the resident was NJ Ex Order 26.4(b)(1) and could NJ Ex Order 26.4 safely.

A review of the resident's "NJ Ex Order 26.4(b)(1 Contract/Agreement" provided by the facility was signed by the resident on NJ Ex Order 26.4(b)(1 The facility could not provide a NJ Ex Order 26.4(b)(contract upon admission.

On 12/6/24 at 1:24 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that smoking assessments were completed upon admission and quarterly. The U.S. FO also stated that NJ Ex Order 26.4(b)(contracts are signed by the resident on admission. The U.S. FO acknowledge that Resident #82 was U.S. FOIA (b)(6).

On 12/9/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated NJ Ex Order 26.4(b)(1 Contracts should be completed within 72 hours of admission. The U.S. FOIA (b) could not speak to when NJ Ex Order 26.4(b)(1 Contracts should be completed other than upon admission.

On 12/9/24 at 11:05 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) in training and the survey team, stated that the Smoking Contracts were completed upon admission. The U.S. FOIA (b)(6 acknowledge a NJ Ex Order 26.4(b)(1 Contract should have been completed in NJ Ex Orde upon admission.

A review of the facility's "Smoking Policy -

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE LONG BRANCH, NJ 07740**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 Residents, Staff and Visitors" no revision date, included the resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: ... e. All residents that smoke are required to sign a smoking agreement contract. NJAC 8:39-27.1(a)	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) NJ Ex Order 26.4(b)(1) equipment was stored and dated properly and b) ensure a physician's order was in place for a resident who received NJ Exec Order 26.4b. This deficient practice was identified for 3 of 3 residents reviewed for NJ Exec Order 26.4b1 (Resident #19, Resident #54, and Resident #239), and the evidence was as follows: 1. On 12/3/24 at 10:38 AM, the surveyor observed Resident #19 in the bathroom performing morning care. At that time, the surveyor observed on the resident's bedside an	F 695	1. Residents affected by deficient practice: The facility failed to ensure NJ Ex Order 26.4(b)(1) equipment was stored and dated properly and ensure a physician□s order was in place for a resident who received NJ Exec Order 26.4b Resident #19□s NJ Exec Order 26.4b1 was replaced, correctly labeled, dated and stored in a protective covering on 12/3/24. Resident #54 NJ Exec Order 26.4b1 was replaced, correctly labeled, dated and a dated storage bag was provided on 12/3/24. Resident #239 was discharged from the facility. 2. Identifying other residents who could	1/17/25

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F 695	Continued From page 36 NJ Exec Order 26.4b1) that was turned off and the NJ Exec Order 26.4b1 NJ Ex) was draped across the top of the NJ Exec Order 26.4b1. The NJ Ex Order 26 was not labeled or dated when it was changed, and it was not stored in a protective covering. On 12/4/24 at 11:25 AM, the surveyor reviewed the medical records for Resident #19. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but not limited too; NJ Exec Order 26.4b1 A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 which indicated a NJ Exec Order 26.4b1. A review of the individualized comprehensive care plan included a focus area dated NJ Exec Order 26.4b, and revised NJ Exec Order 26.4b, for NJ Ex Order 26.4(b)(1) status and NJ Ex Order 26.4(b)(1) related to (r/t) diagnosis (dx) of NJ Ex Order 26.4(b)(1). Interventions include to administer NJ Exec Order 26.4b1 .	F 695	be affected by the deficient practice: Residents that require oxygen therapy could be affected by this deficient practice. Audit of all residents who require oxygen was completed to ensure orders in place, care plan in place, and all equipment dated and bagged. No other concerns were identified. 3. Measures or systemic changes to ensure that the deficiencies will not recur: Licensed nurses were in-serviced by the Assistant Director of Nursing on the policy/process of residents requiring oxygen therapy. The in-service included that respiratory tubing gets changed, bagged and dated each Wednesday on the 11-7 shift and licensed nurse is to ensure the oxygen liter flow on the concentrator matches the oxygen order in PCC. 4. Monitoring the continued effectiveness of the systemic change: Unit Managers/Designee will conduct audits of residents requiring oxygen to ensure orders, care plans, and all equipment is in place weekly x 4 then Monthly x 2. Results of the audit will be reviewed at the Monthly Quality assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 695	Continued From page 37 A review of the active Order Summary Report (OSR) reflected a physician's order (PO) dated NJ Exec Order 26.4b to change NJ Exec Order 26.4b1 when in use weekly on Wednesdays on the 11:00 PM to 7:00 AM (11-7) shift or PRN. A review of the corresponding Treatment Administration Record (TAR) revealed that the nurses were signing for the changing of the NJ Exec weekly on Wednesdays. On 12/5/24 at 11:05 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that staff were expected to follow the facility's policy and change the NJ Exec as reflected on the physician's orders and on the TAR. The U.S. FOIA (b)(6) stated the facility had the policy in place to prevent contamination and infection from old, dirty, or broken NJ Ex Order 26.4 The U.S. FOIA (b)(6) stated when the nursing staff changed the tubing, they were supposed to label, initial, and date it to ensure accountability and allows the rest of the facility staff to know it was done. On 12/6/24 at 11:10 AM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated that the nursing staff changed any NJ Exec Order 26.4b1 every Wednesday night on the 11-7 shift. The U.S. F stated that staff labeled the NJ Ex Order 26 with the date and their initials, and they provided a labeled and dated NJ Ex Order 26.4(b)(1) bag so the NJ Ex Order 26 can be placed in it when not in use to prevent contamination and infection. The U.S. F stated proper storage of the respiratory equipment prevented infection, and daily rounds were done by management to ensure policy was followed and that something was not missed. On 12/9/2024 at 12:34 PM, the surveyor informed	F 695		

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F 695	Continued From page 38	F 695		

the U.S. FOIA (b)(6)) the above concern.

2. On 12/3/24 at 10:44 AM, the surveyor observed Resident #54 lying in bed receiving NJ Exec through a NJ Exec Order 26.4b1. The NJ Exec Order was labeled and dated 1 NJ Exec Order 26.4b which indicated the NJ Exec Order 26 was in use for twelve days. At that time, the surveyor did not observe an U.S. FOIA NJ Exec Order 2 storage bag.

On 12/4/24 at 12:15 PM, the surveyor reviewed the medical record for Resident #54.

A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included but not limited too; NJ Exec Order 26.4b1

A review of the quarterly MDS dated NJ Exec Order 26, reflected that the resident had a BIMS score of NJ Exe, which indicated a NJ Exec Order 26.4b1

A review of the ICCP r included a focus area dated NJ Exec Order 26, and revised NJ Exec Order 26.4b1, for NJ Exec Order 26. Interventions included; to administer NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1.

A review of the active OSR reflected a PO dated NJ Exec Order 26.4, to change NJ Exec Order 26.4b1 weekly, label, date, and initial each component every night shift on Wednesdays.

On 12/5/24 at 11:05 AM, the surveyor interviewed the U.S. FOIA (b)(6), who stated that staff were expected to follow the facility's policy and change the U.S. FOIA

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F 695	Continued From page 39 tubing as reflected on the physician's orders and on the TAR. The U.S. FOIA (b)(6) stated the facility had the policy in place to prevent contamination and infection from old, dirty, or broken NJ Ex Order 26.4 The U.S. FOIA (b)(6) stated when the nursing staff changed the tubing, they were supposed to label, initial, and date it to ensure accountability and allows the rest of the facility staff to know it was done. On 12/6/24 at 11:10 AM, the surveyor interviewed the U.S. FO, who stated that the nursing staff changed any respiratory tubing every Wednesday night on the 11-7 shift. The U.S. F stated that staff labeled the tubing with the date and their initials, and they provided a labeled and dated NJ Ex Order 26.4(b)(1) so the NJ Ex Order 26 can be placed in it when not in use to prevent contamination and infection. The U.S. F stated proper storage of the NJ Ex Order 26.4(b)(1) equipment prevented infection, and daily rounds were done by management to ensure policy was followed and that something was not missed. On 12/9/2024 at 12:34 PM, the surveyor informed the U.S. FOIA (b)(6) the above concern. A review of the facility's "Oxygen Administration" policy dated 9/1/24, included...5...d) change O2 delivery tubing per facility policy and as needed if they become soiled; e) keep delivery devices covered in a plastic bag when not in use... 3. On 12/3/24 at 10:51 AM, the surveyor observed Resident #239 in bed resting. The resident had a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1	F 695		

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F 695	Continued From page 40 NJ Exec Order 26.4b1) with a clear plastic mask used to deliver NJ Exec Order 26.4b over top of the NJ Exec Orde that was connected to a hose that was connected to an NJ Exec Order 26.4b1 at the resident's bedside. The NJ Exec Order 26.4b1 was set to deliver NJ Exec Order 26.4b1 to the resident. On 12/4/24 at 10:39 AM, the surveyor reviewed Resident #239's electronic medical record (EMR). A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnosis which included but was not limited to; NJ Exec Order 26.4b1 A review of the physician's Order Summary Report did not include a physician's order for NJ Exec Order 26.4 administration. A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area that the resident had a NJ Exec Order 26.4b1 and interventions included but were not limited to; NJ Exec Order 26 to be administered via NJ Exec Order 26.4b1 as ordered. A review of the Progress Notes included an Admission Summary note dated NJ Exec Order 26.4b1 which included the resident's vital signs and indicated the resident had a NJ Ex Order 26.4(b)(1) level of NJ Ex Orde while being administered NJ Ex Order 26.4(b)(1) A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) did not include that the nurse's were signing for the administration of NJ Exec Order 26. On 12/6/24 at 11:43 AM, the surveyor interviewed	F 695		

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F 695	Continued From page 41 the U.S. FOIA (b)(6) who stated that residents who used of NJ Exec Order 26.4 required a physician's order for the use. At that time, the U.S. FOIA (b) reviewed Resident #239's physician's orders and confirmed that there were no order for the administration of NJ Exec Order 26.4, and the resident received NJ Exec Order 26.4b On 12/9/24 at 11:02 AM, the U.S. FOIA (b), in the presence of the survey team, the U.S. FOIA (b)(6) who acknowledged that Resident #239 was supposed to have an order for NJ Exec Order 26.4 in place and did not. A review of the facility's "Oxygen Administration" policy dated 9/1/24, included...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... NJAC 8:39-11.2(b); 27.1(a)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure a physician's order was in place to properly assess	F 698	1. Resident affected by deficient practice: The facility failed to ensure a physician's order was in place to properly assess a	1/17/25

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F 698	Continued From page 42 a resident's NJ Exec Order 26 access site. This deficient practice was identified for 1 of 1 residents reviewed for NJ Exec Order 26 (Resident #81), and was evidenced by the following: On 12/3/24 at 12:04 PM, during initial tour of the facility, the surveyor observed Resident #81 in their room. The resident informed the surveyor that they recently had a medical emergency where the resident's NJ Exec Order 26 NJ Ex Order 2 started to NJ Ex Order 26 and they had to be sent to the hospital for NJ Ex Order 26.4(b)(1). On 12/6/24 at 1:42 PM, the surveyor reviewed Resident #81's medical record. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnosis which included but was not limited to: NJ Exec Order 26.4b1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, reflected the resident indicated in "Section C - Cognitive Patterns" that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, indicating a NJ Ex Ord NJ Exec Order 26.4b1. A review of Section O, Special treatments, procedures, and programs, included NJ Exec Order 26 as an active treatment. A review of the physician's Order Summary Report revealed no order to assess the resident's NJ Exec Order 26 access. A review of the individualized comprehensive care plan (ICCP) included a focus care area that the resident was on NJ Exec Order 26 three days per week, but	F 698	residents NJ Exec Order 26.4 NJ Ex Order 26.4 site. Order was entered for resident #81 to check for NJ Exec Ord 2. Identifying other residents who could be affected by the deficient practice. Residents with a dialysis access site have the potential to be affected. Other residents with a dialysis access site were audited with no negative findings noted. 3. Measures or systemic changes to ensure that the deficiencies will not recur: Licensed Nurses in-serviced on the policy/process of resident requiring dialysis to include assessing bruit and thrill by Assistant Director of Nursing. 4. Monitoring the continued effectiveness of the systemic change: Unit Manager/designee will audit up to four dialysis resident's charts and ensure orders/care plan is in place weekly x 4 then monthly x 2. Results of the audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 698	Continued From page 43 did not have interventions to monitor or assess the NJ Exec Order 26.4 NJ Ex Order 26.4(b)(1) A review of the NJ Exec Order 26.4b1 Medication Administration (MAR) and Treatment Administration Record (TAR) did not include the nurses were signing that the NJ Exec Order 26 site was assessed or monitored. On 12/9/24 at 9:53 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1), who confirmed that Resident #81 had a NJ Exec Order 26 access called a NJ Exec Order 26.4b1 On 12/9/24 at 9:55 AM, the surveyor interviewed LPN #2, who stated Resident #81 had an NJ Exec O and that she was not allowed to monitor NJ Exec Orde LPN #2 further stated that she felt for a NJ Exec Order 26.4b1), but it was not documented. On 12/9/24 at 10:01 AM, the surveyor interviewed the U.S. FOIA (b)(6)), who stated that a resident with a NJ Exec Order 26 NJ Ex Order 26.4 should have orders to check the NJ Exec Order 26.4 NJ Ex Order 26.4 that the nurses signed as completed on the TAR. At that time, the U.S. FOIA (b) reviewed Resident #81's physician's orders and confirmed that there was no order for assessing the NJ Exec Order 26 NJ Ex Order 26.4(b The U.S. FOIA (b) acknowledged that the facility could not provide documentation that the NJ Ex O was being assessed by the nurses, and the U.S. FOIA (b) stated "we all know the golden rule" in healthcare indicating if it was not documented, it was not done. The U.S. FOIA (b) stated "sometimes the nurses forget to document." A review of the facility's "Hemodialysis" policy	F 698		

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F 698	Continued From page 44 dated of 9/1/24, included...the nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating (listening) for a bruit and palpating (feeling) for a thrill... NJAC 8:39- 27.1(a)	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		1/17/25

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F 755	Continued From page 45 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a) dispensed and administered NJ Ex Order 26.4(b)(1)) medication was accurately counted, and b) the Individual Patien NJ Ex Order 26.4(b)(1) Administration Record NJ Ex Order 26.4(b)(1))reconciliation sheet was incorrect for 8 shifts with 16 occurrences on Medication Cart NJ Exec Order 2 floor. This deficient practice was identified on 1 of 2 medication carts reviewed for medication storage, and was evidenced by the following: On 12/05/24 at 09:33 AM, the surveyor observed the U.S. FOIA (b)(6) with the U.S. FOIA (b)(6) begin the cycle count for the NJ Ex Order 26.4(b)(1) medications on medication NJ Exec Order 2 on the NJ Exec O floor. At that time, the surveyor in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b), observed on the NJ Ex Order 26.4(b)(that there should be one tablet left on the declining count. Upon review of the blister pack, there were no tablets remaining of NJ Exec Order 26.4b1). The surveyor reviewed the NJ Exec Order 26.4b1 Medication Administration Record (MAR) which revealed that the missing NJ Ex Order 26.4(b)(1) was administered and signed off on the residents MAR on U.S. FOIA (b)(6), for the scheduled 10:00 pm	F 755	1. 1. Resident affected by the deficient practice: The facility failed to provide pharmaceutical services in accordance with professional standards to ensue dispensed and administered controlled substance medication was accurately counted, and the individual patient NJ Ex Order 26.4(b)(1) administration record sheet was incorrect for 8 shifts with 16 occurrences on medication Cart NJ on the NJ Ex Or floor. Investigation was initiated. Nurse who signed MAR was interviewed and indicated that medication was administered but was not documented on Individual Patient Controlled Substance Administration Record (IPSCAR). Individual nurse who did not accurately document on IPSCAR received in person education on the Controlled Substance Administration and Accountability Policy. Nurses who completed the shift counts for 12/2/24 (11pm-7am shift), 12/3/24 (11p-7am, 7a-3p, and 3p-11p), 12/4/24 (11p-7a, 7a-3p and 3p-11p) and 12/5/24 (11p-7a and 7a-3p) received in person education on the Controlled Substance Administration and Accountability. 2. Identifying other residents who could be affected by the deficient practice: Residents who receive narcotic	

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F 755	Continued From page 46 dose but was not signed off correctly on the NJ Ex Order 26.4(declining medication sheet correctly. A review of the 'NJ Ex Order 26.4(b) Shift Count" log indicated that there were 8 shifts with 16 occurrences for change of shift that the blister pack was inaccurately counted as having one left for the following dates: NJ Ex Order 26.4((11pm-7am shift), NJ Ex Order 26.4((11pm-7am, 7A-3pm and 3pm-11pm shift), NJ Ex Order 26.4(b) (11pm-7am, 7am-3pm and 3pm-11pm shift), and NJ Ex Order 26.4((11pm-7am, and 7am-3pm shift). A review of the 'NJ Ex Order 26.4(b) Shift Count" log on NJ Ex Order 26.4(, for 11pm-7am shift indicated that there were no reconciliation signatures present for the NJ Ex Order 26.4(b) Shift Count. On 12/5/24 at 10:51 PM, the surveyor interviewed the Licensed Practical Nurse/ Unit Manager #2 (LPN/UM #2) who stated that a NJ Ex Order 26.4(b count is done during shift change with the departing and receiving nurses for all NJ Ex Order 26.4(b)(1). The NJ Exec Order 26.4b1 acknowledged that the facility policy was not being followed and that the NJ Ex Order 26.4(b count was not done correctly. On 12/9/24 at 11:49 PM, the survey team met with the NJ Exec Order 26.4b1 who acknowledged the discrepancies with the NJ Ex Order 26.4(b count and the reconciliation signatures. A review of the policy "Controlled Substance Administration and Accountability", dated 9/1/24, indicated ... 1) General Protocols: a) Controlled substances are stored in a separate compartment of a locked storage unit with access limited to approved personnel. f) All controlled substances	F 755	medication could be affected by this deficient practice. 3. Measures or systemic changes to ensure that the deficiencies will not recur: Licensed Nurses received in person education on the Medication Administration Policy and the process of end of shift narcotic count by Director of Nursing / Designee by reviewing the Medication Administration Policy and the end of shift count with the Nurses. 4. Monitoring the continued effectiveness of the systemic change: The Director of Nursing or Designee will complete an audit of all narcotic count sheets to ensure accuracy weekly x4 then monthly x 2. Results of the audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 755	Continued From page 47 are accounted for in one of the following ways: ii) all controlled substances obtained from non -automated medication cart or cabinet are recorded on the designated usage form. g) In all cases the dose noted on the usage form must match the dose recorded on the MAR, controlled drug record, or other facility specified form serves dual purpose of recording both narcotic disposition and patient administration. 9) Inventory verification: b) For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. NJAC 8:39-29.3(a)6, 29.4 (g)	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		1/17/25

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F 756	Continued From page 48 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documents, it was determined that the facility failed to ensure recommendations made by the U.S. FOIA (b)(6) were acted upon in a timely manner for 2 of 5 residents (Resident #54 and Resident #35) reviewed for unnecessary medications. This deficient practice was evidenced by the following: 1. On 12/04/24 at 12:15 AM, the surveyor reviewed the medical records for Resident #54. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with the diagnoses which included but was not limited to; NJ Exec Order 26.4b1	F 756	1. Residents affected by the deficient practice: For residents #54 and #35, provider and nursing reviewed and addressed pharmacy consultant recommendations for six months for both residents. 2. Identifying other residents who could be affected by the deficient practice: All residents with recommendations from the pharmacy consultant are at risk if the Consultant Pharmacy Report is not followed up with in a timely manner. All pharmacy recommendations for December were audited by the Director of Nursing to confirm that provider and nursing recommendations were completed, with no issues noted. 3. Measures or systemic changes to	

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F 756	Continued From page 49 NJ Exec Order 26.4b1 A review of the quarterly Minimum Data Set (qMDS) dated NJ Exec Order, reflected that the resident's cognitive skills for daily decision making scored a NJ Exec Order 26.4b1, indicating they were NJ Exec Order 26.4b1 A review of the U.S. FOIA report dated NJ Exec Order 26.4b, indicated to consider that the potential for NJ Exec Order 26.4b1 was increased with the concurrent use of NJ Exec Order 26.4b1. The report added to please evaluate the risk verses the benefit for this NJ Exec Order 26.4b. The U.S. FOIA report was not signed or dated by the attending physician. A review of the corresponding Medication Administration Record (MAR) reflected that the recommendation was not completed by the facility. A review of the U.S. FOIA report dated NJ Exec Order 26.4b, indicated to consider NJ Exec Order 26.4b1 was recommended once daily per manufacturer and to consider changing NJ Exec Order 26.4b1. Also, concurrent use of NJ Exec Order 26.4b1 may be considered duplicate therapy and to please consider discontinuing one of the orders. The U.S. FOIA report was not signed or dated by the attending physician. A review of the corresponding MAR reflected that the recommendation was not completed by the facility. A review of the U.S. FOIA (b)(6) report dated U.S. FOIA (b)(6), indicated to consider changing NJ Exec Order 26.4b1 (it was never addressed from the U.S. FOIA reported dated NJ Exec Order 26.4). The report also indicated that U.S. FOIA (b)(6) was an NJ Exec Order 26.4b1 and may produce toxic effects in	F 756	ensure that the deficiencies will not recur: Beginning on 12/6/24, Unit Managers and U.S. FOIA (b) (6) received education on Pharmacy Recommendations by Director of Nursing. Monthly Pharmacy recommendations are to be completed within one week of receiving from Pharmacy Consultant. DON/or designee will follow up to ensure all recommendations have been addressed by the Physician. 4. The Director of Nursing will review/ensure accurate completion of the Monthly Pharmacy Consultant reports x3 months and Quarterly x2. Results will be reviewed during Quality Assurance Meeting over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 756	Continued From page 50 the elderly and to please evaluate the risk versus benefit for use for more then 7 day or more then once every 3 months. The U.S. FOIA report was not signed or dated by the attending physician. A review of the corresponding MAR reflected that the recommendation was not completed by the facility. A review of the U.S. FOIA (b)(6)) report dated U.S. FOIA (b)(6) indicated a 2nd request for the U.S. FOIA (b)(6) to be evaluated stating it was not addressed in NJ Exec Order 26.4b1 The U.S. FOIA report was not signed or dated by the attending physician. A review of the corresponding MAR reflected that the recommendation was not completed by the facility. On 12/06/24 at 11:48 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that the U.S. FOIA reports were given to the facility monthly; that a copy was sent to her, the NJ Ex Order 26.4(b)(1)), and unit managers (UM). The U.S. FOIA (b) stated the CP's recommendations were to be completed by the UMs. Furthermore, she stated that an appropriate time for the U.S. FOIA (b) recommendations to be completed was within 10 days of receiving them, and she was unable to explain why the recommendations provided from the U.S. FOIA from NJ Ex Order 26.4(b) NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) of the year NJ Ex Order were not completed. 2. On 12/6/24 at 9:45 AM, the surveyor reviewed Resident #35's medical record and the following was indicated: The Admission Record indicated that Resident #35 was admitted to the facility with diagnosis which included but was not limited to NJ Exec Order 26.4b1	F 756		

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F 756	Continued From page 51 NJ Exec Order 26.4b1 A review of the physician's Order Summary Report included but was not limited to a discontinued order for NJ Exec Order 26.4b1)NJ Ex Order 26.4(b)(1) every eight hours as needed (PRN) for NJ Exec Order 26.4b1, which had a order start date of NJ Exec Order 26.4 and an order end date of NJ Exec Order 26.4 with a reason to discontinue of "non-use." A review of the CP monthly NJ Exec Order 26.4b1 suggestion reports included but was not limited to the following: On the report dated NJ Ex Order 26.4(, the U.S. FOIA (b)(6) indicated "PRN medications which have not been used for over 60 days are recommended to be discontinued. Please consider discontinuing NJ Exec Order 26.4b" The CP monthly report dated NJ Ex Order 26.4(b) indicated "regarding the comment made on NJ Ex Order 26.4(: PRN medications which have not been used for over 60 days are recommended to be discontinued. Please consider discontinuing NJ Exec Order 26.4b. The U.S. FOIA (b)(6) was not addressed." On 12/6/24 at 11:43 AM, the surveyor interviewed the U.S. FOIA (b) who stated U.S. FOIA (b)(6) recommendations should be addressed within one to two weeks. On 12/9/24 at 11:02 AM, the U.S. FOIA (b)(6), in the presence of the survey team, the U.S. FOIA (b)(6)	F 756		

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F 756	Continued From page 52 U.S. FOIA (b)(6) acknowledged the U.S. FOIA (b) (6) recommendation not being addressed timely. A review of the facility's "Addressing Medication Regimen Review Irregularities" policy, dated 9/1/24, indicated policy explanation and compliance guidelines: 4a-f) The pharmacist must report any irregularities to the attending physician, the facilities medical director and director of nursing and the reports must be acted upon. 5) The report should be submitted to the DON within 10 working days of the review. A review of the facility's " Consultant Physician/Practitioner Orders" policy, dated 9/1/24, included...1) Consulting physician/practitioner orders are those orders provided to the facility by a physician/practitioner other than the residents attending physician. 2) For consulting physicians/practitioner orders received in writing or via fax, the nurse in a TIMELY manner will: a) call the attending physician to verify the order. b) Document the verification order by entering the order and the time, date, and signature on the physician order sheet. A review of the facility's " Pharmacy Services" policy, dated 9/1/24, under Compliance Guidelines: 1) The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologics to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. 7) The pharmacist is responsible for helping the facility obtain and	F 756		

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F 756	Continued From page 53 maintain timely and appropriate pharmaceutical services that support residents" healthcare needs, goals, and quality of life that are consistent with current standards of practice and meet state and federal requirements. A review of the U.S. FOIA (b) (6) agreement revealed a contract signed date of NJ Ex Order 26.4 On 12/09/2024 at 12:34 PM, the above concern was discussed with the U.S. FOIA (b)(6) NJAC 8:39-29.3(a)	F 756		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the	F 791		1/17/25

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F 791	Continued From page 54 dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide the mandatory annual NJ Ex Order 26.4(b)(1) and services. This deficient practice was identified for 1 of 21 residents reviewed (Resident #15), and was evidenced by the following: On 12/3/24 at 10:55 AM, the surveyor observed that Resident #15's NJ Exec Order 26.4b1 On 12/4/24 at 9:00 AM the surveyor reviewed the electronic medical record (eMAR).	F 791	1. Residents affected by deficient practice The facility failed to provide the annual NJ Exec Order 26.4b1 and services to Resident #15. On 12/5/24, Resident #15 was requested to be seen by NJ Exec Order 26.4b1 during next scheduled visit. 2. Identifying other residents who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. 3. Measures or systemic changes to ensure that the deficiencies will not recur:	

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F 791	Continued From page 55	F 791		

A review of the Admission Record (AR) revealed the resident was admitted with a diagnosis of but not limited to: NJ Exec Order 26.4b1

A review of the Nursing Comprehensive assessment, dated NJ Exec Order 26.4b1, revealed under section D) Oral / Nutritional, 12.1) was marked NJ Exec Order 26.4b1

A review of the comprehensive Minimum Data Set (cMDS), dated NJ Exec Order 26.4b1, revealed the resident had a BIMS score of U.S. FOIA (b)(6) which indicated that the resident's NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1). The MDS further revealed under section NJ Ex Order 26.4(b)(1) (which asked if the resident had NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)) that "none of the above were present" was checked. The look back period did not reflect the residents condition based on staff visual in-person assessment.

A review of the comprehensive Minimum Data Set (cMDS), dated U.S. FOIA (b)(6), revealed the resident had Brief Interview for Mental Status (BIMS), score of NJ Exec Order 26.4b1 which indicated that the resident's NJ Exec Order 26.4b1. It further revealed under section NJ Ex Order 26.4(b)(1) status (which asked if the resident had NJ Ex Order 26.4(b) or NJ Ex Order 26.4(b)(1)) that "none of the above were present" was checked. The MDS documentation for a look back period did not reflect the residents condition based on nursing assessment.

A review of the resident's Order Summary Report revealed that there was not an order for a NJ Ex Order 26 consultation.

The Dental Services Policy was reviewed with the Unit Managers, Unit Secretary and Director of Social Services by the Assistant Director of Nursing. Audit conducted for long-term residents to ensure they received a dental consult.

4. Monitoring the continued effectiveness of the systemic change:
The Social Worker will complete an audit of five residents to ensure they have been seen by the Dentist. This audit will be completed Monthly x 3 months. Results of the audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.

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F 791	Continued From page 56	F 791		

A complete review of the resident's eMAR revealed that there was no documentation that the resident was offered and /or refused NJ Ex Order 26 care services. The facility was unable to provide NJ Ex Order 26 consultation records in the last year of admission.

A review of the resident's Care Plan (CP) revealed an initiated revision date of NJ Exec Order 26.4b1 for the following focus areas:

1. Assistive Daily Living (ADL) NJ Ex Order 26.4(b)(1) performance deficit related to NJ Ex Order 26.4(b)(1). Interventions included; the resident was NJ Ex Order 26. on staff for NJ Ex Order 26.4 dated U.S. FOIA (b)(6), and that the resident was NJ Ex Order 26.4(b)(1) on 1 staff for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).
2. The resident has NJ Ex Order 26.4(b)(1) problems r/t NJ Ex Order 26.4(b)(1), dated U.S. FOIA (b)(6). The interventions for this focus were to monitor and report any signs and symptoms of NJ Ex Order 26.4(b)(1), dated U.S. FOIA (b)(6) and provide NJ Ex Order 26.4(b)(1) as per NJ Ex Orde.

A review of the "Resident seen per day detail of NJ Ex Order 26.4(b)(1)" provided by the U.S. FOIA (b)(6) for the months of NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) for the year NJ Ex Order did not reflect that Resident #15 was on the list. The facility and NJ Ex Order 26 office could not provide any other weeks that care was provided to the facility residents.

On 12/04/24 at 11:11 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated, after initial assessment of a newly admitted resident by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING ______ B. WING ______	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE LONG BRANCH, NJ 07740**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 57 nurse, the nurse then calls the physician and gives a report of their findings, to include the medications the resident was on, and then telephone orders would be given according to the needs of the resident i.e... consults, treatment, and care areas. The physician would then follow up either that day or the next day. The residents are also discussed in morning meetings with all department management. The U.S. FOIA (b)(6) would also do an assessment and documentation. On 12/06/2024 at 01:34 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that the resident should have a physician order initiated by nursing under medical review for all consults for issues caught on the admission assessment. The facility policy states that all long-term care residents should be followed by a NJ Ex Order 26.4 annually and as needed. On 12/09/2024 at 12:34 PM, the above concern was discussed with the U.S. FOIA (b)(6) A review of the facility's Dental Services Policy, dated 9/1/24, provided by the U.S. FOIA (b)(6) on 12/6/2023, indicated: The dental needs of each resident are identified through the physical assessment and MDS assessment processes and are addressed in each resident's care plan. On 12/6/24 at 10:54 AM, the surveyor reviewed the facilities "NJ Ex Order 26.4 Services Agreement" revealing it is effective and valid from NJ Ex Order 26.4(b) and renewed in NJ Ex Order 26.4(b)(1).	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING ______ B. WING ______	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 58 NJAC 8:39-15.1(a)	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: NJ Complaint #: 174208 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 12/3/24 at 9:41 AM, the surveyor, accompanied by the U.S. FOIA (b)(6)	F 812	1. Corrective Action The Facility was deficient in its practice of storing and handling food items. • The unlabeled, undated, opened box of Kielbasa was discarded. • The unlabeled, undated, and opened fifteen # box of bacon was discarded. • The sliced turkey deli meat with an expired used by date of 12/2 was discarded. • The unlabeled, undated 4-quart plastic container containing a white powder was discarded.	1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING ______ B. WING ______	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE LONG BRANCH, NJ 07740**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 59	F 812		

U.S. FOIA (b)(6), toured the facility's kitchen.

The following was observed in the kitchen freezer:

One unlabeled, undated opened box of hotdogs/kielbasa, which was opened, the plastic bag inside the box also opened exposing the hotdogs/kielbasa links, which had the appearance of freezer burn, to air.

One opened 15-pound box of single slice bacon. The plastic bag inside the box was also opened and exposing the bacon to air.

At that time, the U.S. FOIA stated that those items should not be stored like that.

At 9:55 AM, the surveyor observed the following in the walk-in refrigerator:

Sliced turkey deli meat wrapped in clear plastic wrap, which was approximated by the U.S. FOIA (b) to be a quarter pound, labeled and dated with a use by date of 12/2. The U.S. FOIA stated the turkey should have been discarded.

At 10:11 AM, the surveyor observed the following on the spice/dry storage rack in the food preparation area:

A four-quart plastic container with a green lid, unlabeled and undated, approximately a quarter full of an unidentifiable white powder. The U.S. FOIA identified this as instant mashed potato mix.

One opened 16-ounce (oz) container of garlic powder, one opened 16 oz container paprika powder, and one opened 32 fluid oz bottle of

Provider's Plan of Correction (F 812):

- The unlabeled, undated spices, garlic powder, paprika powder, and bottle of browning sauce were discarded.
- The two dented cans containing grape jelly and mandarin oranges were moved to the dented can rack in a separate location.

2. Identification of other residents having potential to be affected by the deficient practice
- The deficient practice has the potential to affect all residents.

3. Measures put in place
- Dietary Staff received in person re-education on the Frozen Food Storage Policy, the Dry Food Storage Policy and the Dented/Compromised Cans Policy by the Regional Dietary Director.

4. How facility will monitor corrective actions to ensure the deficient practice does not recur.
- Dietary Director/ Designee will conduct audit weekly x4 and monthly x2 and will report to the Quality Assurance Meeting for the duration of the audit period.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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F 812	Continued From page 60	F 812		

browning seasoning sauce, all undated.

At that time, the U.S. FOIA stated those items should have all been labeled and dated with date opened and expiration date.

On the canned goods rack were the following dented cans:

One number 10 can of mandarin orange slices and one number 10 can of grape jelly.

The U.S. FOIA stated that dented cans should have been removed from this rack and stored with the dented cans in the dry food storage room.

On 12/9/24 at 11:02 AM, in the presence of the survey team, the U.S. FOIA (b)(6) , acknowledged the findings observed by the surveyor in the kitchen.

A review of the facility's "Frozen Food Storage Policy" with revised date of November 2024 included but was not limited to "3. Boxes are labeled with the date received and kept closed until use. 4. When a box or container is opened, it is labeled with an open date and securely covered to prevent frost accumulation and freezer burn."

A review of the facility's "Refrigerated Food Storage Policy" with revised date of November 2024, included but was not limited to "4. When a box or container is opened, it is labeled with an open date and securely covered to preserve food quality and avoid physical, chemical, or bacterial contamination. 5. Food can be stored in the

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	315284	A. BUILDING ______ B. WING ______	C 12/12/2024

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COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE LONG BRANCH, NJ 07740**

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F 812	Continued From page 61	F 812		

refrigerator for time periods according to refrigerated food storage charts and/or manufacturer's instructions."

A review of the facility's "Dry Food Storage Policy" with a revised date of October 2024 included but was not limited to "products opened are marked with 'open' and 'use by' date label."

A review of the facility's "Dented/Compromised Cans Policy" dated October 2023 included but was not limited to "dented cans are stored in a separate location from the regular food supply. Food from a dented can has been compromised and considered contaminated."

NJAC 8:39-17.2(g)

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061318	A. BUILDING: ______ B. WING ______	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE LONG BRANCH, NJ 07740**

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S 000	Initial Comments NJ Complaint #172281 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ #: 172281 Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 3 of 21 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	1. There was no care issues reported on the three-day shifts of the twenty-one reviewed that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. The Director of Nursing/designee reviewed the last 30days of the Certified Nursing Assistant staffing report. The interdisciplinary team reviewed the grievance logs and care conference meetings, and no care issues were identified. 2.All residents have the potential to be affected by staffing below state mandated	1/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 01/01/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061318	A. BUILDING: ______ B. WING ______	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor reviewed the facility completed Nurse Staffing Reports which revealed the following: 1. For the week of Complaint staffing from 03/03/2024 to 03/09/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -03/03/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. 2. For the 2 weeks of staffing prior to survey from 11/17/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -11/20/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs.	S 560	minimum levels. 3. Administrator in -serviced the staffing coordinator regarding the requirement for S560 to ensure Certified Nursing Assistant staffing needs are reviewed daily and addressed as needed to meet the staffing requirement. Recruitment efforts are in place to assist the facility in recruiting, Certified Nursing Assistant receive sign on bonuses, referral bonuses, reimbursement for Certified Nursing Assistant. tuition, and transportation service from certain locations. Facility also has contracts with agencies to recruit Certified Nursing Assistant s. The Director of Nursing/ designee also reviews staff attendance records to ensure that excessive absences are addressed accordingly. 4. The Administrator/designee will have weekly meetings with the staffing coordinator to audit staffing schedules, needs, and the efficacy of the systems in place to fill needs weekly. The findings of the audits will be presented at the QAPI meetings for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061318	A. BUILDING: ______ B. WING ______	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE LONG BRANCH, NJ 07740**

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S 560	Continued From page 2 -11/22/24 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. On 12/6/24 at 11:26 AM, the surveyor interviewed the facility Staffing Coordinator (SC). The SC was able to verbalize the regulations and told the surveyor when staffing deficient they place "massive" texts to employees and if no responses would use agency staff. On 12/9/24 at 1:00 PM, during an interview with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), they both stated that the facility utilized "a lot of staffing" when necessary.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
315284 Y1	Y2	2/5/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550 Reg. # 483.10(a)(1)(2)(b)(1)(2) LSC	Correction Completed 01/17/2025	ID Prefix F0607 Reg. # 483.12(b)(1)-(5)(ii)(iii) LSC	Correction Completed 01/17/2025	ID Prefix F0622 Reg. # 483.15(c)(1)(i)(ii)(2)(i)-(iii) LSC	Correction Completed 01/17/2025
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 01/17/2025	ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 01/17/2025	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 01/17/2025
ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 01/17/2025	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 01/17/2025	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 01/17/2025
ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 01/17/2025	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 01/17/2025	ID Prefix F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 01/17/2025
ID Prefix F0791 Reg. # 483.55(b)(1)-(5) LSC	Correction Completed 01/17/2025	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/17/2025	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315284	A. Building B. Wing	2/5/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550 Reg. # 483.10(a)(1)(2)(b)(1)(2) LSC	Correction Completed 01/17/2025	ID Prefix F0622 Reg. # 483.15(c)(1)(i)(ii)(2)(i)-(iii) LSC	Correction Completed 01/17/2025	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 01/17/2025
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/17/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061318	A. Building B. Wing	2/5/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/17/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING 02 B. WING ______	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/11/24 and 12/12/24 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Monmouth is a two-story building with two (2) partial basements, that was built in 1990's. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The exterior 300 KW diesel generator does 100 % of the building as per the Maintenance Director. The current occupied beds are 93 of 120.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		1/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/01/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING 02 B. WING	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 1 Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be	K 222		

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K 222	Continued From page 2 permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 12/12/24, in the presence of the US FOIA (b)(6)) and US FOIA (b)(6)), it was determined that A.) the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 1 of 1 outer set of sliding doors. B.) it was determined that the facility failed to ensure that 3 of 6 egress doors equipped with a delayed 15-second egress feature were labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds" in accordance with NFPA 101:2012 Edition, Section 7.2.1.6.1.1(3)C and 19.2.2.2.4(2). These deficient practices had the potential to affect all residents and was evidenced by the following: A. Observations on 12/12/24 at 11:15 AM at the main entrance with the US FOIA (b)(6) and US FOIA (b)(6)), revealed that the outer set of sliding doors had a	K 222	1. The lock on the front door was removed on December 24, 2024 Signs were installed on all doors with a 15 second delayed egress stating Push until alarm sounds. Door can be opened in 15 seconds. 2. All residents in the Facility are at risk from Egress doors not meeting the requirements of the National Fire Protection Association. 3. The ability for the front door to open when pushed in case of emergency will be confirmed on the weekly checklist. The presence of signage stating to push until alarms sounds will be confirmed on weekly door checks. The Maintenance Director or designee will be responsible for completing and signing off on weekly rounds. The checklist will be audited monthly by the Administrator for 3 months. 4. The Director of Maintenance or designee will report on the status of daily	

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	315284	A. BUILDING 02 B. WING ______	12/12/2024

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K 222	Continued From page 3 lockset that engaged a hook-type deadbolt. The device on the doors could restrict emergency use of the exit. The sliding doors had signs indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors as stated on the signs. A review of the current evacuation plan revealed that the front doors were designated an exit/egress route. In an interview at the time, the US FOIA (b)(6) both stated that the lockset (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency. B. Observations from 09:30 AM to 1:00 PM, revealed that 5 exit/egress doors were not provided with a sign "Push Until Alarm Sounds, Door Can Be Opened in 15-seconds." The US FOIA activated the 15-second delayed device, but no signs were installed indicating that this type of device was installed on the exit/egress doors in the following areas of the facility: 1). The 2nd floor exit/egress door by elevator #2 across from the Social Services office and the assistant DON office. 2). The 2nd floor exit/egress door #13, stairway #2 by resident room #410. 3). The 2nd floor exit/egress door by resident room #318. The US FOIA confirmed the observations during the building tour. The US FOIA (b)(6) was notified of the deficient practices at the Life Safety Code exit conference	K 222	door rounds to the Administrator at Quarterly QA meeting x 3.	

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	315284	A. BUILDING **02** B. WING ______	**12/12/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE** **LONG BRANCH, NJ 07740**

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K 222	Continued From page 4 on 12/12/24 at 1:30 PM. NJAC 8:39-31.2(e)	K 222		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/24 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 4 of 4 areas, had the potential to affect all residents and was evidenced by the following: 1. Observations at 9:30 AM in the #3 nurse station dining room, revealed that 2 sets of 3 wall switches shutoff all 11 ceiling light fixtures. 2. Observations at 9:35 AM in the #3 nurse station day room, revealed that 2 sets of 3 wall switches shutoff all 11 ceiling light fixtures. 3. Observations at 9:42 AM in the floor #1 dining room, revealed that 2 sets of 3 wall switches shutoff all 12 ceiling light fixtures.	K 281	1. Two switches in each of the three dining room were disabled. Allowing for light fixtures to be on each room at all times. The dining room lights will be powered by the Emergency generator during a power outage. 2. All residents can be at risk of illumination of means of egress not meeting requirements of the National Fire Protection Association. 3. The ability of one light staying on at all times will be added to weekly tasks on Facility Maintenance Software and will be confirmed by the Maintenance Director or Designee on weekly rounds. 4. The Director of Maintenance or designee will report to the Administrator on the stat us of Emergency illumination at Quarterly QA Meeting x 3.	1/17/25

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	315284	A. BUILDING **02** B. WING ______	**12/12/2024**

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K 281	Continued From page 5 4. Observations at 9:48 AM in the day room by resident room 321, revealed that 2 sets of 3 wall switches shutoff all 5 ceiling light fixtures. The area was not provided with any illumination of the means of egress continuously in operation or capable of automatic operation without manual intervention. The US FOIA (b)(6) both confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 12/12/24 at 1:30 PM. NJAC 8:39-31.2(e)	K 281	Completion date	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		1/17/25

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	315284	A. BUILDING 02 B. WING	12/12/2024

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K 353	Continued From page 6 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/16/24 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to maintain sprinkler heads in optimal condition in accordance with NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:48 AM with the US FOIA (b)(6) revealed that 1 of 2 fire sprinkler heads in the laundry exit/egress corridor had a towel with electrical tape wrapped around the pipe and sprinkler head. The US FOIA (b)(6) both confirmed the above observations and indicated they were not sure why the pipe and sprinkler head were like this in the facility. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 12/12/24 at 1:30 PM. NJAC 8:39-31.2(e) NFPA 25	K 353	1. The rag covering the sprinkler head was immediately removed on December 11, 2024 All other sprinkler heads in the Facility were visually inspected to insure they were not covered. 2. All residents are considered at risk of sprinkler heads not meeting the requirement of the National Fire Protection Association. 3. The Maintenance, dietary and housekeeping staff were all in-serviced on not placing any barrier in the path of any sprinkler head. The Maintenance director or designee will follow behind any vendor to ensure they do not leave any obstruction in the path of any sprinkler heads. The Director of Maintenance or designee will perform a visual inspection of all sprinkler heads on a weekly basis. 4. The Director of Maintenance or designee will report to the Administrator on the status of all sprinkler inspections Quarterly QA Meeting x 3.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING **02** B. WING ______	**12/12/2024**

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K 920	Continued From page 7 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/24 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with NFPA 101: 2012, Sections 19.5, 19.5.1, 9.1 and 9.1.2, NFPA 70: 2011 Edition, Sections 400.8 and 590.3 (D), NFPA 99: 2012 Edition, Sections 10.2.3.6 and 10.2.4. This deficient practice was denitrified for 1 of 1 electrical wires observed, had the potential to affect all residents in the facility and was evidenced by the following: An observation at 11:14 AM in the exit/egress	K 920	1. A new outlet was installed for the ice machine inside the kitchen area. 2. All Residents are at risk of electrical equipment not meeting the requirements of the National Fire Protection Association. 3. A visual Electrical receptacle inspection to ensure no use of extension cords will be added to Monthly tasks on Facility maintenance task software and will be confirmed by The Director of Maintenance or designee on Monthly rounds.	

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K 920	Continued From page 8 corridor with the US FOIA, revealed that a black wire with a modified yellow plug was observed through the concrete wall into a GFCI duplex wall outlet. The black wire was observed installed into the facility kitchen supplying power to the ice machine. In an interview at the time, the findings were verified by the US FOIA (b)(6). The US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference on 12/12/24 at 1:30 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K 920	4. The Director of Maintenance or designee will report to the Administrator on the status of all Electrical receptacle inspections at Quarterly QA Meeting x 3.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315284 (Y1)	A. Building 02 - MONMOUTH CARE CENTER B. Wing (Y2)	2/5/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 01/17/2025	ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 01/17/2025	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 01/17/2025
ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 01/17/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO