STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 9/9/19 CENSUS: 98 SAMPLE: 27 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a.) obtain a current physician's order for administration of [redacted] for Resident [redacted], 1 of 2 residents reviewed for [redacted] use; b.) develop a care plan for Resident #[redacted], 1 of 2 residents receiving [redacted] therapy; and c.) label the [redacted] in accordance with the facility policy for Resident #[redacted] 1 of 2 residents reviewed for [redacted] use. This deficient practice was evidenced by the following:	F 695	I. Immediate Correction: Resident [redacted] was immediately assessed by RN for redness on the resident's skin under the [redacted] and skin integrity will be assessed Q shift. MD order was placed in the medical record for the administration of O2 with a plan of care. Resident #[redacted] was assessed and evaluated by the Consulting [redacted] with recommendations for [redacted] usage on 9/8/2019. Resident #[redacted]'s [redacted] was immediately changed by nursing staff and	11/8/19

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

Electronically Signed | 09/25/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 1 1. On 08/29/19 at 10:49 AM, during the initial tour of the facility, the surveyor observed Resident [redacted] in bed. The resident was receiving [redacted] through a [redacted] ([redacted]). The surveyor observed redness on the resident's skin under the [redacted] The resident was [redacted] and spoke coherently for a few minutes, then began speaking in a nonsensical manner to an imaginary person. On 09/03/19 at 11:01 AM, the surveyor observed Resident [redacted] in bed. At that time, the [redacted] was set at [redacted]. The [redacted] was not in the resident's [redacted] while the [redacted] was operating. On 09/04/19 at 9:27 AM, a Licensed Practical Nurse (LPN) was changing the resident's [redacted]. She inserted the [redacted] in the resident's [redacted] and the [redacted] was programmed to deliver [redacted] A review of the Admission Face Sheet revealed that Resident [redacted] was originally admitted to the facility on [redacted]. On [redacted], Resident [redacted] was transferred to the hospital and was readmitted to the facility on [redacted]. The resident's diagnoses included [redacted] According to the resident's Quarterly Minimum Data Set, an assessment tool dated [redacted] Resident [redacted] had a [redacted] mental status.	F 695	dated at time of discovery. The facilities [redacted] Policy was reviewed by the DON, Contracted Respiratory Therapist, and [redacted] Contractor related to replace [redacted] at least once a week or PRNs and must be dated when changed. II: Identification of Other Areas: All residents that utilize [redacted] were be audited by Nursing Unit Managers and the facilities [redacted] Therapy Contractor on 9/9/2019 to ensure compliance. No other issued noted. Findings will be recorded and held for verification by the DON. DON will create and utilize an Oxygen QAPI Tool. III. Systematic Changes: All nursing staff will be re-educated by DON or designee on facilities [redacted] policy including but not limited to weekly [redacted] changes, proper dating, corresponding physician orders, [redacted], [redacted] verification, corresponding orders in the TAR, and [redacted] responsibilities related to [redacted]. An nursing [redacted] competency will be completed annually by the Nurse Educator to ensure compliance. The contracted [redacted] Therapist will randomly audit [redacted] residents weekly for proper disposable changes. Any clinician who demonstrates incorrect technique will be immediately counseled and repeat competency to ensure proficiency. On weekly basis this written report will be submitted to the DON for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 2 A review of the resident's Physician's Order Sheet (POS), as of [redacted], revealed an order on [redacted] to "Change [redacted] on Tuesday on 11pm-7am (one time a week)." The POS did not reflect a current order for the administration of [redacted] The [redacted] Treatment Administration Record (TAR) reflected the above order to change the [redacted] weekly. There was no entry reflected on the TAR for [redacted] administration. A review of the POS from [redacted] through [redacted] did not reveal an [redacted] order for Resident #[redacted] A review of the resident's current Interdisciplinary Care Plan revealed that the resident's [redacted] condition was not addressed. On 09/04/19 at 11:16 AM, the surveyor observed Resident [redacted] reclining in a [redacted] while receiving [redacted] by [redacted]. On 09/04/19 at 11:43 AM, the Unit Manager (UM) provided the surveyor with copies of the resident's current POS, TAR and Interdisciplinary Care Plan. These documents did not reflect the [redacted] administration for Resident [redacted] The UM stated that she would check to see why the order for [redacted] therapy would have been omitted. On 09/04/19 at 11:56 AM, the UM stated that she contacted the resident's physician who stated that the resident was hospitalized. The UM stated that the order should have been carried over, but wasn't. On 09/05/19 at 11:14 AM, the surveyor observed Resident [redacted] lying in bed. At that time, the [redacted] [redacted] was running at [redacted] and the [redacted]	F 695	IV. Quality Assurance Monitoring: Contracted [redacted] Therapist will randomly audit [redacted] residents weekly for proper disposable changes on an ongoing basis. Reports will be submitted to DON for review weekly. Documentation will be held for validation and verification. The DON or designee, will audit all residents using [redacted] using the [redacted] QAPI Tool, weekly over 4 weeks then monthly over 2 months, then quarterly ongoing. DON will review reports for trends and compliance. Audit findings will be presented to the QAPI Committee quarterly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 3 tubing was not in the resident's [redacted]. When the surveyor asked Resident [redacted] why the [redacted] was not in his/her [redacted], the resident replied, "It broke." At 12:20 PM on 09/05/19, the surveyor observed Resident [redacted]1 in bed. The surveyor observed the [redacted] was operating at [redacted] and the [redacted] was not in the resident's [redacted]. On 09/05/19 at 1:00 PM, Resident #11 was in bed being fed lunch by two Certified Nursing Assistants (CNA). The surveyor observed the [redacted] was running at [redacted] and that the [redacted] was not in the resident's nose. The surveyor asked the staff members why the [redacted] was not in the resident's [redacted]. One CNA stated that the resident pulls the [redacted] out of his/her [redacted]. She then placed the [redacted] in the resident's [redacted]. On 09/06/19 at 9:26 AM, the surveyor reviewed the resident's current POS which included an order, with a start date of [redacted], for [redacted] therapy [redacted] (every shift). On 09/06/19 at 11:47 AM, the Director of Nursing (DON) provided a list of discontinued orders for [redacted] and [redacted] which did not contain an order to discontinue the administration of [redacted] to Resident [redacted]. On 09/06/19 at 12:14 PM, the surveyor interviewed the UM who stated that in an emergency they would not need a physician's order for administering [redacted] up to [redacted] and that for longer term [redacted] usage, they would need to obtain a physician's order.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 4 On 09/09/19 at 11:32 AM, the UM stated that Resident [redacted] had an initial order for [redacted] when he/she was admitted and "somewhere along the way, the order for [redacted] dropped off." The UM indicated that she did not know when the order "dropped off." The UM also presented an updated Interdisciplinary Care Plan. As of [redacted], the care plan included interventions for Resident [redacted] to remain free of signs and symptoms of [redacted]. 2. On 08/29/19 at 10:05 AM, during the initial tour of the facility, the surveyor observed Resident [redacted] lying in bed. The resident wore [redacted] via [redacted]. The [redacted] was not dated. A review of a History and Physical Form, dated [redacted], revealed that Resident [redacted] was alert and oriented and was receiving [redacted] care. The resident's diagnoses included [redacted] and [redacted] with [redacted]. On 09/03/19 at 9:04 AM, the surveyor observed Resident [redacted] lying in bed. The resident's [redacted] and [redacted] were placed on the bed. The resident stated that he/she had removed the [redacted] for comfort during breakfast. The surveyor observed the [redacted] was not dated. When interviewed, the resident stated that the [redacted] was normally labeled and dated when changed by the [redacted] nurse. A review of the physician orders for Resident [redacted] revealed an order, dated [redacted], for [redacted] prn (as needed). The orders did not reveal an order to change the [redacted]	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 5 On 09/04/19 at 12:25 PM, the surveyor observed Resident [redacted] lying in bed. The resident wore [redacted] via [redacted]. The [redacted] was not dated. The resident was not able to recall when the [redacted] was changed. On 09/05/19 at 12:17 PM, the surveyor met with Resident [redacted] who wore [redacted]. The resident stated that the [redacted] was not dated or changed by the [redacted] nurse during the last visit. On 09/06/19 at 10:50 AM, the surveyor observed Resident #[redacted] who wore [redacted]. The resident stated that the [redacted] was not changed. The surveyor observed that the [redacted] was not dated. On 09/06/19 at 11:07 AM, the LPN examined Resident [redacted] in the presence of the surveyor and then confirmed that it was not dated. The LPN stated that the facility nursing staff were responsible to change the [redacted] on Tuesday night on the 11 PM - 7 PM shift. The LPN was unable to provide the surveyor with documented evidence that the facility nursing staff changed the resident's [redacted]. At that time, the LPN changed the [redacted]. On 09/06/19 at 1:01 PM, the surveyor interviewed the UM who stated that the [redacted] should be changed weekly. The UM further stated that the order should be located on the TAR. In the presence of the surveyor, the UM reviewed the resident's TAR. The UM was unable to locate an entry that pertained to the frequency the [redacted] was changed. She stated that she did not know when the [redacted] was changed.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 6	F 695		

In a later interview with the UM on 09/06/19 at 1:31 PM, the UM stated that she would normally expect staff to change the [redacted] on a weekly basis and date the [redacted] when applied to the resident. The UM further stated that since the order reflected that it was prn, she would think that it should be dated when changed if visibly soiled.

On 09/09/19 at 11:37 AM, the surveyor interviewed the DON, who stated that Resident [redacted] order was placed under General Orders. The DON further stated that she didn't think that a General Order or prn order would show up on the TAR. She stated that it merely served as a reminder for the nurses.

The DON stated that if [redacted] was administered, the nurses would document it at that time. The surveyor informed the DON that Resident [redacted] wore [redacted] via [redacted] on all observations except during meals and confirmed there was no documented evidence in the TAR or Progress Notes that the [redacted] was changed.

The Administrator and the DON were unable to furnish the surveyor with additional documentation to demonstrate that the [redacted] tubing was changed by facility nursing staff.

A review of the facility policy, [redacted] Therapy - [redacted] (February 25, 2009) revealed, "Replace [redacted] at least once a week or PRNs and must be dated when changed."

NJAC 8:39-25.2 (c) (3)
NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 7	F 756		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		11/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 8 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to act on or respond to recommendations made by the Consultant Pharmacist in a timely manner. This deficient practice was identified for Resident [redacted] 1 of 1 resident reviewed for [redacted] Care and was evidenced by the following: During the initial tour of the facility on 08/29/19 at 9:30 AM, the surveyor observed Resident [redacted] who was seated in a wheelchair within the doorway of the resident's room. When interviewed, the resident stated that transportation was coming to take the resident to a [redacted] appointment. A review of the History and Physical Form, dated 02/26/19, revealed that Resident [redacted] was [redacted] and [redacted] with some [redacted]. The resident had diagnoses that included: [redacted] and [redacted]. A review of a Progress Note, written by the facility Dietician on [redacted], revealed that she phoned the [redacted] center and spoke with a representative regarding the resident's abnormal labs which included a [redacted] level of [redacted] (reference range [redacted] The Dietician noted that the [redacted] representative spoke with the resident's nurse and provided a reminder to	F 756	I. Immediate Correction: Resident [redacted] was reassessed and reevaluated by an RN. [redacted] times were changed to give daily at 6:00AM with oatmeal. [redacted] was separated by 3 hours from other medications. Two orders for [redacted] were entered to be given with breakfast and dinner on [redacted] days and on [redacted] days to give with all three meals. Resident [redacted] was discontinued by the Nurse Practitioner on 9/8/19. Consultant Pharmacist and DON reviewed the Drug Regimen Review policy. The DON and Nursing Staff Educator re-in-serviced both Nursing Unit Managers regarding the facilities drug regimen review policy and procedure. II. Identification of Other Areas: The DON or designee will conduct an audit of pharmacy recommendations in the last 60 days to ensure compliance. Any negative findings will be addressed and corrected in the MAR accordingly. III. Systematic Changes: A new Consultant Pharmacist will be hired and transition into the position. The consultant Pharmacist and DON will ensure: 1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 2. This review must include a review of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 9 provid [redacted] with meals. A review of the [redacted] Medication Administration Record (MAR) revealed that [redacted] was ordered three times daily at 8:00 AM, 12:00 PM and 7:00 PM with food. A review of the Consultant Pharmacist (CP) Recommendation, dated [redacted], revealed a recommendation for the facility to clarify and give [redacted] with meals. The recommendation reflected to give [redacted] 3 hours before or 1 hour after other oral medications. The written response from the facility was: Written as TID (three times daily) with meals. A review of the CP Recommendation, dated [redacted], revealed that the CP documented that [redacted] was not an active form of [redacted] and residents on [redacted] required [redacted] as the [redacted] cannot convert [redacted] to the active form. The recommendation further reflected that the [redacted] administered active [redacted] during treatments. The CP requested that the facility coordinate with [redacted] and consider discontinuance of [redacted]. The CP suggested an alternate form of [redacted] be ordered if necessary. "Note was written to physician," was specified in the follow-through portion of the form. A review of the [redacted] MAR revealed an order for [redacted] by mouth one time a week at 6:00 PM on Monday. The medication was administered on	F 756	the resident's medical chart. 3. Report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. 4. Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. 5. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. 6. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. The DON will oversee that recommendations made by the Consultant Pharmacist are followed up on in a timely manner and according to facility policy and procedure. Upon completion DON will keep copies of all monthly pharmacy recommendations and physician responses to ensure compliance. IV. Quality Assurance Monitoring: The pharmacy drug regimen review will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 10 09/02/19. The surveyor reviewed all physician progress notes and orders written between [redacted] and [redacted]. The physician progress notes did not reflect that the CP recommendations were noted or followed. A review of a CP Recommendation, dated [redacted] reflected that the CP documented, "Please give [redacted] with meals. Resident is scheduled to receive [redacted] at 8am, 12pm and 7pm. Be sure the resident is receiving meals at these times." The CP further recommended writing two orders for [redacted] to be given with breakfast and dinner on [redacted] days and on [redacted] days to give with all three meals. The CP recommended that there should be two separate orders and for the facility not to document "out of facility." The CP recommendation reflected, "DO NOT GIVE [redacted]) WITH OTHER MEDICATIONS AS [redacted] MAY ABSORB OTHER MEDS." In the "Follow-Through" section of the form, the following notation was observed: [redacted] times adjusted no 2 entries needed." On 09/05/19 at 8:50 AM, the surveyor interviewed the Director of Nursing (DON) about the CP Recommendation that was written on [redacted] The DON stated that the facility received the recommendations on [redacted] and had one week to act on them. She further stated that the CP recommendations may not yet have been implemented. On 09/05/19 at 10:25 AM, the surveyor interviewed the Registered Nurse (RN) assigned to administer medications to Resident [redacted]. She stated that the resident was served breakfast at 7:30 AM. She further stated that she gave the	F 756	audited by DON and Consultant Pharmacist monthly for 3 months then on an ongoing basis. Results of findings will be presented to the QAPI Committee on a quarterly basis for review and recommendations to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 11	F 756		

resident [redacted] and all scheduled medications that were due at 8 AM and 9 AM together, as the resident went out to [redacted]

The RN explained that the noon dose of [redacted] was missed on [redacted] days as the resident was out of the facility. She added that [redacted] was not given at [redacted], as the medication would be [redacted] out of the resident's system during treatment. She stated that Renvela was skipped at noon on [redacted] days.

On 09/05/19 at 11:48 AM, the surveyor interviewed the Unit Manager (UM) who stated that she noted the [redacted] CP Recommendation and responded that the order was written to give the medication three times daily with meals. She further stated that the evening dose was scheduled at 7:00 PM because the resident sometimes went out to dinner with family. The UM was unable to state why the [redacted] CP Recommendation to discontinue [redacted] was not followed or addressed.

On 09/06/19 at 12:34 PM, the surveyor interviewed the CP by telephone. The CP stated that a report was provided to both the physician and the facility. She further stated that when she reviewed a clinical record and determined that a recommendation was not followed, the facility was responsible to follow-up with the physician for clarification. She added that a meeting was held earlier in the year to educate the physicians to respond to CP Recommendations.

On 09/06/19 at 1:02 PM, the surveyor interviewed Resident [redacted] who stated that nursing administered all pills together. The resident further stated that no pills were administered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 12	F 756		

separately except for [redacted] medication as needed. The resident added that dinner was served between 5:00 PM and 5:30 PM. The resident specified that no medications were administered at 7:00 PM.

On 09/09/19 at 9:22 AM, the surveyor interviewed the Registered Dietician (RD) who stated that [redacted] needed to be administered with a meal as a [redacted]. She further stated that if the medications were given apart from a meal it would not bind [redacted], which could affect bone health as [redacted] was excreted by the [redacted]. The RD stated that on 09/06/19, Resident [redacted] level was [redacted] (Reference Range [redacted]).

In a later interview with the UM on 09/09/19 at 10:00 AM, the UM stated that when she received the CP Recommendations, she placed them in a designated folder for the Physician or Nurse Practitioner to address. The UM added that she also filed a copy of the CP Recommendation in the resident's clinical record for the Physician or Nurse Practitioner to address. She examined the resident's medical record in the presence of the surveyor and concluded that the form was not there. She stated that if she saw them, she would verbally remind them to follow-up.

The UM stated that she phoned the Nurse Practitioner on 09/08/19 and Resident [redacted]'s order for [redacted] was discontinued. She showed the surveyor a progress note which detailed the conversation and added that Resident [redacted] received [redacted] mcg (microgram) while at [redacted] and did not require [redacted] units.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 13 On 09/06/19 at 12:08 PM, the DON provided the surveyor with a facility policy titled, "Drug Regimen Review" which revealed, "If/when an attending physician fails to respond to a Pharmacy Drug Regimen Review within five (5) working days, the physician will be contacted by the licensed nurse and/or the medical director." The policy indicated that the "Director of Nursing will track physician response reports and if no response is received within five (5) working days, the DON or designee will place a phone call to the physician for a phone order response." The policy continued, "If no response is received from the physician within ten (10) working days, the facility's Medical Director will be contacted for requested response/recommendations." In addition, the policy revealed that "All responses will be documented in the elder's clinical record." Both the DON and the Administrator were unable to provide documented evidence that the facility adhered to their policy. NJAC 8:39-(a)(1)	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061318	A. BUILDING: _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on review of employee health files, it was determined that new employees did not always	S1405	I. Immediate Correction: Employee #2 had a health history	11/8/19

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

Electronically Signed | 09/25/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061318	A. BUILDING: _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1405	Continued From page 1 receive a physical examination upon employment by a physician, advanced practice nurse, NJ licensed physician assistant or receive a nursing assessment by a Registered Nurse (RN) with a follow-up physical examination by a physician, advanced practice nurse or physician assistant within 30 days from the first day of employment. This deficient practice was identified in 2 of 5 employee files reviewed and was evidenced by the following: 1. Employee #2 was hired on [redacted]. There was no physical examination in this employee's medical file. There was a note on the outside of the employee's file which revealed, "Physical due [redacted]" 2. Employee #3 began working at the facility on [redacted]. The physician examined the staff member on [redacted]. There was no indication that an RN had assessed the employee prior to the physician's examination. On 09/09/19 at 1:18 PM, the surveyors met with the Administrator, Director of Nursing, Assistant Director of Nursing, Corporate Nurse and the Vice President of Clinical Operations. The surveyor reported the details of the employees health files. There were no comments offered by the facility staff regarding the employee physicals.	S1405	completed by an RN on [redacted] and physical examination performed by the Medical Director on [redacted] Employee #3 has a health history completed by an RN on [redacted]. The Human Resource Department re-reviewed 8:39-19.5(a)Mandatory Infection Control and Sanitation criteria for new employees specific to determining the completeness of physical examinations. II. Identification of Other Areas: The Human Resource Director and ADON will audit all existing employee medical files to ensure all new employees have a complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. A copy of audit will be retained for reference and validation. III. Systematic Change: The Human Resource Director and ADON will audit monthly for 3 months new employee health history's and physical examinations to ensure compliance. Findings will be reported to QAPI Committee quarterly. The Human Resource Director will also inform the Administrator immediately of any negative findings to ensure corrections are timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061318	A. BUILDING: _____ B. WING _____	09/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1405	Continued From page 2	S1405	IV. Quality Assurance Monitoring: The Human Resource Director and ADON will audit monthly for 3 months then quarterly new employee health history's and physical examinations to ensure compliance. Findings will be reported to Quality Assurance Committee quarterly. Director will also inform the Administrator immediately of any negative findings to ensure corrections are timely.	