STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315038	A. BUILDING _____ B. WING _____	03/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SUMMIT RIDGE	20 SUMMIT STREET WEST ORANGE, NJ 07052

(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 DATE: 3/29/21 CENSUS: 97 SAMPLE: 20 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. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found to be in compliance with 42 CFR Part 483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards 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: Based on observation, interview, review of the medical records and other pertinent facility documents, it was determined that the facility failed to accurately follow the physician's orders for the administration of [redacted]. This deficient practice was observed for 1 of 2 residents reviewed for accuracy following the physician's [redacted] orders, Resident #44.	F 658	F658 1. Physician order for oxygen administration was clarified for resident # 44. [redacted] assessment was performed for resident #44 and found unremarkable. 2. Any residents that have orders for	4/19/21

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

Electronically Signed | 04/15/2021

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 658	Continued From page 1 This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 3/22/21 at 11:01 AM, the surveyor observed Resident #44 lying in bed, receiving [redacted]. The surveyor inspected the [redacted] dated [redacted], and the [redacted] was [redacted]. On 3/23/21 at 10:15 AM, the surveyor observed Resident #44 lying in bed, receiving [redacted] The surveyor inspected the [redacted], which was once again [redacted] at [redacted]. The surveyor reviewed the records for Resident #44. Resident #44 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that included but were not limited to [redacted] The surveyor reviewed the [redacted] Physician's Orders, which included an order dated [redacted] to "[redacted] every shift."	F 658	[redacted] have potential to be impacted by this deficient practice, therefore an audit of residents on [redacted] therapy were identified, to include correct liter per physician's orders. No further residents were identified with this deficient practice. 3. DON/designee provided re-education to all licensed nurses regarding following physician orders for oxygen administration and on checking concentrator setting for physician ordered liter flow. 4. Director of Nursing/designee will conduct audit weekly x 4 weeks and then monthly x 2 for new physician orders for oxygen administration to ensure oxygen administration/liter flow settings is per physician orders. All findings will be discussed at the monthly Quality Assurance Performance Improvement meetings.	

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F 658	Continued From page 2 On 3/24/21 at 2:30 PM, the surveyor brought the Licensed Practical Nurse (LPN) assigned to Resident #44 to the resident's room to check the [redacted] rate that Resident #44 was receiving. The LPN, in the presence of the surveyor, verified that the rate on the [redacted] was set at [redacted]. The LPN acknowledged that the Physician's order was for the [redacted] to be administered at [redacted]. The LPN could not explain why the [redacted]. On 3/24/21 at 2:45 PM, the surveyor met with the Administrator, Regional Nurse, and the Director of Nursing regarding the above concern. The DON acknowledged that the [redacted] was not administered according to the most current Physician's order. The DON could not explain why the [redacted] was being administered at [redacted]	F 658		
F 921 SS=B	NJAC 8:39- 29.2 (d) Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/24/21, it was determined that the facility failed to provide a safe and sanitary physical environment. This deficient practice was evidenced by the following findings: During a tour of the facility's basement at 11:00	F 921	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: a. All residents have the potential to be affected. b. The Ceiling tiles will be replaced.	4/19/21

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F 921	Continued From page 3 AM, with the facility's Administrator and Maintenance Director, the surveyor observed 5 of 5 rooms used for storage with stained or missing suspended ceiling tiles. Some of the stained ceiling tiles were water-logged and sagged, causing them to fall from the ceiling. Many ceiling tiles had varying degrees of an unidentified brown substance ranging from light brown to dark brown. Each storage room had two to four stained ceiling tiles with missing ceiling tiles scattered throughout. This finding was acknowledged and confirmed in interviews with the Administrator and Maintenance Director during the discovery. They indicated that they did not know the source of the problem. At 12:00 PM, the Administrator stated in an interview that he was aware of this issue. The Maintenance Director did not have a chance to address the problem and replace the ceiling tiles due to the daily demands of other repairs requested. Also, he indicated that he was unaware of how long this problem existed. The surveyor noted that residents did not occupy the basement area, and the facility had an ample supply of new ceiling tiles. The surveyor verbally informed the Administrator of these findings during the Life Safety Code survey exit conference at 1:00 PM. NJAC 8:39-31.2(e)	F 921	2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: a. The Maintenance Director has rounded the whole facility and has replaced all affected tiles. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: a. The Maintenance Director will do rounds to check that it does not continue, if any leak is identified, source of the leak will be corrected, and ceiling tile changed. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: a. Maintenance director will do monthly rounds x 3months and then quarterly rounds x 3 quarters. Results will be brought to the quarterly QAPI meeting for review.	