STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. Building B. Wing	05/29/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38080 Based on interview and review of pertinent facility documents, it was determined that the facility failed to notify the New Jersey Department of Health (NJDOH) an allegation of neglect for a Certified Nursing Aide who was discovered sleeping during a shift in a resident's room who reported they were under the influence of a substance. This deficient practice was identified for 1 of 6 terminated employee files reviewed, and was evidenced by the following: During entrance conference on 5/20/24 at 9:54 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to provide the survey team with a list of all employees hired since last standard survey who were still employed by the facility or terminated. The surveyor requested the facility provide the reason for termination. On 5/24/24 at 9:35 AM, the surveyor requested from the DON ten employee files including personal and medical from the provided list. A review of CNA #1's files revealed the following: The employee was hired on 11/16/23, with an Employee Termination form dated effective 1/17/24, with a termination summary for staff was observed to be under the influence of a substance. According to her, she stated she took too much of her anxiety [medications] and never brought in a script. A review of the New Employee Physical Examination signed by CNA #1 on 11/16/23, indicated for list of medical conditions was left blank, and the list of all medications you are currently using and indication of use did not include anxiety medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/24 at 11:40 AM, the surveyor interviewed the DON regarding CNA #1's termination, and the DON stated she received a phone call from the Supervisor that aide was very sleepy and she was sleeping in a chair in a resident's room. Staff woke CNA #1 up and she stated she was tired and went back to work, but was found sleeping again so she was sent home. The DON stated she spoke to CNA #1 the next day who stated she said had been under a lot of stress, and she took too much of her anxiety medication. The DON requested a copy of the prescription, and the CNA stated she would provide the medication bottle, but she never did. The DON stated when the facility suspected an employee being under the influence, they were sent out to the hospital for drug testing, but the facility did not drug test CNA #1 because the aide stated she had a prescription that was never confirmed and the CNA could not provide the name of the prescribed medication. The DON stated CNA #1 never brought in the prescription so she never worked again, and the DON confirmed she did not report the CNA's condition to any agency or licensing boards since the CNA was just sleepy. The DON stated she was unsure who in the state would be notified. At that time, the surveyor requested a copy of CNA #1's assignment sheet for the day, as well as their time card, and the facility's policy regarding an employee under the influence. A review of CNA #1's time card revealed the last day she worked was 12/12/23 from 4:49 PM until 10:45 PM. A review of the CNA Assignment sheet for the 3:00 PM to 11:00 PM shift on 12/12/23, revealed CNA #1 was assigned fourteen residents, which included twelve residents who needed assistance with transferring from bed to chair or chair to bed with five of the residents using a hoyer lift (an assistive device that uses a sling to lift the resident in the air to be transferred between a bed and chair). On 5/28/24 at 2:05 PM, the DON in the presence of the LNHA, Assistant Director of Nursing (ADON), Regional LNHA, Regional Nurse, and survey team, stated the incident with CNA #1 occurred on 12/12/23, and the CNA returned to the facility the next day to speak with the DON. The DON stated CNA #1 stated she was on an antianxiety medication that the aide was unsure of the name, and never provided the prescription. The DON could still not speak to who the incident should have been reported to. On 5/29/24 at 10:13 AM, the LNHA in the presence of the DON, Regional LNHA, Regional Nurse, and survey team stated the facility would report the incident to the NJDOH. The DON stated that CNA #1 at the beginning of her shift was fine, and staff noticed at the end of the shift she was very sleepy. The DON confirmed she was found sleeping in a resident's room, and that the Supervisor had called her that evening because she was concerned with the CNA. The DON confirmed the CNA had a full assignment of residents, and someone impaired by a substance should not be operating a hoyer lift because it was a safety concern. A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated reviewed January 2024, included protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not limited to: a. facility staff .identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property; investigate and report any allegations within the timeframes required by federal requirements . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Substance Abuse in the Workplace policy dated 2020, included the facility is committed to ensuring a drug and alcohol-free workplace in order to maintain the safety of its residents . being under the influence of alcohol or illegal drugs while at the facility poses a serious health and safety risk to all residents .staff may not present in the Facility .conduct any Facility-sanctioned task while impaired on a substance .this policy does not prohibit appropriate use of over the counter and legal prescription medication when used to treat a disability .nothing in this policy is meant to prohibit the appropriate use of over-the-counter medication or other medication that can legally be prescribed under both federal and state law, to the extent that it does not impair a staff member's job performance or safety or safety of others .a violation of this policy is subject to disciplinary action, up to and including termination of employment. NJAC 8:39-4.1(a)5

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 38080 Based on interview and review of pertinent facility documents, it was determined that the facility failed to investigate an allegation of neglect when a Certified Nursing Aide was discovered sleeping during shift in a resident's room who reported they were under the influence of a substance. This deficient practice was identified for 1 of 6 terminated employee files reviewed, and was evidenced by the following: During entrance conference on 5/20/24 at 9:54 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to provide the survey team with a list of all employees hired since last standard survey who were still employed by the facility or terminated. The surveyor requested the facility provide the reason for termination. On 5/24/24 at 9:35 AM, the surveyor requested from the DON ten current and terminated employee files including personal and medical from the provided list. A review of CNA #1's files revealed the following: The employee was hired on 11/16/23, with an Employee Termination form dated effective 1/17/24, with a termination summary for staff was observed to be under the influence of a substance. According to her, she stated she took too much of her anxiety [medications] and never brought in a script. A review of the New Employee Physical Examination signed by CNA #1 on 11/16/23, indicated for list of medical conditions was left blank, and the list of all medications you are currently using and indication of use did not include anxiety medication. On 5/28/24 at 11:40 AM, the surveyor interviewed the DON regarding CNA #1's termination, and the DON stated she received a phone call from the Supervisor that aide was very sleepy and she was sleeping in a chair in a resident's room. Staff woke CNA #1 up and she stated she was tired and went back to work, but was found sleeping again so she was sent home. The DON stated she spoke to CNA #1 the next day who stated she said had been under a lot of stress, and she took too much of her anxiety medication. The DON requested a copy of the prescription, and the CNA stated she would provide the medication bottle, but she never did. The DON stated when the facility suspected an employee being under the influence, they were sent out to the hospital for drug testing, but the facility did not drug test CNA #1 because the aide stated she had a prescription that was never confirmed and the CNA could not provide the name of the prescribed medication. The DON stated CNA #1 never brought in the prescription so she never worked again, and the DON confirmed she never took any statements from employees or conducted an investigation. At that time, the surveyor requested a copy of CNA #1's assignment sheet for the day, as well as their time card, and the facility's policy regarding an employee under the influence. A review of CNA #1's time card revealed the last day she worked was 12/12/23 from 4:49 PM until 10:45 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the CNA Assignment sheet for 12/12/23, revealed CNA #1 was assigned fourteen residents, which included twelve residents who needed assistance with transferring from bed to chair or chair to bed with five of the residents using a hoyer lift (an assistive device that uses a sling to lift the resident in the air to be transferred between a bed and chair). On 5/28/24 at 2:05 PM, the DON in the presence of the LNHA, Assistant Director of Nursing (ADON), Regional LNHA, Regional Nurse, and survey team, stated the incident with CNA #1 occurred on 12/12/23, and the CNA returned to the facility the next day to speak with the DON. The DON stated CNA #1 stated she was on an antianxiety medication that the aide was unsure of the name, and never provided the prescription. The DON confirmed she obtained no written statements from any staff. On 5/29/24 at 10:13 AM, the DON in the presence of the DON, Regional LNHA, Regional Nurse, and survey team stated that CNA #1 at the beginning of her shift was fine, and staff noticed at the end of the shift she was very sleepy. The DON confirmed she was found sleeping in a resident's room, and that the Supervisor had called her that evening because she was concerned with CNA. The DON confirmed the CNA had a full assignment of residents, and someone impaired by a substance should not be operating a hoyer lift because it was a safety concern. A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated reviewed January 2024, included protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not limited to: a. facility staff .identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property; investigate and report any allegations within the timeframes required by federal requirements . A review of the facility's Substance Abuse in the Workplace policy dated 2020, included the facility is committed to ensuring a drug and alcohol-free workplace in order to maintain the safety of its residents . being under the influence of alcohol or illegal drugs while at the facility poses a serious health and safety risk to all residents .staff may not present in the Facility .conduct any Facility-sanctioned task while impaired on a substance .this policy does not prohibit appropriate use of over the counter and legal prescription medication when used to treat a disability .nothing in this policy is meant to prohibit the appropriate use of over-the-counter medication or other medication that can legally be prescribed under both federal and state law, to the extent that it does not impair a staff member's job performance or safety or safety of others .a violation of this policy is subject to disciplinary action, up to and including termination of employment. NJAC 8:39-4.1(a)5

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Complaint NJ#: 160630; 169902; 170619; 172027 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure that incontinence care was provided to dependent residents for 5 of 8 residents observed during incontinence rounds (Residents #94, #16, #8, #109 and #137) on 1 of 2 nursing units (Applewood), and b.) provide activities of daily living (ADL) care for 4 of 7 residents reviewed for ADL care (# 95, #94, #109 and #16). This deficient practice was evidenced by the following: 1. On 5/20/24 at 11:41 AM, the surveyor observed Resident #94 in bed. The Resident's Representative (RR #1) informed the surveyor that Resident #94 had not received care that morning, which included incontinence care, and was still wearing the same jeans from last night. At that time, Resident #94 nodded in agreement. On 5/20/24 at 11:52 AM, the surveyor found Resident #94's Certified Nursing Assistant (CNA #1) who confirmed she was the resident's aide for the day, and stated she had provided incontinence care earlier that shift. The surveyor accompanied by CNA #1, entered the resident's room and pulled back the resident's blanket. It was revealed that the resident was wet with urine that saturated through their jeans and bed sheets. At that time, the surveyor observed a strong unpleasant odor. CNA #1 stated she had not provided care yet for that resident, and was previously mistaken. CNA #1 further stated that she had ten residents on her assignment that day and had not provided care. Review of the CNA assignment sheet revealed the unit had a census of 51 Residents with five assigned aides. CNA #1 had an assignment of ten residents on that shift. The surveyor reviewed the medical record for Resident #94. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included chronic kidney disease, Alzheimer's Disease, and a urinary tract infection. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/25/24, reflected the resident had a brief interview for mental status (BIMS) score of 10 out of 15, which indicated a moderately impaired cognition. A further review revealed the resident required assistance from staff for personal hygiene and toileting and was frequently incontinent of bladder and occasionally incontinent of bowel. A review of the individualized comprehensive care plan (ICCP) dated 10/21/22, included a focus area that the resident was at risk for skin breakdown related to incontinence and immobility. Interventions included to change incontinent product as soon as possible (ASAP) after voiding or bowel movement; keep bed linen clean and dry; keep skin clean and dry. An additional focus area dated 10/21/22, included ADL self-care performance with interventions that included to provide assistance with personal hygiene and assistance with transfers from bed to wheelchair and wheelchair to the toilet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/22/24 at 7:23 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated that incontinence rounds should be completed every two hours. On 5/24/24 at 10:17 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that incontinence care should be done every two hours on the day shift. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours. 2. On 5/22/24 at 7:45 AM, the surveyor performed incontinence rounds with the UM/LPN on the Applewood Unit and observed Resident #16 in bed with an incontinence brief that was saturated with urine. The surveyor and UM/LPN observed a strong unpleasant odor. At that time, the UM/LPN confirmed that the brief should have been changed every two hours and agreed that, given the extent of the saturation, the resident's brief could not have been changed at 5:00 AM. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides on the 11:00 PM to 7:00 AM (11-7) shift. The resident's assigned CNA (CNA #2) had an assignment of 18 residents on that shift. The surveyor reviewed the medical record of Resident #16. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included gastronomy status (surgical procedure to insert a tube into the stomach for nutrition), chenille (paralysis of one side of the body), and empress (muscle weakness on one side of the body) following cerebral infarction (stroke), and diabetes mellitus. A review of the most recent comprehensive MDS dated [DATE], reflected the resident had severely impaired cognition and was incontinent of bowel and bladder. A review of the ICCP dated included a focus area dated 2/19/21, that the resident has a history of and was at risk for pressure ulcer development due to decline in mobility and bowel and bladder incontinence. Interventions included to change incontinent product ASAP after voiding or bowel movement; keep bed linen clean, dry and free of wrinkles; keep nails short and filed; and keep skin clean and dry. On 5/23/23 at 9:24 AM, the surveyor attempted a phone interview with the CNA #2 with no answer. On 5/24/24 at 10:17 AM, the surveyor interviewed the DON who confirmed that incontinence care should be provided every two hours on the day shift and twice on the night shift. The first incontinence rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours. 3. On 5/20/24 at 12:13 PM, the surveyor observed Resident #8 in their room seated in a wheelchair. The Resident's Representative (RR #2) stated that on Saturday, he/she observed the resident's clothing was saturated with urine and observed a puddle of urine on the floor under their wheelchair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/24 at 10:44 AM, the surveyor observed Resident #8 in his/her room seated in a wheelchair with CNA #3 in the room. The surveyor observed a strong unpleasant odor in the room. CNA #3 acknowledged the odor, and confirmed that the resident's incontinence brief, bed clothing, and bed sheets were all saturated with urine. Upon making this observation, CNA #3 stated, not sure what night shift does. CNA #3 further acknowledged that it was her first incontinence care provided for Resident #8 for that day. On 5/22/24 at 7:41 AM, during the incontinence rounds, the surveyor observed the resident with an incontinence brief with two bladder pads that were wet with urine and inserted inside the adult brief. At that time, the surveyor interviewed the UM/LPN who stated that placing two incontinence pads inside a diaper was unacceptable and that it could cause skin breakdown. Review of the 11-7 CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift. The surveyor reviewed the medical record of Resident #8. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included dementia, chronic obstructive pulmonary disease and non-Hodgkin lymphoma. A review of the most recent comprehensive MDS dated [DATE], reflected the resident had a BIMS score of 3 out of 15, which indicated a severely impaired cognition. A further review reflected the resident required the assistance of staff for toileting and personal hygiene. A review of the ICCP included a focus area dated 1/24/23, that the resident had the potential for skin breakdown with regards to incontinence and immobility. Interventions included to change incontinent product ASAP after voiding or bowel movement; keep bed linen clean, dry and free of wrinkles; keep skin clean and dry. An additional focus area dated 1/24/23, included ADL with interventions that included assistance of staff member for personal hygiene and transfers. On 5/23/23 at 9:30 AM, the surveyor attempted a phone interview with the CNA #4 with no answer. On 5/24/24 at 10:17 AM, the surveyor interviewed the DON who confirmed that incontinence care should be provided every two hours on the day shift and twice on the night shift. The first incontinence rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours and that bladder pads should not be placed inside incontinence brief unless requested by the family or the resident. The DON acknowledged that inserting bladder pads inside incontinence briefs increased the chance of skin breakdown. 4. On 5/22/24 at 7:32 AM, during incontinence rounds with the UM/LPN on the Applewood Unit, Resident #109 was observed in bed wearing an incontinence brief with a wet bladder pad inside. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift which included Resident #109. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the medical record for Resident #109. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included dementia, seizure disorder and facial weakness following cerebral infarction (stroke). A review of the most recent comprehensive MDS dated [DATE], reflected the resident had severely impaired cognition and required staff assistance for personal hygiene and toileting. A further review reflected that the resident was incontinent of bowel and bladder. A review of the ICCP included a focus area dated 1/3/22, that the resident was at risk for pressure ulcer development due to a decline in mobility. Interventions included to keep nails short and filed and change incontinence product ASAP after voiding or bowel movement. On 5/24/24 at 10:17 AM, the surveyor interviewed the DON who confirmed that incontinence care should be provided every two hours on the day shift and twice on the night shift. The first incontinence rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours and that bladder pads should not be placed inside incontinence briefs unless requested by the family or the resident. The DON acknowledged that inserting bladder pads inside incontinence briefs increased the chance of skin breakdown. 5. On 5/22/24 at 7:36 AM, during incontinence rounds, the surveyor and UM/LPN observed Resident #137 in bed with an incontinence brief and a bladder pad inside the diaper. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift which included Resident #137. The surveyor reviewed the medical record of Resident #137. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included Alzheimer's Disease and urinary retention. A review of the most recent comprehensive MDS dated [DATE], reflected the resident had a BIMS score of 3 out of 15, which indicated severely impaired cognition. A further review revealed the resident required staff assistance with toileting and dressing. A review of the ICCP included a focus area dated 2/8/24, that the resident required assistance with ADLs with interventions that included to assist with bathing, dressing, and personal hygiene. On 5/24/24 at 10:17 AM, the surveyor interviewed the DON who confirmed that incontinence care should be provided every two hours on the day shift and twice on the night shift. The first incontinence rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours and that bladder pads should not be placed inside incontinence briefs unless requested by the family or the resident. The DON acknowledged that inserting bladder pads inside incontinence briefs increased the chance of skin breakdown. 6. On 5/20/24 at 11:41 AM, the surveyor interviewed Resident #95 who stated that he/she did not receive their scheduled shower on Friday 5/17/24, and their last reported shower was on Tuesday 5/14/24. Resident #95 stated that their showers were scheduled weekly for Tuesdays and Fridays, but the facility was often short-staffed, and he/she was lucky if they even get one shower per week. The surveyor reviewed the medical record for Resident #95. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included chronic atria fibrillation, heart failure and chronic kidney disease. A review of the most recent quarterly MDS dated [DATE], reflected the resident had a BIMS score of 14 out of 15, which indicated a fully intact cognition. A further review revealed the resident required staff assistance for showers. A review of the ICCP included a focus area dated 10/21/22, that the resident needed assistance with ADLs with interventions that included to provide staff assistance to complete a shower or bed bath. On 5/28/24 at 10:10 AM, the surveyor interviewed CNA #5 who informed the surveyor that resident shower days were listed on each of the CNA's assignments. CNA #5 further stated that when a shower was done, the CNAs signed the Applewood Shower Sheet which was kept in a notebook. On 5/28/24 at 10:15 AM, the surveyor interviewed the UM/LPN who provided the surveyor with copies of Resident #95's Shower Sheets. A review of the shower sheets revealed that Resident #95 had not received their scheduled showers on 5/3, 5/7, 5/10, 5/17, or 5/24/24. At that time, the UM/LPN confirmed that Resident #95 had not had his/her scheduled showers on those scheduled days, and that she was responsible for ensuring that showers were done. On 5/29/24 at 9:19 AM, the surveyor interviewed CNA #3 who stated that she was not always able to give the residents showers on their assigned shower days because sometimes she had too many residents and it gets too hectic. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged showers should be given on the resident's assigned days. The DON further stated if the shower was not given on the assigned day, it should be given the following day. 7. On 5/20/24 at 11:41 AM, Resident #94's Representative (RR #1) informed the surveyor that Resident #94 had not received their scheduled shower on Friday 5/17/24, and that their last shower was on Tuesday 5/14/24. RR #1 further stated that Resident #94's showers were scheduled weekly for Tuesdays and Fridays, but that the facility was often short-staffed, and he/she was lucky if they even get one shower per week. The surveyor reviewed the medical record of Resident Resident #94. (continued on next page)

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Complete Care at Shorrock	75 Old Toms River Road Brick, NJ 08723

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included chronic kidney disease, Alzheimer's Disease, and a urinary tract infection. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/25/24, reflected the resident had a brief interview for mental status (BIMS) score of 10 out of 15, which indicated a moderately impaired cognition. A further review revealed the resident required assistance from staff for personal hygiene and toileting and was frequently incontinent of bladder and occasionally incontinent of bowel. A review of the ICCP included a focus area dated 10/21/22, that the resident was at risk for skin breakdown related to incontinence and immobility. Interventions included to change incontinent product ASAP after voiding or bowel movement; keep bed linen clean and dry; keep skin clean and dry. An additional focus area included ADL self-care performance with interventions that included to provide staff assistance with shower, bed bath, personal hygiene and assistance with transfers from bed to wheelchair and wheelchair to the toilet. On 5/28/24 at 10:10 AM, the surveyor interviewed CNA #5 who informed the surveyor that the resident's shower days were listed on each of the CNA's assignments. CNA #5 further stated that when a shower was done, the CNAs signed the Applewood Shower Sheet which was kept in a notebook. On 5/28/24 at 10:15 AM, the surveyor interviewed the UM/LPN who provided the surveyor with copies of Resident #94's Shower Sheets. A review of the shower sheets revealed that Resident #94 had not received their scheduled showers on 5/3, 5/7, 5/10, 5/17, or 5/24/24. At that time, the UM/LPN confirmed that Resident #94 had not had his/her scheduled showers on those days and stated that she was responsible for ensuring that showers were done. On 5/29/24 at 9:19 AM, the surveyor interviewed CNA #3 who stated that she was not always able to give the residents showers on their assigned shower days because sometimes she had too many residents and it gets too hectic. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged showers should be given on the resident's assigned days. The DON further stated if the showers were not given on the assigned day, they should be given the following day. 8. On 5/20/24 at 11:06 AM, the surveyor observed Resident #109 in bed and observed his/her fingernails were long, jagged, and soiled with a brown material underneath. On 5/22/24 at 7:32 AM, the surveyor accompanied by the UM/LPN entered Resident #109's room. The UM/LPN confirmed the fingernails were long, jagged and soiled. The UM/LPN stated that the nurses were responsible for clipping the nails and the CNAs were responsible for cleaning them and that they should be checked and cleaned daily. The surveyor reviewed the medical record for Resident #109. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included dementia, seizure disorder and facial weakness following cerebral infarction (stroke). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent comprehensive MDS dated [DATE], reflected the resident had severely impaired cognition and required staff assistance for personal hygiene and toileting. A review of the ICCP included a focus area dated 1/3/22, that the resident was at risk for pressure ulcer development due to a decline in mobility. Interventions included to keep nails short and filed and change incontinence products ASAP after voiding or bowel movement. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse stated that fingernail care was part of grooming and that CNAs should be checking, clipping, filing and cleaning the residents fingernails. The DON further stated that if a resident had a diagnoses of diabetes, the CNAs should not clip nails, but should still file and clean them. 9. On 5/21/24 at 11:45 AM, the surveyor observed Resident #16 seated in a geriatric chair and observed the resident had a hand splint in place to their left hand. The surveyor observed that Resident #16's fingernails on both their left and right hands were long, jagged soiled. The surveyor reviewed the medical record of Resident #16. A review of the Admission Record face sheet, reflected that the resident was admitted to the facility with diagnoses that included gastrostomy status (a surgical procedure inserting a tube into the stomach for nutrition), hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) and diabetes mellitus. A review of the most recent comprehensive MDS dated [DATE], reflected the resident had severely impaired cognition and was dependent on staff for eating and toileting. A review of the ICCP included a focus area dated 3/9/23, that included ADLs with interventions that included to provide staff assistance with personal hygiene, bathing and bed mobility. On 5/23/24 at 12:51 PM, the surveyor interviewed the LPN assigned to Resident #16's care who acknowledged that the resident's nails were long, jagged, and soiled and stated that both the nurse and CNA were responsibility for providing nail care for the residents. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse stated that fingernail care was part of grooming and that CNAs should be checking, clipping, filing and cleaning the residents fingernails. The DON further stated that if a resident had a diagnoses of diabetes, the CNAs should not clip nails, but should still file and clean them. A review of the facility's Activities of Daily Living (ADLs) Supporting policy dated revised March 2018, included resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living . NJAC 8:39-27.1(a), 27.2(h)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure a residents who received hemodialysis were being assessed in accordance to their hemodialysis access site and professional standards of practice every shift and b.) ensure a resident who received hemodialysis services was care planned for. This deficient practice was identified for 2 of 2 residents reviewed for hemodialysis (Resident #62 and #84), and was evidenced by the following: 1. On 5/21/24 at 11:39 AM, the surveyor observed Resident #62 in their room watching television. The resident informed the surveyor that he/she received dialysis treatments (removes waste products and excess fluid from the blood when the kidneys no longer function properly). The surveyor reviewed the medical record for Resident #62. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included end stage renal disease, chronic kidney disease stage 3 unspecified, and heart failure. A review of the Order Summary Report included the following physician's orders (PO): A PO dated 1/30/24, for dialysis three times a week on Mondays, Wednesdays, and Fridays. A PO dated 1/30/24, to monitor right subclavian permacatheter (temporary or permanent tunneled or connected port under the skin into the subclavian vein in the chest which can be used for a dialysis access point) for signs and symptoms of bleeding. A PO dated 3/12/24, to elevate right arm on pillows every shift for post surgery right arm arteriovenous (AV) fistula (surgically placed shunt that connects an artery to a vein in preparation for dialysis). A review of the comprehensive care plan did not include a focus area with interventions for dialysis. On 5/23/24 at 10:45 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated the resident was on dialysis and was cleared to use the AV shunt as an access point two to three weeks ago. The LPN stated the resident also had a permacatheter in their chest that was covered. The LPN stated there were no assessments that she needed to do for the AV shunt or permacatheter; no dressings that were done either. The resident had a communication record that went with him/her to dialysis, and dialysis obtained pre and post weights. The LPN stated the Unit Manager/LPN (UM/LPN) completed the care plans. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/23/24 at 10:54 AM, the surveyor interviewed the UM/LPN who stated for a resident who went to dialysis, the facility obtained vital signs prior to leaving and the dialysis center obtained pre and post weights. The facility used a communication record to communicate with the dialysis center anything that occurred at dialysis, or anything that the facility needed to follow-up on. The UM/LPN stated if a resident had a permacatheter, professional standards of practice was to monitor the site, keep clean and dry, and make sure no trauma or bleeding every shift. The UM/LPN stated professional standards of practice for an AV shunt was to check bruit and thrill every shift; which was an assessment done by feeling their AV fistula for electric pulse that can be done with fingers or stethoscope done every shift to make sure functioning, no deep vein thrombosis or clogged. If there was any issues, the nurse notified the physician immediately. The UM/LPN confirmed there should be a physician's order to check bruit and thrill as well as a care plan. At that time, the UM/LPN review Resident #62's medical record, and confirmed the resident was using the AV shunt since 5/3/24, and there was no physician's order to check bruit and thrill every shift as well as no care plan. The UM/LPN stated there should also be an arm precaution order; no blood pressure or blood drawn from that arm. On 5/23/24 at 11:22 AM, the UM/LPN in the presence of the surveyor checked Resident #62's bruit and thrill, which the UM/LPN confirmed there was one. The UM/LPN stated as long as the resident had an AV shunt, whether it was in use or not, the nurses should have checked for bruit and thrill every shift. The surveyor continued to review the resident's medical record. A review of the Progress Notes since March did not include a Nurse's Note every shift that the bruit and thrill was monitored. On 5/24/24 at 8:12 AM, the surveyor interviewed the Director of Nursing (DON) who stated if a resident had a permacatheter, there should be orders to check it, and if the resident had an AV shunt, there should be orders to check bruit and thrill every shift. The DON acknowledged that she was aware there was no physician's order to check the resident's bruit and thrill every shift as well as dialysis care plan prior to surveyor inquiry. On 5/29/24 at 10:13 AM, the DON in the presence of the Licensed Nursing Home (LNHA), Regional LNHA, Regional Nurse, and survey team stated Resident #62 had an AV shunt created on 3/12/24, that was cleared for use on 5/3/24. The DON confirmed that the nurse should be assessing for bruit and thrill every shift regardless if the AV shunt was in use or not. 2. The surveyor reviewed the medical record for Resident #84. A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included chronic kidney disease, end stage renal disease, and hypertension (high blood pressure). A review of the Order Summary Report included the following physician's Orders (PO): A PO dated 5/15/24, for dialysis three times a week on Mondays, Wednesdays, and Fridays. A PO dated 3/13/24, monitor right fistula (shunt) for excessive bleeding redness, swelling, pain, fever greater than 101 Fahrenheit, signs and symptoms of infection post surgery every shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PO dated 5/15/24, for no blood pressure or vein puncture to the right arm every shift. A review of the comprehensive care plan included a focus area dated 9/16/2020 for I need dialysis due to renal failure; no blood pressure to upper extremities; I require blood transfusions related to low hemoglobin and hematocrit levels (iron levels). Interventions included to not draw blood or draw blood pressure in right arm with graft; I may need encouragement to go to scheduled dialysis appointments on Mondays, Wednesdays, Fridays; monitor for signs and symptoms of infection to access site; monitor for dry skin and apply lotion as needed; monitor for peripheral edema; monitor for signs and symptoms of renal insufficiency; monitor for signs and symptoms of bleeding, hemorrhage, bacteremia, septic shock; monitor labs; obtain vital signs and weights. On 5/23/24 at 10:54 AM, the surveyor interviewed the UM/LPN who stated for a resident who went to dialysis, the professional standards of practice for an AV shunt was to check bruit and thrill every shift; which was an assessment done by feeling their AV fistula for electric pulse that can be done with fingers or stethoscope done every shift to make sure functioning, no deep vein thrombosis or clogged. If there was any issues, the nurse notified the physician immediately. The UM/LPN confirmed there should be a physician's order to check bruit and thrill every shift. On 5/23/24 at 11:25 AM, the surveyor re-interviewed the UM/LPN who confirmed Resident #84 did not have a PO to check bruit and thrill every shift, and she was putting one in now. The UM/LPN stated the resident's shunt was revised multiple times, and the resident had developed a blood clot. The dialysis center is looking into a permacatheter at this point. The surveyor continued to review the resident's medical record. A review of the Progress Notes since March did not include a Nurse's Note every shift that the bruit and thrill was monitored. On 5/24/24 at 8:12 AM, the surveyor interviewed the DON who stated if a resident had an AV shunt, there should be orders to check bruit and thrill every shift. The DON acknowledged that she was aware there was no physician's order to check the resident's bruit and thrill every shift prior to surveyor inquiry. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, Regional Nurse, and survey team stated Resident #84 had a PO to check bruit and thrill until they were readmitted from a hospitalization on [DATE], and the PO was never put in. The DON stated from 4/12/24 through 5/22/24, there was twelve documented times on the dialysis communication record that bruit and thrill was checked, as well as the Progress Notes contained twenty-seven times nurses documented bruit and thrill was checked from 3/13/24 to 5/17/24. The DON acknowledged that bruit and thrill needed to be checked every shift, every day. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Hemodialysis Access Care policy dated reviewed January 2024, included .care involves the primary goal of preventing infection and maintaining patency of the catheter (preventing clots); to prevent infection and/or clotting: keep access site clean and dry at all times; do not use the access site to take blood samples, administer intravenous fluids or give injections; needle access for hemodialysis should be rotated; check for signs of infection (warmth, redness, tenderness, or edema) at the access site when performing care and at regular intervals; do not access arm to take blood pressure; advise resident not to sleep on, wear tight jewelry or lift heavy objects with access arm; check color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals; and check patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of the blood flow through the access site .the general medical nurse should document in the resident's medical record every shift as follows: location of the catheter; condition of the dressing (interventions if needed); if dialysis was done during shift; any part of report from dialysis nurse post-dialysis being given; observations post-dialysis. A review of the facility's Care Plans, Comprehensive Person-Centered policy dated reviewed January 2024, included a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident .the comprehensive, person-centered care plan will: .describe the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being . NJAC 8:39-27.1 (a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 45209 Complaint NJ #: 161027 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the resident's primary physician wrote and signed their Physician's Progress Notes at the time of each visit. This deficient practice was identified for 1 of 3 residents reviewed for closed records (Resident #147) , and evidenced by the following: The surveyor reviewed the closed medical record for Resident #147. A review of the Admission Record face sheet (an admission summary) reflected that Resident #147 was admitted to the facility with diagnosis that included, but not limited to, aftercare following joint replacement surgery, and infection/inflammation reaction due to internal right knee prosthesis. A review of the Physician's Progress Notes (PPN) in the electronic medical record (eMR) revealed the following had a LATE ENTRY, a designation which indicated the notes were not written on the effective date (Date of service): 1. PPN with an effective date of 2/15/24, but with a created date of 2/19/24. 2. PPN with an effective date of 2/16/24, but with a created date of 2/19/24. 3. PPN with an effective date of 2/19/24, but with a created date of 3/22/24 at 12:33:29. 4. PPN with an effective date of 2/20/24, but with a created date of 3/22/24 at 12:32:56. 5. PPN with an effective date of 2/21/24, but with a created date of 3/22/24 at 12:32:20. On 5/28/24 at 10:16 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who reviewed the resident's eMR and confirmed the above entries were not entered at the time of visit. On 5/28/24 at 1:58 PM, in the presence of the survey team, the surveyor informed the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), ADON, Regional Nurse, and Regional LNHA the concern that physician progress notes were entered days after the patient visit. On 5/29/24 at 11:23 AM, the DON, in the presence of the LNHA, Regional Nurse, and Regional LNHA confirmed that the physician did not document and sign the PPN at the time of the physician visit. A review of the facility's Physician Visits policy, last reviewed January 2024, included [.] 5. The Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. NJAC 8:39-23.2(b)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 45209 Complaint NJ #: 161027 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes at least every 30 days. This deficient practice was identified for 1 of 3 residents reviewed for closed records (Resident #151) and was evidenced by the following: The surveyor reviewed the closed medical record for Resident #151. A review of the Admission Record face sheet (an admission summary) reflected that Resident #151 was admitted to the facility with diagnosis that included, but not limited to dementia and polyosteoarthritis (inflammation of one or more joints). According to the Admission Record, Resident #151 was in the facility for a total of 66 days. Upon review of Resident #151's electronic medical record (eMR), the surveyor located Nurse Practitioner (NP) handwritten physical assessments; however, the surveyor was not able to locate any physician assessments for Resident #151. On 5/28/24 at 10:16 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that it was the facility's expectation that a physician examined all residents upon admission and every 30 days. The ADON reviewed the resident's eMR and confirmed that there was no physician assessment entries. On 5/28/24 at 1:58 PM, in the presence of the survey team, the surveyor informed the Licensed Nursing Home Administrator (LHNA), Director of Nursing (DON), ADON, Regional Nurse and Regional LNHA the concern that Resident #151 did not have any documented physician visits or admission assessment. On 5/29/24 at 11:123 AM, the DON confirmed that there were no physician assessments on record. A review of the facility's Physician Visits policy, last reviewed January 2024, included [.] 2. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter [.]. NJAC 8:39-11.2(b)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36419 Complaint NJ #: 157735; 160630; 164199; 170619; 172027 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure sufficient and competent staff were available to a.) provide appropriate incontinence care to dependent residents for 5 of 8 residents (Resident # 94, #16, #8, #109, and #137) and b.) ensure residents received showers as scheduled for 2 of 2 residents (Resident #95 and #94) reviewed for sufficient staffing, and was evidenced by the following: Refer to F677 1. On 5/20/24 at 11:41 AM, the surveyor observed Resident #94 in bed with their eyes open, very soft-spoken. The Resident's Representative (RR #1) informed the surveyor that Resident #94 had not received care that morning which included incontinence care, and that they were still wearing the same jeans from last night. At that time, Resident #94 nodded in agreement. On 5/20/24 at 11:52 AM, the surveyor found Resident #94's Certified Nursing Assistant (CNA #1) who confirmed she was the resident's aide for the day, and stated she had provided incontinence care earlier that shift. The surveyor accompanied by CNA #1, entered Resident #94's room and pulled back the resident's blanket which revealed the resident was saturated with urine through their jeans and bed sheets, and the surveyor observed a strong unpleasant odor. CNA #1 stated she had not provided care yet for that resident, she was mistaken. CNA #1 further stated that she had ten residents on her assignment that day and had not provided care. Review of the CNA assignment sheet revealed the unit had a census of 51 Residents with five assigned aides. CNA #1 had an assignment of ten residents on that shift. On 5/22/24 at 7:23 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated that incontinence rounds should be completed every two hours. On 5/24/24 at 10:17 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that incontinence care should be done every two hours on the day shift. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours. 2. On 5/22/24 at 7:45 AM, the surveyor did incontinence rounds with the UM/LPN on the Applewood Unit and observed Resident #16 in bed with an incontinence brief saturated with urine. The surveyor and UM/LPN observed a strong unpleasant odor. At that time, the UM/LPN confirmed that the brief should have been changed every two hours, and that the resident's brief could not have been changed at 5:00 AM. On 5/23/24 at 9:24 AM, the surveyor attempted a phone interview with the CNA #2 who was assigned to Resident #16 on the 5/21/24 11:00 PM to 7:00 AM (11-7) shift with no answer. (continued on next page)

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Complete Care at Shorrock	75 Old Toms River Road Brick, NJ 08723

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #2 had an assignment of 18 residents on that shift. On 5/24/24 at 10:17 AM, the surveyor interviewed the DON who confirmed that incontinence care should be provided every two hours on the day shift and twice on the night shift. The first incontinence rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours. 3. On 5/20/24 at 12:13 PM, the surveyor observed Resident #8 in their room seated in a wheelchair. The Resident's Representative (RR #2) stated that on Saturday he/she observed the resident's clothing was saturated with urine, and observed a puddle of urine on the floor under their wheelchair. On 5/21/24 at 10:44 AM, the surveyor observed Resident #8 in his/her room seated in a wheelchair with CNA #3 in the room. The surveyor observed a strong unpleasant odor in the room. CNA #3 acknowledged the odor and stated that the resident's incontinence brief, bed clothing, and bed sheets were all saturated with urine and stated, not sure what night shift does. CNA #3 confirmed that was her first incontinence care provided for Resident #8 for that day. On 5/22/24 at 7:41 AM, during incontinence rounds, the surveyor observed the resident with an incontinence brief with two bladder pads wet with urine inserted inside the adult brief. At that time, the surveyor interviewed the UM/LPN who stated that placing two bladder pads inside an incontinence brief was unacceptable, and that it could cause skin breakdown. On 5/23/23 at 9:30 AM, the surveyor attempted a phone interview with CNA #4 who was assigned to Resident #8 on the 5/21/24 11-7 shift with no answer. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift. On 5/24/24 at 10:17 AM, the surveyor interviewed the DON who confirmed that incontinence care should be provided every two hours on the day shift and twice on the night shift. The first incontinence rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours and that bladder pads should not be placed inside incontinence briefs unless requested by the family or the resident. The DON acknowledged that inserting bladder pads inside an incontinence brief increased the chance of skin breakdown. 4. On 5/22/24 at 7:32 AM the surveyor did incontinence rounds with the UM/LPN on the Applewood Unit and observed Resident #109 in bed wearing an incontinence brief with a wet bladder pad inside their incontinence brief. On the same date at 7:36 AM, the surveyor and UM/LPN observed Resident #137 in bed with an incontinence brief and a bladder pad inside the brief. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/23/23 at 9:30 AM, the surveyor attempted to interview CNA #4 who was assigned to Resident #109 and #137 on the 5/21/24 11-7 shift with no answer. Review of the CNA assignment sheet revealed the unit had a census of 52 Residents with three assigned aides. CNA #4 had an assignment of 18 residents on that shift which included Resident #109 and #137. On 5/24/24 at 10:17 AM, the surveyor interviewed the DON who confirmed that incontinence care should be provided every two hours on the day shift and twice on the night shift. The first incontinence rounds should be done between 12:00 AM and 2:00 AM, and then again between 5:00 AM and 7:00 AM. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged incontinence care should be provided every two hours and that bladder pads should not be placed inside incontinence briefs unless requested by the family or the resident. The DON acknowledged that inserting bladder pads inside an incontinence brief increased the chance of skin breakdown. 5. On 5/20/24 at 11:41 AM, the surveyor interviewed Resident #95 who stated that he/she did not receive their scheduled shower on Friday 5/17/24, and that their last shower was on Tuesday 5/14/24. Resident #95 stated that their showers were scheduled weekly for Tuesdays and Fridays, but that the facility was often short-staffed, and he/she was lucky if they even received one shower per week. On 5/28/24 at 10:10 AM, the surveyor interviewed CNA #5 who informed the surveyor that resident shower days were listed on each of the CNA's assignments. CNA #5 further stated that when a shower was done, the CNAs signed the Applewood Shower Sheet which was kept in a notebook. A review of the Applewood Shower Sheet revealed that Resident #95 had not received their shower on 5/17/24. On 5/28/24 at 10:15 AM, the surveyor interviewed the UM/LPN who confirmed that the shower sheet had not been signed indicating that Resident #95 had not received their shower. The UM/LPN further stated that she was responsible for ensuring all residents received their showers on the assigned shower days. On 5/29/24 at 9:19 AM, the surveyor interviewed CNA #3 who stated that she was not always able to give the residents showers on their assigned shower days because sometimes she had too many residents and it gets too hectic. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged showers should be given on the resident's assigned days. The DON further stated if the shower was not given on the assigned day, it should be given the following day. 6. On 5/20/24 at 11:41 AM, Resident #94's representative (RR #1) informed the surveyor that the resident had not received their scheduled shower on Friday 5/17/24, and that their last shower was on Tuesday 5/14/24. RR #1 further stated that Resident #94's showers were scheduled weekly for Tuesdays and Fridays, but that the facility was often short-staffed, and he/she was lucky if they even received one shower per week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/28/24 at 10:10 AM, the surveyor interviewed CNA #5 who informed the surveyor that the resident shower days were listed on each of the CNA's assignments. CNA #5 further stated that when a shower was done, the CNAs signed the Applewood Shower Sheet which was kept in a notebook. A review of the Applewood Shower Sheet revealed that Resident #94 had not received their shower on 5/17/24. On 5/28/24 at 10:15 AM, the surveyor interviewed the UM/LPN who confirmed that the shower sheet for Resident #94 had not been signed indicating that Resident #94 had not received their shower. The UM/LPN further stated that she was responsible for ensuring all residents received their showers on their assigned shower days. On 5/29/24 at 9:19 AM, the surveyor interviewed CNA #3 who stated that she was not always able to give residents showers on their assigned shower days because sometimes she had too many residents and it gets too hectic. On 5/29/24 at 10:13 AM, the DON in the presence of the LNHA, Regional LNHA, and Regional Nurse acknowledged showers should be given on the resident's assigned days. The DON further stated if the showers were not given on the assigned day, they should be given the following day. A review of the facility's Staffing policy updated September 2023, included our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care and facility assessment .staffing numbers and skills requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care . A review of the facility's Activities of Daily Living (ADLs) Supporting policy dated revised March 2018, included resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living . NJAC 8:39-5.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38080 Based on observation and interview, it was determined that the facility failed to a.) store potentially hazardous foods to prevent food-borne illness; b.) maintain multiuse food-contact surface cutting board in a manner to prevent microbial growth; c.) ensure washed cookware was dried in a manner to prevent microbial growth; d.) maintain storage areas in a sanitary manner. This deficient practice was evidenced by the following: On 5/21/24 at 8:40 AM, the surveyor toured the kitchen with the Dining Service Director (DSD) and observed the following: 1. In front on the walk-in freezer unit, stored directly on the floor, five stacks of twenty-four cases in total of ice cream cups, and a stack of frozen vegetables with a box of oriental blend vegetables directly on the floor. The DSD stated the frozen items were just delivered and the Dietary Aide was labeling the boxes before transferring them into the freezer. The DSD acknowledged food should not be stored or come in direct contact with the floor. 2. In the walk-in freezer, the vinyl strip curtains located in the entrance to the freezer, two curtain strips were missing in the middle of the doorway. These curtains protect the inside of the freezer from outside dust particles as well as keep the cold air from escaping the freezer when the door was opened. The freezer was currently at 25 degrees Fahrenheit. The DSD stated the temperature had increased from the door being opened for the deliveries. 3. On the shelves in the walk-in freezer, the boxes were covered in a thick layer of frost which included the following items that the DSD identified for the surveyor: a case of beef hamburger patties; three liquid coffee containers; broccoli florets; broccoli spears; health shakes; cheese blintz; and stuffed cabbage. The DSD confirmed frost and ice should not be covering the food, and was caused by the door being opened for deliveries. 4. In the walk-in freezer, the condenser unit had a build-up of ice, and the top shelf under the condenser unit contained rods of ice approximately four to six inches in length. The DSD acknowledged the unit and shelves should not have ice buildup. 5. The ice cream chest had a build up of ice on the inside. 6. In dry storage ,one six-pound four-ounce can of cut sweet potatoes dented was in active inventory. 7. On a storage shelf, one large brown cutting board deeply pitted with black discoloration; one large light blue cutting board pitted and yellowish discoloration in grooves; one large brown cutting board pitted; one large yellow cutting board pitted and discolored black; two large red cutting boards pitted; and one large green cutting board pitted with yellow discoloration in the grooves. The DSD stated cutting boards were replaced every quarter or six months and acknowledged those cutting boards needed to be replaced. The DSD stated the grooves could cause bacterial growth. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On the storage rack, two four-inch half pans were wet nesting and five four-inch plastic half pans were wet nesting. One of the plastic half pans had brownish debris in it and was missing a corner of the plastic. The DSD confirmed the broken plastic half pan should not be in use, and pans should not be wet nested. On 5/22/24 at 8:30 AM, the Licensed Nursing Home Administrator (LNHA) stated the walk-in freezer repair company was at the facility yesterday afternoon who replaced the motor on the freezer unit which was now operating properly. On 5/29/24 at 10:13 AM, the LNHA in the presence of the Director of Nursing (DON), Regional LNHA, and Regional Nurse, acknowledged the surveyor's concerns. A review of the facility provided undated Dish Washing and Pot Washing policy included .all items must be air dried. This will allow the sanitizer to break down any biofilms and avoid nesting. Note: nesting is when two or more wet pans are placed together. This causes moisture to become trapped and does not allow it to dry. This can cause bacterial growth and contaminate clean pans . A review of the facility provided undated Kitchen Equipment policy included all kitchen equipment is inspected daily by food service director, by maintenance during rounds and with recommendations from outside service companies during visits . A review of the facility provided undated Receiving and Inspecting Guidelines policy included .product placement .store items away from the walls and at least six inches off the floor . A review of the undated facility provided policy Cutting Board Policy included .replace when needed. A review of the undated facility provided policy Dented Can Policy included .the Food Service Director or designee will spot check all cans upon delivery to ensure there are no dents, bulges, or punctures; all cans identified to not be in good condition will be moved to the designated dented can area . NJAC 8:39-17.2(g)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 38080 Based on observation and interview, it was determined that the facility failed to properly dispose and maintain cardboard waste in dumpster areas. This deficient practice was identified for 1 of 3 garbage dumpsters, and was evidenced by the following: During a tour of the kitchen on 5/21/24 at 8:40 AM, the surveyor accompanied by the Dining Service Director (DSD) observed the facility's garbage compactor and cardboard dumpster. The surveyor observed the cardboard dumpster to be overfilled with intact cardboard boxes that prevented the lid from closing. The area surrounding the dumpster had piles of intact cardboxes surrounding the side walk of the dumpster area approximately four to five feet in height, as well as intact cardboard boxes in the fire zone of the facility parking lot. The DSD stated the cardboard dumpster was disposed of twice a week, and today was a delivery day. The DSD acknowledged the cardboard boxes should not be around the dumpster area, that it was not being maintained in a sanitary manner. On 5/28/24 at 8:53 AM, the surveyor interviwed the Maintenance Director (MD) who stated the garbage compactor was collected every other Tuesday, and cardboard was collected every Monday and Friday. The MD stated he did not see the cardboard dumpster area until after the surveyor observed it with the DSD, and staff had already cleaned the area. At that time, the surveyor showed the MD a picture of the area at the time of observation, and the MD confirmed the condition of the area was unacceptable. The MD stated the boxes that were identified still intact were both from the nursing department as well as dietary, and the boxes should have been broken down and not left intact. On 5/29/24 at 10:13 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Regional LNHA, Regional Nurse, and survey team stated it was the facility's policy if the cardboard dumpster was filled, the cardboard boxes could be stored next to the dumpster. At that time, the surveyor showed the LNHA a picture of the dumpster area at the time of observation and asked if the area was maintained in acceptable condition, and the LNHA did not respond. A review of the undated facility provided Garbage and Trash Disposal Policy included the Dining Services Director coordinates with the Directors of Maintenance and Housekeeping to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris .cardboard and other recycling dumpsters should be properly maintained: dumpster door or lid must be closed at all times when not in use; all staff is responsible to breakdown cardboard boxes after each use; and all boxes should be placed in the recycling dumpster flattened as to not take up additional space. If cardboard dumpster is full, stack cardboard on concrete next to dumpster until emptied; area around dumpster should remain clean and free from refuse; report any dumpster or trash compactor issues to maintenance immediately. NJAC 8:39-19.3(a); 19.7(a)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45209 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control standards of practice and procedures to a.) ensure appropriate hand hygiene was performed during lunch meal in 2 of 5 dining areas; b.) ensure appropriate infection control practices were maintained for 1 of 1 Resident (Resident #16) observed during wound treatments and c.) follow appropriate hand hygiene practices during resident care for 1 of 7 residents (Resident #8) reviewed for Activities of Daily Living (ADLs). The evidence was as follows: 1. On 5/20/24 from 11:35 AM to 11:48 AM, the surveyor observed dining in the Meadows Unit. Prior to handing out lunch trays, the Unit Manager/Licensed Practical Nurse (UM/LPN #1) was observed placing alcohol based hand rub (ABHR) on top of the food truck that contained resident lunch trays. During tray pass, a Licensed Practical Nurse (LPN #1) and Activity Aide (AA #1) were each observed being handed a tray by UM/LPN #1. LPN #1 and AA #1 were observed placing the tray in front their designated resident. LPN #1 and AA #1 proceeded to uncover each resident's plate, use the resident's utensils to cut food, then immediately proceeded to obtain another resident's tray without performing hand hygiene. During the course of the meal observation, staff was not observed performing hand hygiene in between each tray pass. On 5/20/24 from 11:52 AM to 12:21 PM, the surveyor observed dining in the Main Dining Room prior to meal service, hand hygiene was not performed to the residents seated in the room. Meals were delivered to the residents by waitress style to each table. The surveyor observed Restorative Aide (RA #1) assist a resident and used their utensils to cut their meal, and then proceeded to pour coffee and open sweetener packages. RA #1 continued to additional residents performing the same process of cutting residents' meals and serving coffee without performing hand hygiene. On 5/20/24 at 12:27 PM, the surveyor interviewed AA #1 who stated that hand hygiene was required as needed between every couple residents or deemed necessary. When asked if hand hygiene was required after tray contact AA #1 responded, not necessarily. On 5/20/24 at 12:34 PM, the surveyor interviewed LPN #1 who confirmed that hand hygiene was required after every couple residents and was not necessary after every tray contact. On 5/20/24 at 12:39 PM, the surveyor interviewed UM/LPN #1 who stated that there was no expectation of hand hygiene in between residents since the staff was not touching food. When asked if hand sanitation should be expected after touching resident utensils, UM/LPN #1 stated that they were not sure. On 5/20/24 at 12:49 PM, the surveyor interviewed RA #1 regarding hand hygiene who explained hand sanitation was to be completed as necessary or when hands were visibly dirty. RA #1 confirmed it was not expected between every resident contact. When asked how hand sanitation was completed with the residents, RA #1 explained that it would be completed by floor staff before the residents are brought to the dining room. RA #1 confirmed that hand hygiene was not completed with residents in the dining room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/24 at 10:32 AM, the surveyor re-interviewed UM/LPN #1 who stated that they spoke with the Regional Infection Preventionist and was instructed that hand hygiene was required between each resident when food was cut up and in between tray pass. UM/LPN #1 confirmed that hand hygiene was not performed the day prior in between each tray pass and after assisting residents with their meal set up. On 5/28/34 at 10:16 PM, the surveyor interviewed Assistant Director of Nursing/Infection Preventionist (ADON/IP) who stated that it was expected that staff was to perform hand hygiene in between any interaction with lunch trays that included use of resident utensils for meal set up. When asked regarding the hand sanitation of residents in the main dining room, the ADON/IP confirmed that handwipes were to be handed out by the person overseeing the dining room prior to meal service. On 5/29/24 at 10:13 AM, the Director of Nursing (DON), in the presence of the LNHA, Regional Nurse, and Regional LNHA confirmed handwashing was expected between passing out trays and cutting up food. A review of the facility's Hand Washing policy last revised January 2024, included 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors .7. Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .o. before and after eating or handling food; before and after assisting a resident with meals . 36419 2. On 5/22/24 at 7:45 AM, the surveyor observed Resident #16 in bed. The surveyor reviewed the medical record of Resident #16. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included gastrostomy status (a surgical procedure to insert a tube into the stomach for nutrition), hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) and diabetes mellitus. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 3/28/24, reflected the resident had severely impaired cognition and was incontinent of bowel and bladder. A further review revealed the resident had one stage 4 pressure ulcer and two unstageable pressure ulcers. A review of the May 2024 Physician Order Summary (POS) which was transcribed onto the Treatment Administration Record (TAR) included a physician's order dated 5/7/24, to cleanse the left heel wound with Vashe (a wound cleanser), apply Santyl ointment (wound debridement) and calcium alginate cover (absorbs wound moisture/exudate), with abdominal (ABD) pad (used to absorb heavy drainage); wrap with rolled gauze daily and when needed (prn); cleanse left lateral lower leg wound with Vashe wound cleanser and apply Santyl and calcium alginate, cover with ABD pad and wrap with rolled gauze daily and prn; soak right medial foot with moistened gauze for 3-5 minutes, apply Santyl and calcium alginate, cover with ABD pad and wrap with rolled gauze daily and prn. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/22/24 at 10:55 AM, the surveyor observed LPN #2 perform a treatment to Resident #16's wounds with UM/LPN #2 who assisted with the resident's positioning. The surveyor observed the following: LPN #2 disinfected the over-bed table (OBT) with sanitizing wipes and applied a clean barrier. LPN #2 then assembled the needed supplies from the treatment cart and placed them on the OBT in the resident's room. Among the supplies were a bottle of wound cleanser, a tube of Santyl ointment, calcium alginate, gauze sponges, ABD pads, scissors, and a marker. The LPN put small amounts of the Santyl ointment into two separate medicine cups. LPN #2 provided the treatment for Resident #16's wounds according to the physician's orders, and after the treatment, the LPN put the scissors she used to remove the soiled dressings and the pen she used to initial and date the dressings into her pocket without first sanitizing them. The LPN then placed the tube of Santyl ointment and wound cleanser back into the treatment cart without sanitizing them. The LPN did not sanitize the overbed table after she completed the treatment. On 5/22/24 at 11:49 AM, the surveyor interviewed LPN #2 regarding the wound treatment observation who acknowledged that she should not have brought the tube of Santyl ointment and bottle of wound cleanser into the resident's room; she should have taken only what she needed. She further confirmed that she should not have put the contaminated scissors and marker into her pocket but rather should have sanitized them and then returned them to the treatment cart. On 5/24/24, at 11:47 AM, the surveyor interviewed the DON who confirmed that anything used in a resident's room should be disinfected before being placed in the treatment cart. On 5/24/24 at 12:06 PM, the surveyor interviewed the ADON/IP, who confirmed that LPN #2 should not have brought the tube of Santyl and bottle of wound cleanser into the room, but only the amounts needed for the treatment. The ADON/IP further stated that the scissors and marker should have been disinfected and returned to the treatment. A review of the facility's Clinical Competency Validation Wound Dressing-Aseptic checklist reflected discarding materials and PPE according to infection control policy. 3. On 5/23/24 at 10:32 AM, the surveyor observed Resident #8 in bed and observed CNA #3 providing ADL care. The surveyor observed that CNA #3 handled Resident #8's soiled adult brief, then wet her hands with water, applied soap, and immediately placed her hands under the stream of running water. On 5/23/24 at 12:30 PM, the surveyor interviewed CNA #3, who confirmed that she should have washed her hands outside the stream of water for 20 seconds. On 5/24/24 at 11:47 AM, the surveyor interviewed the DON, who confirmed that staff should lather their hands with soap for 20 seconds outside the stream of water. On 5/24/24 at 12:06 PM, the surveyor interviewed the ADON/IP, who confirmed that staff should apply soap to their hands and lather for 30 seconds before placing them under running water. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. Building B. Wing	05/29/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Hand Washing policy last revised January 2024, included 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors .7. Use an alcohol-based hand rub containing at least 62% alcohol or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .before and after eating or handling food; before and after assisting a resident .Washing Hands 1. vigorously lather hands with soap and rub them together, creating friction for a minimum of 20 seconds . NJAC 8:39-19.4 (a) 27.1 (a)