STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ 154756; NJ 155543; NJ 156657; NJ 159371; NJ 159454 Survey Date: 3/30/23 Census:106 Sample: 22 + 3 + 5 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: NJ Complaint # 154756	F 684	¿ Resident # 20 is no longer in the facility as resident NJ Exec. Order 26:4.b.1	4/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/16/2023

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 684	Continued From page 1 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who sustained NJ Exec. Order 26:4.b.1 from a fall was re-admitted to the facility from the hospital with NJ Exec. Order 26:4.b.1 received appropriate care and services which included physician visits and assessments associated with NJ Exec. Order 26 every shift that developed into NJ Exec. Order 26:4.b.1 with the beginning stages of NJ Exec. Order 26:4. which required NJ Exec. Order 26:4.b.1 treatments. This deficient practice was identified for 1 of 27 residents (Resident #20) reviewed for quality of care, and was evidenced by the following: On 3/22/23 at 1:40 PM, the surveyor interviewed Certified Nursing Aide (CNA #1) who stated Resident #20 was a NJ Exec. Order 26:4 resident who had NJ Exec. Order 26:4.b.1. CNA #1 continued that last year, the resident had a fall in the facility and was sent to the hospital for treatment, and returned to the facility with NJ Exec. Order 26:4.b.1 CNA #1 continued that one day went she went to assist CNA #2 in providing activities of daily living (ADL) care, she noticed a NJ Exec. Order 26:4.b.1 CNA #1 continued it was the NJ Exec. Order 26:4.b.1 ever smelled. CNA #1 stated she was informed by the previous Unit Manager that the hospital discharge instructions did not include NJ Exec. Order 26:4.b.1, so the facility had no idea how to care for NJ Exec. Order 26:4.b, so it probably remained on the resident for six weeks untouched. CNA #1 stated she was not a nurse, but heard there should have been some sort of treatment. On 3/22/23 at 2:04 PM, the surveyor interviewed	F 684	Care on March 9, 2023. ¿ All residents with casts are at risk for the same deficient practice. The Unit Managers conducted an audit of current residents in the facility to identify any residents with cast(s). This is to ensure that appropriate care and services, including physician visits and assessments associated with a cast every shift are developed. No other residents were affected. ¿ All licensed nurses will be in-serviced by Assistant Director of Nursing or Designee on the provision of proper treatment and care of residents with casts, in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Emphasis was made on ensuring that physician visits are done and assessments associated with a cast every shift are developed. Education on Caring for a patient with a cast will be on-going for newly hired nurses and annually thereafter. ¿ Director of Nursing or designee will conduct medical review audits on all residents with cast(s) weekly x 4 weeks, and then monthly thereafter x 5 months. Audits will focus on the provision of proper treatment and care for residents with casts, including physician visits and the the development, implementation and documentation of assessments	

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F 684	Continued From page 2 CNA #2 who confirmed she cared for Resident #20 and was with CNA #1 the day they discovered the NJ Exec. Order 26:4.b.1 from Resident #20. CNA #2 continued that the resident had a fall in the facility that he/she was in the hospital for maybe two weeks and returned with NJ Exec. Order 26:4.b.1 CNA #2 stated when she went to perform ADL care with CNA #1; they observed a NJ Exec. Order 26:4.b.1, but she could not recall who the nurse was who cared for the resident that she informed. CNA #2 stated that the resident had a NJ Exec. Order 26:4.b.1 that should have been taken care of, but it was not. CNA #2 stated she was not a nurse, so it was not her responsibility to NJ Exec. Order 26:4.b.1, but she cleaned the resident around it. CNA #2 stated if she saw something different or smelled something different, she had to inform the nurse, which she did. The surveyor reviewed the closed medical record for Resident #20. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec. Order 26:4.b.1 with diagnoses which included NJ Exec. Order 26:4.b.1 A review of the electronic Progress Notes reflected the following notes: An Admission Summary dated NJ Exec. Order at 7:52 PM, included the resident was received via stretcher with two attendants; [he/she] was alert and oriented, some forgetfulness, maximum assistance of two-person with all ADLs and	F 684	associated with a cast every shift. Negative findings will be rectified immediately. Audit results will be submitted to the QAPI Committee monthly x 6 months, then will reassess need for further action or follow-up for on-going compliance.	

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F 684	Continued From page 3 mechanical lift for all transfers. Resident had a NJ Exec. Order 26:4.b.1 ..All medications verified and read back to Physician #1. An Admission Summary dated NJ Exec. Order 26:4 at 6:29 AM, included admission day four; resident was alert and oriented with periods of forgetfulness; total care of two-person assistance required. NJ Exec. Order 26:4.b.1 no signs or symptoms of infection. An Admission Summary dated NJ Exec. Order 26:4 at 10:13 PM, included admission day five; resident had an NJ Exec. Order 26:4.b.1 no signs or symptoms of infection. An Admission Summary dated NJ Exec. Order 26:4 at 6:42 AM, included admission day five; resident had an NJ Exec. Order 26:4.b.1 , no signs or symptoms of infection. A General Note dated NJ Exec. Order at 11:01 AM, included change of primary physician to Physician #2; Physician #1 no longer coming to the facility. A Health Status Note dated NJ Exec. Order 26:4 at 2:33 PM, written by the Unit Manager/Licensed Practical Nurse (UM/LPN) included during morning care being rendered, CNA noted to have a NJ Exec. Order 26:4.b.1 coming from NJ Exec. Order 26:4.b.1 . Resident previously had a NJ Exec. Order 26:4.b.1 applied. Registered Nurse (RN #1) assessed, noted	F 684		

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F 684	Continued From page 4 NJ Exec. Order 26:4.b.1 coming from the NJ Exec. Order 26:4.b.1 and at the end of the NJ Exec. Order 26:4.b.1. Resident noted no NJ Exec. Order 26:4.b.1 during RN #1's assessment. Made the Nurse Practitioner (NP #1) aware of area of concern who ordered a NJ Exec. Order 26:4.b.1. New orders received by the NP #1 to remove NJ Exec. Order 26:4.b.1; obtained and completed. Wound Care NP conducted a televisit (visit conducted via video conference rather than in person) immediately with new recommendations to NJ Exec. Order 26:4.b.1 daily. Follow-up with a televisit with the Orthopedic Physician on NJ Exec. Order 26:4.b.1 A review of the NJ Exec. Order 26:4.b.1 Medication Administration Record (MAR) included the following physician's orders (PO) for NJ Exec. Order 26:4.b.1 A PO dated NJ Exec. Order 26:4.b.1 and discontinued NJ Exec. Order 26:4.b.1, for NJ Exec. Order 26:4.b.1 mg; give one tablet by mouth every twelve hours for NJ Exec. Order 26:4.b.1 A PO dated NJ Exec. Order 26:4.b.1 and discontinued NJ Exec. Order 26:4.b.1, for NJ Exec. Order 26:4.b.1 administrations until finished. A PO dated NJ Exec. Order 26:4.b.1 and discontinued NJ Exec. Order 26:4.b.1, for NJ Exec. Order 26:4.b.1; give one tablet by	F 684		

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F 684	Continued From page 5 mouth every twelve hours for NJ Exec. Order 26:4.b.1 administrations until finished. A PO dated NJ Exec. Order 26:4.b.1, for NJ Exec. Order 26:4.b.1 mg; give one tablet by mouth every twelve hours for NJ Exec. Order 26:4.b.1 at 11:59 PM. A further review of the NJ Exec. Order 26:4.b.1 MAR revealed a PO dated NJ Exec. Order 26:4.b.1, for NJ Exec. Order 26:4.b.1); give one tablet three times a day for NJ Exec. Order 26:4.b.1 subsequent encounter for NJ Exec. Order 26:4.b.1 During the time period of NJ Exec. Order 26:4.b.1 when the resident received their NJ Exec. Order 26:4.b.1 it was documented on seventeen shifts that the resident had a NJ Exec. Order 26:4.b.1 which indicated NJ Exec. Order 26:4.b.1 A review of the hospital Discharge Instructions dated NJ Exec. Order 26:4.b.1, included follow-up with Orthopedic Physician as needed and with Physician #1 (name crossed-out in pen with handwritten Physician #2) in two days. (Physician #2 was not the resident's primary physician until NJ Exec. Order 26:4.b.1 as documented in the Progress Notes.) The Discharge Instructions also included the resident had a NJ Exec. Order 26:4.b.1 . Instructions included if you have a NJ Exec. Order 26:4.b.1 everyday...If you have a NJ Exec. Order 26:4.b.1 as told by your doctor. Remove it only as told by your doctor. NJ Exec. Order 26:4.b.1	F 684		

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F 684	Continued From page 6	F 684		

A review of the Accident/Incident Report Checklist dated NJ Exec. Order 26:4.b.1, included on NJ Exec. Order 26:4.b.1 at 1:24 PM, the resident had a NJ Exec. Order 26:4.b.1. The nursing description included I was called to the resident's room by the CNA that noted during care NJ Exec. Order 26:4.b.1 coming from the resident's NJ Exec. Order 26:4.b.1 removed. NJ Exec. Order 26:4.b.1. Resident area noted to be an open NJ Exec. Order 26:4.b.1 that opened up and was now showing signs and symptoms of infection. Immediate actions included NJ Exec. Order 26:4.b.1 removed; NJ Exec. Order 26:4.b.1 consultation completed and found NJ Exec. Order 26:4.b.1 that opened up leading to the beginning signs of NJ Exec. Order 26:4.b.1).

On 3/23/23 at 1:50 PM, the surveyor requested from the Director of Nursing (DON) for all Physician Notes and Nurse Practitioner Notes for Resident #20 from last standard survey dated 5/11/21.

On 3/27/23 at 9:25 AM, the surveyor reviewed all Physician and Nurse Practitioner Progress Notes provided by the DON as requested. There were no notes provided by the DON from either a physician or nurse practitioner from NJ Exec. Order 26:4.b.1 until NJ Exec. Order 26:4.b.1 with a progress note dated NJ Exec. Order 26:4.b.1 from Physician #2.

On 3/27/23 at 9:58 AM, the surveyor reviewed the documentation provided with the DON and

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F 684	Continued From page 7 requested any physician or nurse practitioner notes from NJ Exec. Order through NJ Exec. O, as well as the facility's physician visit policy. On 3/27/23 at 11:42 AM, the DON informed the surveyor that the Licensed Nursing Home Administrator (LNHA) found additional physician documentation in the closed medical record that was provided. On 3/27/23 at 12:04 PM, the surveyor reviewed the additional two Physician Progress Notes written by Physician #2 from NJ Exec. Order 26:4.b.1. The note dated NJ Exec. Order 26:4 included the resident was transferred to our service; resident was undergoing NJ Exec. Order 26:4.b.1 treatment and was on NJ Exec. Order 26:4.b.1 following-up with Orthopedic Physician. On 3/28/23 at 8:52 AM, the DON informed the surveyor that she had thought Resident #20 had refused to follow-up with the Orthopedic Physician when he/she returned from the hospital in NJ Exec. Order 26:4.b.1, but stated she was unable to locate any documentation to confirm. The DON stated that she reached out to NP #1 to see if he had any additional documentation. On 3/28/23 at 10:30 AM, the DON informed the surveyor that Physician #1 was the resident's primary physician who stopped seeing residents at the facility, but she could not speak to when Physician #1 stopped seeing residents. The DON continued that NP #1 was seeing Physician #1's residents and then Physician #2 took over. The DON stated NP #1 was still at the facility, and the facility had reached out to him. At this time, the surveyor requested NP #1's phone number. The DON continued that Physician #1 did not	F 684		

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F 684	Continued From page 8 document in the electronic medical record; she documented all her notes on paper. The surveyor asked how long the facility was required to maintain a resident's medical record after discharge or death, and the DON stated she thought ten years. The surveyor then stated so then the facility should have all of Resident #20's medical record maintained, and the DON confirmed yes. The DON stated she had reached out to Physician #1's medical practice to request any documentation from this resident, and she was still waiting to hear back. The surveyor requested the phone number for RN #1 and the DON informed the surveyor the nurse had NJ Exec. Order 26:4 The surveyor requested the phone number for the UM/LPN, and the DON stated she no longer worked at the facility but would provide the nurse's phone number. On 3/28/23 at 10:48 AM, the LNHA provided the surveyor with all of Physician #1's progress notes for Resident #20. The LNHA confirmed the last documented visit by Physician #1 was from 10/15/21. This meant the resident was not seen by a primary physician from NJ Exec. Order 26:4.b until NJ Exec. Order 26:4, when the resident was found to have a NJ Exec. Order 26:4.b.1 with the beginning signs of NJ Exec. Order 26:4.b. On 3/28/23 at 11:17 AM, the surveyor requested from the DON the NJ Exec. Order 26:4.b.1 note from NJ Exec. Order 26:4 and the orthopedic visit from NJ Exec. Order 26:4. At this time, the DON provided the surveyor with NP #1 and the UM/LPN's telephone numbers. On 3/28/23 at 11:19 AM, the surveyor interviewed the UM/LPN via telephone who confirmed she no longer worked at the facility since NJ Exec. Order 26:4.b.1. The UM/LPN stated she recalled Resident #20,	F 684		

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F 684	Continued From page 9 and the resident returning from the hospital. The UM/LPN stated she thought the resident had a NJ Exec. Order 26:4.b.1, but was unsure if the nurse could remove NJ Exec. Order 26:4. The UM/LPN stated she did not recall Physician #1 seeing the resident upon return from the hospital, and she recalled the resident developed a NJ Exec. Order 26:4.b.1, but she could not speak to or recall specifics. The UM/LPN stated she could not speak to any treatments the resident received or how the NJ Exec. Order 26 developed. On 3/28/23 at 11:25 AM, the surveyor attempted to interview NP #1 via telephone with no response. The surveyor requested NP #1 to call back. On 3/28/23 at 11:34 AM, the surveyor interviewed the Director of Rehabilitation (Rehab) who stated a NJ Exec. Order 26:4.b.1 was an NJ Exec. Order 2 wrapped around the NJ Exec. Order The Director of Rehab continued that depending on the physician's orders would determine if the NJ Exec. Or was removed, and there would be a follow-up visit with the physician. The Director of Rehab stated nursing would generally do NJ Exec. Order 26:4.b.1 by NJ Exec. Order 26:4.b.1 with a physician's order. The Director of Rehab stated that a NJ Exec. Order 26:4.b would not be worded as an NJ Exec. Order 26:4.b.1; and generally speaking, an NJ Exec. Order 26:4.b.1 would be removed with physician's orders. If the resident was admitted to the facility with no orders regarding NJ Exec. Order 26:4.b, nursing would be expected to follow-up with the physician. The Director of Rehab stated the resident did receive treatment from rehab when he/she returned from the hospital, but it was for NJ Exec. Order 26:4.b.1. According to the notes, the resident had a NJ Exec. Order 26:4.b.1 which would be at the NJ Exec. Order portion of	F 684		

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F 684	Continued From page 10 the NJ Exec. Ord. The Director of Rehab stated she would find additional information for the surveyor regarding what type of NJ Exec. Ord Resident #20 had. On 3/28/23 at 12:00 PM, the surveyor received the Orthopedic Physician's consultation report from NJ Exec. Order 26:4. The Orthopedic Physician indicated that the visit was a televisit and the resident was observed immobilized with pillows and NJ Exec. Order 26; the resident had no complaints; and the facility obtained x-rays. Services performed was a follow-up visit. Instructions included resident's x-ray was unavailable for review and to send a copy when available; maintain NJ Exec. Orde; and follow-up in one month. On 3/28/23 at 1:21 PM, the Director of Rehab informed the surveyor that the resident had a NJ Exec. Order 26:4.b.1 The NJ Exec. Order 26:4.b.1 and surrounding area, and then conforming NJ Exec. Order 26:4.b.1 around that and the surrounding area; and then an NJ Exec. Order 26:4.b.1 on top of that. The Director of Rehab stated nursing staff needed to NJ Exec. Order 26:4.b.1 to check the NJ Exec. Order 26:4.b.1, but she was unsure how often the nurse was required, but stated there would need to be a physician's order. The surveyor reviewed the Orthopedic Physician's consultation from 3/25/22 with the Director of Rehab who stated the resident could not have been in NJ Exec. Order 26 during this appointment because NJ Exec. Order 26:4.b.1 was positioned straight in the NJ Exec. Order 26:4.b.1. The Director of Rehab continued that NJ Exec. Order 26:4.b.1 at the other end of the NJ Exec. Order 26:4.b.1. On 3/29/23 at 8:33 AM, the surveyor attempted again to interview NP #1 via telephone with no	F 684		

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COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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F 684	Continued From page 11 response. The surveyor left a message to call back. On 3/29/23 at 9:15 AM, the surveyor interviewed the Medical Director (MD) via telephone who stated physicians were expected to complete an in-person visit and complete a health and physical with forty-eight hours of resident being admitted or re-admitted from the hospital to the facility. The MD stated residents also needed to be seen monthly by their physician, but after the initial visits, a nurse practitioner could alternate monthly visits. The MD stated that the nurse practitioner could not see the resident monthly in place of the physician or complete the health and physical; the physician was expected to oversee the resident's care with the assistance of a nurse practitioner. The MD stated the physician and nurse practitioner were both expected to document in the resident's medical record during each visit. The surveyor asked the MD in terms of professional standards of practice, what was the expected process when a resident was admitted to the facility with NJ Exec. Order 26:4.b.1. The MD stated first the physician had to review the medical record and the x-ray, ensure there was an Orthopedic Physician involved and make a follow-up appointment. The MD stated you would look at the resident's pain levels and determine if pain management needed to be done. The physician ordered the nurse to check capillary refills, ensure skin was intact, and complete assessments; it would be the Orthopedic Physician's decision if NJ Exec. Order 26:4 was removed. The MD stated that was why it was important for the health and physical to be completed within forty-eight hours of admission to ensure the proper treatment. The MD stated Physician #1 had retired from practicing, and stated Resident #20 should have	F 684		

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	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 684	Continued From page 12 been seen by the physician when they returned from the hospital; it was "not good medical practice." The MD stated he should have been made aware by the facility if the resident was not seen, and he would have seen the resident himself. The MD stated NP #1 is a nurse practitioner from the insurance company and was not one of the physician's nurse practitioners. The MD continued NP #1 saw acute issues; and the attending physician was ultimately responsible for the care of the resident. The surveyor continued to review the closed medical record for Resident #20. A review of the Order Summary Report dated as of [NJ Exec. Order 26:4], did not include [NJ Exec. Order 26:4.b.1] every shift, or any additional assessments [NJ Exec. Order 26:4.b.1] A review of the corresponding [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1] MARs and Treatment Administration Records (TAR) did not include [NJ Exec. Order 26:4.b.1] every shift, or any additional assessments for [NJ Exec. Order 26:4] On 3/29/23 at 10:58 AM, the DON informed the surveyor that the facility did not have a health and physical policy and they would provide the surveyor with a skin assessment policy. On 3/29/23 at 11:19 AM, the surveyor interviewed the DON who confirmed NP #1 worked as a nurse practitioner for the insurance company and saw residents with acute issues; he was not part of any of the attending physicians' practices. The DON continued upon admission or re-admission to the facility, the physician was notified of the resident's admission and a call was placed to	F 684		

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F 684	Continued From page 13 review medications and order any laboratory tests. The physician was expected to examine the resident within twenty-four to forty-eight hours of admission or re-admission and complete and health and physical in the progress notes. The DON stated it was not the nurse's responsibility if the physician did not come in to see the resident; it would be the responsibility of the LNHA. The DON continued the nurse as a courtesy could contact the physician, but it was ultimately the LNHA's responsibility. The surveyor asked the DON what the expectation was if a resident was admitted NJ Exec. Order 26:4.b.1, and the DON stated usually the nurse would not touch NJ Exec. Order 26:4 until there was a follow-up with an Orthopedic Physician. The surveyor asked if there should be any type of assessments completed or skin assessments, and the DON stated should be a skin assessment around NJ Exec. Order 26:4.b but cannot look underneath the NJ Exec. Ord The DON stated usually on the discharge instructions, there would be a follow-up with the Orthopedic Physician, and it was the responsibility of the Unit Clerk to make a follow-up appointment. The DON acknowledged there was no documentation that the resident refused to see the Orthopedic Physician upon return from the hospital, and he/she was not seen until NJ Exec. Order 26:4. The DON stated Resident #20 had a NJ Exec. Order 26:4.b.1 over it. The DON continued the resident developed NJ Exec. Order 26:4 underneath NJ Exec. Order 26:4 that could not be seen, until the CNA noticed the NJ Exec. O and it was removed. The surveyor informed the DON they were told it smelled like a NJ Exec. Order 26:4.b.1 and the DON confirmed she was told that too. The DON stated she would follow-up with NP #1 to determine what happened. On 3/29/23 at 11:47 AM, the surveyor interviewed	F 684		

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F 684	Continued From page 14 LPN #1 who stated she had been at the facility for almost NJ Exec. Order 26 and was not familiar with Resident #20. The surveyor asked LPN #1 in terms of standards of practice, what was a nurse expected to do for a resident with a cast. LPN #1 stated the nurse had to ensure the cast was not too tight, no swelling or cutting off of circulation by placing three fingers under the cast. They needed to perform capillary refills which was a three second restriction time on the capillary refills to the nail bed. LPN #1 continued for a soft cast would look around the cast for discoloration. LPN #1 stated if the cast was too tight, it could cause swelling which could result in nerve damage. LPN #1 stated this would have to be done every shift, and it required a physician's order, and sometimes the physician ordered the wrap to be changed. LPN #1 stated if there was no order for the resident, the nurse was expected to call the physician to obtain an order because there was care that was expected with any cast. On 3/29/23 at 2:41 PM, the survey team met with the LNHA and DON. The surveyor requested a timeline which included supporting documentation for Resident #20 from the time they were re-admitted to the facility on NJ Exec. Order with the NJ Exec. O until they developed NJ Exec. Order 26:4.b with the beginning of NJ Exec. Order 26:4.b.1 including what measure were taken to prevent NJ Exec. Order 26:4.b.1. The surveyor also informed administration they made multiple attempts to contact NP #1, and they had not received a call back. On 3/30/23 at 10:02 AM, the DON in the presence of the LNHA stated she was still typing the timeline and would be completed in ten minutes. The DON continued NP #1 emailed additional notes that she had to review first. The	F 684		

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F 684	Continued From page 15 surveyor asked the DON in accordance with professional standards of practice, what assessments were completed for a resident with a cast. The DON responded capillary refills to check circulation; checking warmth of extremities because if there is a cast, you need to know if something was wrong to inform the physician immediately; and put two fingers underneath the cast to ensure there was no edema. The surveyor asked how often these assessments should be completed by nursing, and the DON responded every shift. The surveyor asked if the nurse needed a physician's order for these assessments, and the DON responded yes, and she confirmed the resident had no order and could not speak to why. The DON continued the nurse should have called the physician to obtain an order. The DON confirmed no physician including Physician #1 or #2 saw the resident when he/she returned from the hospital. The DON stated a physician should complete the health and physical within twenty-four to forty-eight hours of admission. The DON acknowledged that a physician should have been seeing the resident because the physician was ultimately responsible for the care of the resident and not NP #1. The surveyor asked when a resident typically followed-up with an orthopedic physician, and the DON stated within one to weeks of admission NJ Exec. Order 26:4.b.1. The DON confirmed there was no documentation that an appointment was scheduled, or the resident refused. The DON acknowledged there were missing steps with NJ Exec. Order 26:4.b. that should have been done. On 3/30/23 at 11:11 AM, the DON informed the surveyor the notes provided by NP #1 were not during this time period. The DON provided the	F 684		

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F 684	Continued From page 16	F 684		

surveyor with the timeline, and confirmed there was nothing done NJ Exec. Order 26:4.b.1. The DON confirmed the facility did not have a policy regarding NJ Exec. Order 26:4.b.1.

The surveyor did not receive a return phone call from NP #1.

A review of the facility's "Physician Services Policy and Procedure" dated 2020, included each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs...the facility shall ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable...each resident shall be seen by a physician at least every 30 days for the first 90 days after admission and at least once every 60 days after.

A review of the facility's "Physician's Services" policy dated updated 1/2023, included the resident's attending physician participates in the resident's assessments and care planning, monitoring changes in resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident...the physician will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage...

A review of the facility's "Pressure Ulcers/Skin

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F 684	Continued From page 17 Breakdown - Clinical Protocol" policy dated updated 1/2023, included the physician will help identify factors contributing or predisposing residents to skin breakdown... NJAC 8:39-27.1(a)	F 684		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure residents who received NJ Exec. Order 26:4.b.1 and were on fluid restriction diets received the appropriate amount of fluids daily in accordance with their physician's orders. This deficient practice was identified for 2 of 2 residents (Resident #35 and #80) reviewed for NJ Exec. Order 26:4, and the evidence was a follows: 1. On 3/20/23 at 11:34 AM, the surveyor observed Resident #80's room, and the resident was not in his/her room. Certified Nursing Aide (CNA #1) informed the surveyor that Resident #80 was currently out of the facility at their NJ Exec. Order 26:4 appointment. The surveyor observed on the resident's tray table two four-ounce cups of cranberry juice, one sixteen-ounce disposable cup of water with a lid and straw, and one empty eight-ounce hot beverage mug.	F 698	Residents #35 and #80 were affected by this deficient practice. The deficient practice was identified that the facility failed to ensure residents who received NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 received appropriate amounts of fluids daily. All Licensed staff were educated by DON prior to survey exit on the facility policy and procedure on NJ Exec. Ord All residents who receive dialysis treatment and are on fluid restriction diets have the potential to be affected All Licensed staff educated by DON/IP/Designee on the facility policy and	4/21/23

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F 698	Continued From page 18 On 3/21/23 at 11:39 AM, the surveyor observed Resident #80 sitting in their room being administered NJ Exec. Order 26:4.b.1 . The resident informed the surveyor that they were at their NJ Exec. Order 26:4 appointment yesterday, and that their NJ Exec. Order 26: chair time was changed from leaving the facility at 3:00 PM to now leaving at 11:00 AM. The resident stated he/she went to NJ Exec. Order 26:4 three times a week on Monday, Wednesday, and Friday for four hours. The surveyor observed on the resident's tray table a sixteen-ounce disposable cup of water with a lid and straw, an eight-ounce cup of cranberry juice labeled Monday 3/21/23, and an eight-ounce plastic mug with a lid labeled cranberry juice. The surveyor asked the resident if they were on a fluid restriction diet because of their NJ Exec. Order 26:4 treatments, and the resident stated he/she was unaware. The resident continued "some days yes and somedays no; some days told cannot have soup and then the doctor the next day says can have soup." The resident informed the surveyor he/she would not drink the cranberry juice labeled Monday 3/21/23, since it was sitting out too long. The resident also confirmed he/she always received the sixteen-ounce water cup with a straw and lid every day, and he/she drank out of that. The surveyor reviewed the medical record for Resident #80. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec. Order 26:4.b.1 with diagnoses which included NJ Exec. Order 26:4.b.1	F 698	procedure on Fluid Restriction The DON/IP/Designee will conduct audits of all residents on fluid restriction and the following of the policy and ensure assignments, Kardex contain resident on fluid restriction and clinical report reviews residents on fluid restriction., Weekly X 4 weeks then monthly x 3 months. Results of audit will be brought to Administrator or Designess to be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

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COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

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F 698	Continued From page 19 NJ Exec. Order 26:4.b.1 . A review of the admission Minimum Data Set (MDS), an assessment tool dated NJ Exec. Order 26:4, reflected the resident had a brief interview for mental status (BIMS) score of a NJ Exec out of 15, which indicated NJ Exec. Order 26:4.b.1. A further review included the resident received NJ Exec. Order 26:4 treatments while a resident at the facility. A review of the March 2023 Medication Administration Record (MAR) included a physician's order (PO) dated NJ Exec. Order and discontinued NJ Exec. Order 26:4, for a NJ Exec. Order 26:4.b.1 with breakfast four-ounces (4 oz) milk, 4 oz sugar free cranberry juice, 6 oz tea; lunch 6 oz tea, 4 oz sugar free cranberry juice; 2:00 PM 4 oz sugar free cranberry juice; and dinner 6 oz super soup (soup fortified with extra calories) and 4 oz sugar free cranberry juice. A review of the NJ Exec. Order 26:4 day shift signed by nursing reflected the resident received NJ Exec. Order 26:4.b.1 by nursing during that shift. This did not correspond with the sixteen-ounces of water observed on the resident's tray table. A review of the Order Summary Report included a PO dated NJ Exec. Order 26:4 for NJ Exec. Order 26:4.b.1. An additional PO dated NJ Exec. Order 26:4, included NJ Exec. Order 26:4.b. ith breakfast 4 oz milk, 4 oz sugar free cranberry juice, 6 oz of tea; 10:00 AM 4 oz sugar free cranberry juice; lunch 6 oz tea, 4 oz sugar free cranberry juice; dinner 6 oz super soup and 4 oz sugar free cranberry juice. Nursing could provide NJ Exec. Order 26:4.b.1 every shift.	F 698		

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F 698	Continued From page 20	F 698		

A review of the corresponding NJ Exec. Order 26:4.b.1 MAR reflected the nurse had signed every shift from NJ Exec. Order 26:4 until review of NJ Exec. Order 26:4, that the resident received NJ Exec. Order 26:4.b.1 during their shift except for the following shifts:

NJ Exec. Order 26:4 night shift NJ Exec. O mL
NJ Exec. Order 26:4 day shift NJ Exec. O mL
NJ Exec. Order 26:4 night shift NJ Exec. O mL
NJ Exec. Order 26:4 night shift NJ Exe mL

This did not correspond with the sixteen-ounce disposable cup of water observed by the surveyor on the day shift for NJ Exec. Order 26:4.

A review of the individualized person-centered care plan included a focus area dated initiated NJ Exec. Order 26:4 and revised NJ Exec. Order 2, for I have a potential nutritional problem with regards to NJ Exec. Order 26:4.b.1 Interventions included to provide a NJ Exec. Order 26:4.b.1 with NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1; NJ Exec. Order 26:4.b.1 on Mondays, Wednesdays, and Fridays; and provide, serve diet as ordered.

On 3/27/23 at 10:58 AM, the surveyor observed the resident at the nurse's station. The resident was informing the Registered Nurse (RN) that he/she was leaving for their NJ Exec. Order 26:4 treatment, and they had not received their turkey on rye bread sandwich to take with them. The RN informed the resident he would obtain from the kitchen.

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F 698	Continued From page 21	F 698		

On 3/27/23 at 11:02 AM, the surveyor interviewed CNA #1 who stated that residents received sixteen-ounce disposable water cups with straws and lids every shift, and she changed the water on her shift. CNA #1 continued she refilled water cups throughout her shift as needed. The surveyor asked how she would know if the resident was on a fluid restriction, and CNA #1 responded by their meal ticket. The surveyor asked if any of the residents on her assignments had fluid restrictions, and CNA #1 stated "no." CNA #1 confirmed she was Resident #80's assigned aide as she proceeded into the resident's room to clean. The surveyor observed on the resident's tray table a sixteen-ounce disposable water cup with a lid and straw and an additional four-ounces of water in a plastic cup.

On 3/27/23 at 11:08 AM, the surveyor interviewed the RN who stated Resident #80 went NJ Exec. Order 26:4.b.1 on Mondays, Wednesdays, and Fridays at 11:00 AM. The RN continued that the resident usually received a turkey sandwich at 10:00 AM prior to leaving, and they received their sandwich. The RN stated the resident was on NJ Exec. Order 26:4.b.1 and could only drink the fluids provided on their meal trays from dietary as well as NJ Exec. Order 26:4 The RN stated that the resident did not ask for additional fluids; he/she drank only the fluids provided. The RN stated residents on NJ Exec. Order 26:4.b.1 should not have a disposable water cups in their rooms. At this time, the RN accompanied the surveyor to the resident's room and confirmed the resident had a sixteen-ounce disposable cup of water and four-ounces of additional water in a plastic cup. The RN confirmed the resident should not have these fluids, and he removed the lid from the water cup and confirmed there was

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COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 698	Continued From page 22 sixteen-ounces of water in the cup. On 3/27/23 at 11:34 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated residents' water cups were changed daily during the 11:00 PM to 7:00 AM shift. The cups were filled each shift by the aide and if a resident asked for additional water, staff provided. The surveyor asked how staff would know if a resident was on a fluid restriction, and the UM/LPN stated that nurses were aware through the physician's orders and CNAs were aware through the Kardex which included resident care. The UM/LPN stated she was aware Resident #80 received a sixteen-ounce disposable cup of water today and should not have because the resident was on NJ Exec. Order [redacted] The surveyor informed the UM/LPN that they observed a water cup on NJ Exec. Order 26.4 and NJ Exec. Order 26.4 as well. At this time, the surveyor requested a copy of Resident #80's Kardex. On 3/27/23 at 11:42 AM, the surveyor interviewed the Director of Nursing (DON) who stated CNAs knew a resident was on fluid restrictions by the Kardex and nurses were aware by the physician's order. The DON confirmed residents on fluid restrictions did not receive sixteen-ounce disposable cups of water by the CNAs, unless the nurse put the appropriate amount ordered for that shift in the cup. At this time, the surveyor informed the DON about the observations of the sixteen-ounce disposable water cup on NJ Exec. Order 26.4, NJ Exec. Order 26.4, and today made by the surveyor; as well as the RN confirmed the cup contained sixteen-ounces of water today. A review of the resident's Kardex dated as of NJ Exec. Order 26.4, included for eating/nutrition the resident	F 698		

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COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 698	Continued From page 23 was on NJ Exec. Order 26:4.b.1. On 3/29/23 at 10:50 AM, the surveyor interviewed the Registered Dietitian (RD) who stated the resident started NJ Exec. Order 26:4.b.1 prior to being admitted to the facility. The resident went for NJ Exec. Order 26:4 treatments three days a week, and she was in communication with the NJ Exec. Order 26:4 facility's dietitian. The RD stated that the resident was on NJ Exec. Order 26:4.b.1. On 3/30/23 at 10:02 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team acknowledged the resident was NJ Exec. Order 26:4.b.1 and all staff should have been aware not to give NJ Exec. Order 26:4.b.1 2. On 3/21/23 at 12:18 PM, the surveyor observed Resident #35 eating lunch in their room with a visitor present. The resident stated he/she received NJ Exec. Order 26:4 treatments on Tuesdays, Thursdays, and Saturdays, and they had received NJ Exec. Order 26:4 at 5:30 AM this morning. The surveyor observed on the resident's tray 4 oz cranberry juice, an 8 oz mug of tea, a sixteen-ounce disposable cup of water with a lid and straw, and the resident was drinking from a sixteen-ounce paper coffee cup with a lid and straw. The surveyor asked the resident what they were drinking, and they stated tea from home. The surveyor asked if they had to limit fluids because of the NJ Exec. Order 26:4 treatments, and the resident stated no. The surveyor reviewed the medical record for Resident #35. A review of the Admission Record face sheet	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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F 698	Continued From page 24 reflected the resident was admitted to the facility in NJ Exec. Order 26:4.b.1 with diagnoses which included NJ Exec. Order 26:4.b.1 A review of the admission MDS dated NJ Exec. Order 26:4, reflected the resident had a BIMS score of a NJ Exe out 15, which indicated NJ Exec. Order 26:4.b.1. A further review reflected the resident received NJ Exec. Order 26:4 treatments while a resident at the facility. A review of the Order Summary Report reflected a PO dated NJ Exec. Order 26:4 for NJ Exec. Order 26:4.b.1. An additional PO dated NJ Exec. Order 26:4, reflected a NJ Exec. Order 26:4.b. with breakfast 6 oz tea and 4 oz milk; lunch 4 oz sugar free juice; dinner 6 oz tea and 4 oz sugar free juice; and NJ Exec. Order 26:4.b.1 each shift. A review of the corresponding NJ Exec. Order 26:4.b.1 MAR, reflected on the day shift for NJ Exec. Order 26:4, the resident received NJ Exec. Order 26:4.b.1, which did not reflect the sixteen-ounce disposable water cup the surveyor observed. A review of the resident's individualized person-centered care plan included a focus area initiated NJ Exec. Order 26:4, that I have nutritional problem or potential nutritional problem with regards to NJ Exec. Order 26:4.b.1; NJ Exec. Order 26:4.b.1); and I have NJ Exec. Order 26:4 three times a week; Tuesdays, Thursdays, and Saturdays. I will have a snack	F 698		

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	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

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COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 698	Continued From page 25	F 698		

prior to leaving and lunch when I return.

On 3/27/23 at 11:17 AM, the surveyor interviewed the resident's LPN who stated CNAs were aware of fluid restrictions because the nurses informed them as well as the dietary meal tickets indicated it. The LPN continued the nurses were aware from the physician's orders. The LPN stated residents on a fluid restriction did not receive the sixteen-ounce disposable cups of water each shift and only the nurse and dietary staff could provide the resident with fluids. The LPN confirmed the resident was on NJ Exec. Order 26:4.b.1 , and the resident could be forgetful, but they were compliant with their restrictions. At this time, the LPN accompanied the surveyor into the resident's room and observed the resident with a sixteen-ounce disposable cup of water with the resident's name and today's date as well as a sixteen-ounce paper cup of tea the resident's visitor brought. The LPN informed the resident they were on a NJ Exec. Order 26:4.b.1, and they would have to measure out the tea for them. The LPN also removed the sixteen-ounce disposable water cup and removed the lid and confirmed the cup was filled with water.

On 3/27/23 at 11:29 AM, the surveyor interviewed CNA #2 who confirmed she was typically assigned to Resident #35. CNA #2 continued that the 7:00 AM to 3:00 PM shift gave residents fresh water daily in their disposable cup. CNA #2 stated she had no residents currently on any fluid restrictions, and confirmed Resident #35 was on no dietary restrictions including a fluid restriction.

On 3/27/23 at 11:34 AM, the surveyor interviewed the UM/LPN who stated residents' water cups

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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F 698	Continued From page 26 were changed daily during the 11:00 PM to 7:00 AM shift. The cups were filled each shift by the aide and if a resident asked for additional water, staff provided. The surveyor asked how staff would know if a resident was on a fluid restriction, and the UM/LPN stated that nurses were aware through the physician's orders and CNAs were aware through the Kardex which included resident care. The UM/LPN stated she was aware Resident #35 received a sixteen-ounce disposable cup of water today and NJ Exec. Order 26:4.b.1 The surveyor informed the UM/LPN that they observed a water cup on 3/21/23 as well. At this time, the surveyor requested a copy of Resident #35's Kardex. On 3/27/23 at 11:42 AM, the surveyor interviewed the DON who stated CNAs knew a resident was on fluid restrictions by the Kardex and nurses were aware by the physician's order. The DON confirmed residents on fluid restrictions did not receive sixteen-ounce disposable cups of water by the CNAs, unless the nurse put the appropriate amount ordered for that shift in the cup. At this time, the surveyor informed the DON about the observations of the sixteen-ounce disposable water cup on NJ Exec. Order 26:4 and today made by the surveyor; as well as the LPN confirmed the cup contained sixteen-ounces of water today. The surveyor requested a copy of Resident #35's Kardex. A review of the resident's Kardex dated as of NJ Exec. Order 26:4, included for eating/nutrition the resident was NJ Exec. Order 26:4.b.1. On 3/29/23 at 10:36 AM, the surveyor interviewed the RD who stated the resident received NJ Exec. Order 26:4	F 698		

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	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

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F 698	Continued From page 27 treatments prior to admission to the facility as well as currently at the facility. The RD stated when the resident was first admitted to the facility, they had NJ Exec. Order 26:4.b.1 but NJ Exec. Order 26:4 had since subsided. The RD stated that she had been in contact with the NJ Exec. Order 26:4 Center RD who was familiar with the resident prior to admission to the facility, and the resident had returned to their NJ Exec. Order 26:4.b.1 from six months ago. The RD stated that the resident was NJ Exec. Order 26:4.b.1. On 3/30/23 at 10:02 AM, the DON in the presence of the LNHA and survey team acknowledged the resident was NJ Exec. Order 26:4.b.1 and all staff should have been aware not to NJ Exec. Order 26:4.b.1. A review of the facility's "Encouraging and Restricting Fluids" policy dated updated 1/2023, included the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Verify that there is a physician's order for this procedure...follow specific instructions concerning fluid intake or restrictions. Be accurate when recording fluid intake...when a resident has been placed on fluid restrictions, remove the water pitcher and cup from the room... NJAC 8:39-27.1(a)	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 755	Continued From page 28 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to accurately document the administration of controlled medication for three residents (Resident #11, Resident #14, and Resident #102). This deficient practice was identified on 1 of 3 medication carts (Applewood Low) reviewed and evidenced by the following:	F 755	No residents were affected by this deficient practice. The deficient practice was identified that the facility failed to accurately document the administration of a controlled substance medications for residents and sign narcotic count log. All Licensed staff were educated by the DON prior to survey exit on the facility policy and procedure on Controlled Substances	

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	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

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F 755	Continued From page 29 On 3/23/23 at 1:06 PM, the surveyor in the presence of the Licensed Practical Nurse (LPN) inspected the Applewood Low medication cart. The surveyor and the LPN reviewed the narcotic medication located in the secured and locked narcotic box. When the narcotic medication inventory was compared to the corresponding declining inventory sheet, the surveyor identified the following concerns: Resident #11's NJ Exec. Order 26:4.b.1) tablets, a medication used for NJ Exec. Order 26:4.b.1 did not match. The blister pack contained 89 tablets and the declining inventory sheet indicated there should be 90 tablets remaining. Resident #11's NJ Exec. Order 26:4.b.1), a medication used for NJ Exec. Order 26 did not match. The blister pack contained 17 tablets and the declining inventory sheet indicated there should be 18 tablets remaining. The LPN stated she had just administered Resident #11 their NJ Exec. Order 26:4.b.1 medication that was scheduled to be given at 2:00 PM and had administered the NJ Exec. Order 26:4.b.1 earlier that morning when it was due. Resident #14's NJ Exec. Order 26:4.b.1 tablets, a medication used for NJ Exec. Order 26:4, declining inventory sheet compared with the corresponding blister pack did not match. The blister pack contained 12 tablets and the declining inventory sheet indicated there should be 13 tablets remaining. Resident #102's NJ Exec. Order 26:4.b.1 tablets, a medication used for NJ Exec. Order 26:4, did not match. The blister pack contained nine tablets and the corresponding declining inventory sheet indicated there should be 10 tablets remaining.	F 755	and Documentation of Medication Administration. All residents have the potential to be affected All Licensed staff educated by DON/IP/Designee on the facility policy and procedure on Controlled Substances and Documentation of Medication Administration. The DON/IP/Designee will conduct audits of all licensed staff on Medication Pass and The removal of a controlled substances procedure, signature narcotic log, Documentation of Medication Administration, Weekly X 4 weeks then monthly x 3 months. Results of audit will be brought to Administrator or Designee to be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

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F 755	Continued From page 30	F 755		

On 3/23/23 at 1:20 PM, the surveyor interviewed the LPN who stated the declining inventory sheets should be signed before the end of my shift, so the count was correct for the next nurse. The LPN continued that the Medication Administration Record (MAR) was signed after the medication was administered.

On 3/23/23 at 1:28 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated the nurse signed the declining inventory sheet at the time they removed the medication from the blister pack. Then the nurse administered the medication and signed the MAR indicating the medication had been administered. The ADON continued the declining inventory sheet was an accountability sheet to account that a medication was removed from inventory because you cannot return a medication back to the blister pack; it must be wasted and destroyed. At that time the surveyor and the ADON together reviewed the declining inventory sheets and the blister packages for the medications identified and the ADON confirmed the LPN should have signed the declining inventory sheets immediately after removing the medications from the blister package, not before the end of their shift as stated by the LPN.

On 3/30/23 at 10:07 AM, the survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The DON confirmed the nurse should have signed for the medications as soon as it was removed from the packaging because that was a nursing standard of practice.

A review of the facility provided "Administering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 755	Continued From page 31 Medications" policy dated last updated 1/2023, did not include the facility's process for the use of declining inventory sheets for medication reconciliation. NJAC 8:39- 29.2(d)	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to a.) maintain 2 of 2 kitchen hand washing sinks with accessible paper towels; b.) maintain multi-use food-contact surface resident entree plates in a manner to prevent microbial growth; and c.) maintain potentially hazardous food temperatures above 135 degrees	F 812	1)One paper towel dispenser was refilled and the other was repaired. 2) The 80 chipped plates were all thrown out and replaced with new ones 3)All kitchen staff were in serviced on ensuring proper food temperatures for hot oatmeal. All residents have the potential to be	4/21/23

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	315320	A. BUILDING ____ B. WING ____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 812 Continued From page 32

Fahrenheit.

This deficient practice was evidenced by the following:

On 3/27/23 at 7:00 AM, the surveyor conducted a follow-up survey in the kitchen. At this time, the surveyor entered the kitchen and proceeded to wash their hands in the hand washing sink. After the surveyor washed their hands, they attempted to dry their hands but observed the paper towel dispenser was empty. The surveyor asked the four kitchen staff present; the Cook, Dietary Aide (DA #1), DA #2, and DA #3, how the surveyor should dry their hands since there were no paper towels; all four staff responded they needed to retrieve paper towels from the housekeeping department. The surveyor then asked in the meantime how they should dry their hands or if there was a secondary hand washing sink, and the surveyor was directed to an additional hand washing sink in the cook area. The surveyor observed there were paper towels in the dispenser, but the dispenser was jammed, and no paper towels could be removed.

At this time, the surveyor interviewed the four kitchen staff and was told the following:

An interview with the Cook revealed she arrived at the facility around 5:30/6:00 AM, and she washed her hands in the cook area hand sink.

An interview with DA #1 revealed he arrived at the facility around 6:15 AM, and noticed there were no paper towels in the kitchen, so he washed his hands in the bathroom and then returned to the kitchen.

F 812

affected.
Any other paper towel dispenser was audited by food service director to ensure full and unjammed.
All plates were audited by food service director to ensure none are chipped.
All hot foods audited by food service director to ensure they are being maintained at proper temperatures.
The cook, DA #'s 1,2,and 3, and all kitchen staff were in serviced by food service director on changing of empty paper towels rolls when noted, where to find additional supplies, and reporting any jammed paper towel dispensers for repair.
Food service director to provide education to night cook assistant to refill all rolls at night and morning cook to re-check that all paper towels rolls are full and refill paper towel rolls as needed.
kitchen staff were all in serviced by food service director that all chipped plates are to be immediately discarded and replaced with new ones.
Cook was inserviced by food service director on appropriate temperatures for hot foods. DA #1 was inserviced by food service director on not portioning too many portions at once.

Food service Director or Designee to audit paper towel dispenser supplies, and plates free from chips, weekly for 4 weeks then monthly for 2 months for compliance.
Food service director to audit and log temperatures of two breakfast trays per week for 4 weeks and then monthly for 2 months to ensure compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

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F 812	Continued From page 33 An interview with DA #2 revealed he arrived at the facility around 5:30 AM, and washed their hands in the bathroom since there were no paper towels and then returned to the kitchen. An interview with DA #3 revealed he arrived at the facility around 6:45 AM, and he washed his hands in the kitchen and used a napkin to dry his hands since there were no paper towels. Interviews with staff revealed they were all aware there were no paper towels at the hand washing sink. On 3/27/23 at 7:12 AM, the surveyor observed the Cook calibrate a digital thin probe thermometer in an ice bath to 32 degrees Fahrenheit (F). The Cook then proceeded to obtain the temperatures of the breakfast tray line food items and the following food items were held below 135 F: A half pan deep of oatmeal being held directly on the countertop and not held in the steam table was 122 F. Twelve portioned oatmeals in insulated containers with lids being held directly on the countertop and not in contact with a heating element were 125 F. At this time, the Cook stated DA #1 was new to the facility and portioned the oatmeal, but he portioned too many oatmeals to start. The Cook did not reheat the oatmeal to a higher temperature and observed the kitchen serve the oatmeals. On 3/27/23 at 7:30 AM, the surveyor observed a	F 812	Food service director or designee to report findings of audits to Administrator or designee at monthly QAPI meeting for 3 months to determine compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 34	F 812		

stack of six resident entree plates placed on the breakfast tray line. The surveyor observed four of those plates to have large chips located on the rim of the plates which removed the ceramic coating exposing the plate's porous surface. At this time, the Cook acknowledged the chips in the plates and discard them. The Cook then instructed DA #1 to inspect all the plates from the plate warmer prior to placing the plates on the breakfast tray line for service. DA #1 removed an additional seventy-six entree plates that were all chipped on the rim which removed the ceramic coating exposing the porous surface.

On 3/27/23 at 7:38 AM, the surveyor interviewed the Regional Dietary Director (RDD) who was now present in the kitchen. The RDD confirmed the facility should not be using chipped plates because shards of ceramic from the chip could go in the food; someone could cut their hand; and bacteria could harbor in the exposed porous surface. The RDD acknowledged it was a safety concern.

On 3/27/23 at 7:38 AM, the surveyor reviewed the temperatures of the portioned oatmeal and the deep half pan of oatmeal being held on the tray line counter not on a heat source. The RDD stated hot foods should be held in the kitchen at 140 F or higher.

On 3/27/23 at 9:00 AM, the surveyor interviewed the RDD who stated staff should wash their hands whenever they enter the kitchen area and after changing their gloves. The RDD stated staff were expected to change their gloves anytime leaving the kitchen or changing a task and wash their hands frequently. The RDD stated there were two hand washing sinks in the kitchen that

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	315320	A. BUILDING _______ B. WING _______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

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F 812	Continued From page 35 were expected to have paper towels in the dispensers, and staff should have immediately restocked the dispenser when it was noticed there were no paper towels. On 3/27/23 at 10:15 AM, the RDD informed the surveyor that the facility did not have a policy for maintaining kitchen equipment like entree plates, but he stated entree plates were included on a kitchen checklist and plates with chips should not be used. On 3/29/23 at 12:09 PM, the surveyor interviewed the Dietary Director (DD) who stated he was aware of the incident on 3/27/23 with no paper towels in the kitchen, and staff should have immediately replaced the paper towels when it was first realized. On 3/30/23 at 10:02 AM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team acknowledged the above concerns. A review of the facility's "Dining Services Food Temperatures" policy dated created 2/7/22, included food will be maintained at the proper temperatures to ensure food safety. The temperatures of hot foods at the point of service (steam table) during tray assembly will be 135 degrees Fahrenheit or above. The cook is responsible to see all food is at proper temperature... A review of the facility's "Dinning Service Inc." checklist dated created 2/7/22, included check for cracked trays and check for cracked smallware utensils...	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 36 A review of facility's "Handwashing/Hand Hygiene" policy dated revised 1/2022, included hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, ect.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies... NJAC 8:39-17.2(g)	F 812		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	315320	A. BUILDING: ______ B. WING ______	3/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 804

Nutritive Value/Appear, Palatable/Prefer Temp
CFR(s): 483.60(d)(1)(2)

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure appetizing and palatable temperature of food for 1 of 1 breakfast meals observed on 1 of 3 nursing units (Washington). This deficient practice was evidenced by the following:

On 3/22/23 at 9:58 AM, the surveyor conducted a Resident Council meeting which included three residents (Resident #31, #51, and #68). All three residents informed the surveyor that the breakfast meal served on the nursing units was unappetizing and the temperature was cold. All three residents stated that the facility once a month served breakfast in the dining room, and that was the only time the breakfast meal was hot and "good."

On 3/27/23 at 7:05 AM, the surveyor informed the Cook they wanted to observe breakfast meal for the day including food temperatures. The Cook stated that hot foods should be above 160 degrees Fahrenheit (F) and cold foods should be 40 F or below. The surveyor asked the Cook to calibrate two digital thin probe thermometers in their presence; which the Cook completed using an ice bath, and the thermometers reach 32 F.

On 3/27/23 at 7:12 AM, the surveyor observed the Cook using one of the thermometers calibrated to 32 F and took the following temperatures for the regular texture breakfast meal:

French toast 170 F
Pancake syrup 160 F
Sausage links 163 F
Scrambled eggs 166 F
Farina 165 F
Portioned farina in portioned insulated bowls with lids placed directly on the serving countertop not on a heating element 155 F
Oatmeal located in a half deep pan placed directly on the serving countertop and not on the steam table was 122 F
Twelve portion oatmeals in insulated bowls with lids placed on the serving countertop not on a heating element 125 F
Whole milk 42 F

On 3/27/23 at 7:32 AM, the Cook began serving the breakfast meal. The Cook utilized plastic insulated

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 315320	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 3/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 804

Continued From Page 1

domes and bases, heated plate liners, and heated plates to maintain temperature.

On 3/27/23 at 7:48 AM, the surveyor was informed that the meal cart for the Washington unit was complete and the surveyor requested a regular meal tray which contained French toast, pancake syrup, scrambled eggs, sausage links, whole milk, and one oatmeal and one farina be added to a tray in the meal cart as a test tray.

On 3/27/23 at 7:50 AM, the Dietary Aide (DA) left the kitchen with the meal cart for the Washington unit. At this time, the surveyor and the Regional Dietary Director (RDD) accompanied the DA with a thin probed thermometer that was calibrated to 32 F.

On 3/27/23 at 7:51 AM, the DA arrived to the Washington unit with the meal cart and left the meal cart on the nursing unit.

On 3/27/23 at 7:52 AM, the two Certified Nursing Aides (CNAs) and the Unit Manager/Licensed Practical Nurse (UM/LPN) began delivering the breakfast trays to the residents.

On 3/27/23 at 8:07 AM, the UM/LPN informed the surveyor and RDD that all the residents' meal trays had been served. At this time, the UM/LPN served the surveyor the test tray and poured coffee into the mug located on the tray.

On 3/27/23 at 8:08 AM, the surveyor observed the RDD obtain the following temperatures from the sample tray:

Coffee 157 F
Farina labeled oatmeal 120 F
Farina labeled farina 131 F
Whole milk 47 F
Scrambled eggs 110 F
French toast 110 F
Sausage link 106 F

At this time, the RDD stated the food temperatures were unacceptable. The RDD continued that cold food items including milk should be served at 41 F or below and hot food items should be 140 F or above. The RDD could not speak to at the time the minimum temperature hot food should be served to the residents at, but he confirmed the temperatures were unacceptable. The RDD could not speak to why the farina was mislabeled as oatmeal.

On 3/27/23 at 10:15 AM, the RDD provided the surveyor with the facility's "Dining Services Food Temperatures" policy dated created 2/7/22. The policy included hot food must be served at least 135 degrees Fahrenheit or above and chilled food and beverages should be 41 F or below. The RDD confirmed that food should be served to the residents at 135 F or above, and acknowledged again that the food on the test tray was at unacceptable temperatures.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 315320	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 3/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 804	Continued From Page 2 On 3/30/23 at 10:02 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) and the survey team acknowledged the temperatures on the test tray were not in an acceptable range. NJAC 8:39-17.4(a)(2)

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061526	A. BUILDING: ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

(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 was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 159371 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 13 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1. Staffing ratio requirements were reviewed By Administrator with Staffing Coordinator. Education on ratio requirements provided by Administrator to Staffing Coordinator on importance of meeting these requirements. All residents could have been affected by this deficient practice. 2. Audit of staffing by Staffing Coordinator conducted to ascertain staff willing to work overtime shifts. 10 agency contracts maintained. Staffing coordinator to send all needs to agencies 4 weeks in advance. Recruiters designated to increase efforts for CNA recruitment to meet ratios	4/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061526	A. BUILDING: ____ B. WING ____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

(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 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During entrance conference on 3/20/23 at 9:47 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) informed the surveyor that the facility had both good and bad days with staffing. The DON continued that the facility used Agency staff as needed to cover shifts. At this time, the surveyor requested the facility to complete the "Nurse Staffing Report" for the past two weeks. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 3/5/23 to 3/11/23 and 3/12/23 to 3/18/23, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 3/5/23 had 13 CNAs for 117 residents on the day shift, required 15 CNAs.	S 560	requirements. Staffing coordinator to send needs to recruiter weekly and communicate interview scheduling. Review per diem hire rates. 3. Daily audit conducted for 1 month then weekly for 2 months by Staffing Coordinator or Designee. 4. Administrator or Designee to review and monitor audits by Staffing Coordinator or Designee at monthly QAPI meeting for 3 months to ensure effectiveness of plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061526	A. BUILDING: ______ B. WING ______	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

(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 560	Continued From page 2 3/6/23 had 12 CNAs for 116 residents on the day shift, required 14 CNAs. 3/7/23 had 13 CNAs for 115 residents on the day shift, required 14 CNAs. 3/8/23 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. 3/9/23 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. 3/10/23 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. 3/11/23 had 10 CNAs for 110 residents on the day shift, required 14 CNAs. 3/12/23 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. 3/13/23 had 12 CNAs for 109 residents on the day shift, required 14 CNAs. 3/14/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs. 3/15/23 had 12 CNAs for 107 residents on the day shift, required 13 CNAs. 3/17/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs. 3/18/23 had 11 CNAs for 108 residents on the day shift, required 13 CNAs. NJAC 8:39-5.1(a)	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315320	A. Building B. Wing	5/12/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 04/21/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315320 (Y1)	A. Building B. Wing (Y2)	5/12/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 04/21/2023	ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 04/21/2023	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 04/21/2023
ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 04/21/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061526 (Y1)	A. Building B. Wing (Y2)	5/12/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/21/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING ___	**03/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1990's with no current major renovations or noted additions. It is a one story building Type II (111) construction and is fully sprinklered. The outside 175 KW diesel generator does approximately 40% of the building. The building utilizes an electric fire pump to support the fire sprinkler system. The floor plan indicates 14- smoke zones throughout the facility. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 180 certified beds. At the time of the survey the census was 106. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101	K 211		4/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE: | (X6) DATE: 04/14/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING ___	**03/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 1 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on interviews and documentation review on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for 8 of 9 fire doors observed and was evidenced by the following: On 3/28/23 at approximately 9:45 AM, the surveyor asked the MD and RPOD to provide the annual testing requirements for fire door assemblies in accordance with NFPA 80. The MD stated that currently the facility did inspect fire doors and the last inspection was completed by the previous Maintenance Director. The documents provided by the (current) Maintenance Director were dated 3/1/22. The following information on the "annual inspection of swinging fire door assemblies" were provided revealing that 8 out of 9 reports indicated under "inspection Activity" #4 "are there any missing or broken parts". The report indicated "YES" and the comment section on the form was "BLANK". The MD and RPOD could not provide any further information, and both stated they did not realize the reports indicated: "missing or broken parts"	K 211	The annual fire door inspection was done on 06/30/2022 by ADT Commercial. All residents have the potential to be affected. All fire doors in facility were tested as per required annual fire door test. Annual inspection of fire doors to be completed annually. A new form for the “annual inspection of swinging fire door assemblies” is being created to ensure that all issues on report are not overlooked and are addressed promptly. Regional Director of Maintenance to educate the Director of Maintenance on this new form. Annual Fire Door Inspection Report is to be filed in Maintenance log by Maintenance Director or designee. Director of Maintenance or Designee to ensure annual inspection of fire doors. Upon completion of inspection, Director of Maintenance or Designee to give Annual Fire Door Inspection report to Administrator or Designee to ensure all issues have been addressed and that doors are functioning properly. Annual Fire Door Inspection Report to be reviewed by administrator at quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING 01 B. WING	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 for 8 out of 9 fire doors on the 3/1/22 annual inspection of swinging fire door assemblies and they could not provide any further information. The Licensed Nursing Home Administrator was informed of the finding at the Life Safety Code Exit Conference on 3/29/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	QAPI meeting directly following inspection for 12 months.	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K 222		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING ______	**03/30/2023**

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COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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K 222	Continued From page 3 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 4 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review on 3/29/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD) it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 This deficient practice was identified for 3 of 9 sets of exterior egress doors and was evidenced as follows: On 3/29/23 at 09:50 AM, the surveyor in the presence of the MD and RPOD observed a testing of the fire alarm system to test the operation of the facility nine (9) fire doors. The activation of the fire alarm system revealed 3 of 9 fire doors did not release and open as designed. The three (3) doors were located in the Applewood wing identified as: Applewood 20 hall 23 zone left door # 25 right door # 26 Applewood 30 hall 21 zone left door # 28 right door # 29 Applewood 40 hall 20 zone left door # 30 right door # 31 The three (3) doors were provided with an emergency door release indicating when activated the door would open in 15-seconds. The three (3) fire doors did not open when the fire	K 222	1) On 03/30/2023 ADT and Current Technologies came and replaced the relays on all of the affected doors on Applewood thereby enabling all of the electrical locks to release upon fire alarm engagement. The means of egress is readily accessible and free of all obstructions and/or impediments to allow for full instant use in case of fire or other emergencies. 2) In services were conducted on 03/30/2023 for all staff to ensure that they were aware of the emergency door release that activated the egress set of doors in 15 seconds. All residents on Applewood had the potential to be affected. All egress doors throughout the facility were tested for functionality of release upon fire alarm engagement. Regional Director of Maintenance to educate Director of Maintenance/Designee to test all exit doors on Applewood weekly for 3 months and monthly thereafter facility wide to ensure the electrical locks release upon fire alarm engagement. Results of monthly tests will be brought by Director of Maintenance or Designee to monthly QAPI meeting for 3 months to be reviewed by Administrator or Designee to determine compliance.	

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	315320	A. BUILDING **01** B. WING	**03/30/2023**

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COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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K 222		K 222		

Continued From page 5
alarm was activated in 15-seconds.

The newly hired Maintenance Director and newly hired Regional Plant Operations Director both indicated that they did not conduct a test of the fire alarm system and did not check the operation of the fire doors to see if they opened when the system was activated at this time since they were hired.

The three (3) most recent fire drills that were completed by the fire drill vendor dated: 3/27/23, 2/27/23, and 1/29/23. The documents did not indicate when a fire drill was conducted and that any fire doors were tested for proper operation.

A review of the most recent fire alarm system inspection and testing form from the facility vendor dated 6/30/22, included under "auxiliary control & functions tests and inspections" device type that door control/release was checked for visual, functional and pass. The document confirmed all door control/release features PASSED and no other comments were provided.

The facility provided a policy statement for "exits" dated 10/1/22, which included that "it is the responsibility of all personnel to keep exit-ways clear always and report such violation to his or her immediate supervisor."

Interviews were conducted after the fire alarm test was conducted with the following staff members of the Applewood unit:

On 3/29/23 at 10:14 AM, the surveyor interviewed the newly hired Licensed Practical Nurse (LPN) who confirmed that they were aware of the "emergency door release" that activated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING 01 B. WING	03/30/2023

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K 222	Continued From page 6 egress set of doors in 15-seconds. On 3/29/23 at 10:18 AM, the surveyor interviewed the Part-time (PT) LPN who confirmed that they were aware of the "emergency door release" that activated the egress set of doors in 15-seconds. On 3/29/23 at 11:15 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who confirmed that they were aware of the "emergency door release" that activated the egress set of doors in 15-seconds. On 3/29/23 at 11:20 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who confirmed that they were aware of the "emergency door release" that activated the egress set of doors in 15-seconds. An interview was conducted with the Maintenance Director and Regional Plant Operations Director, and both stated that the facility fire door vendor was called and notified of the findings and responded immediately to identify the issue. The Licensed Nursing Home Administrator was informed of the findings during and at the Life Safety Code Exit Conference on 3/29/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration	K 291		4/17/23

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	315320	A. BUILDING 01 B. WING	03/30/2023

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K 291	Continued From page 7 is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/29/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to provide a battery back-up emergency light above the electric fire pump transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 19.2.9.1.- 7.9.1 (general). This deficient practice was identified for 1 of 1 transfer switches and was evidenced by the following: On 3/29/23 at 11:14 AM, the surveyor in the presence of the RPOD and MD, observed one fire pump transfer switch, inside the fire pump electrical room. The general area was not provided with any emergency lighting. The RPOD and MD both confirmed the findings at the time of the observation. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit on 3/29/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	On 04/05/2023 battery back-up emergency lights were installed in the sprinkler rooms above the electric fire pump transfer switch. All residents had the potential to be affected. Audit conducted on any transfer switch in building for emergency lighting requirement. Regional Director of Maintenance educated Director of Maintenance on requirement of emergency lighting above transfer switch. Director of Maintenance/designee to check for proper functioning of battery back-up emergency lights weekly for 4 weeks and then monthly thereafter for two months. Director of Maintenance/designee to report findings of audits to Administrator at monthly QAPI meeting for 3 months to determine compliance.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination	K 293		4/21/23

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	315320	A. BUILDING **01** B. WING ______	**03/30/2023**

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K 293	Continued From page 8 also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility failed to provide exit signs showing the direction of travel, in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 3 of 25 exit signs observed and was evidenced by the following: On 3/28/23 at 10:28 AM, the surveyor in the presence of the Maintenance Director and Regional Plant Operations Director observed that the exit/egress corridor was not provided with illuminated exit signs. The set of smoke doors by the Jefferson/Washington unit intersection were not provided with an illuminated exit sign on either side of the smoke doors. The long exit/egress corridor leading to the lobby/green house exit was not provided with an exit sign and until you walked three quarters of the way to the lobby exit, it was not obvious where the exit was located. The findings was verified by the Maintenance Director and Regional Plant Operations Director at the time of the observations. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 3/29/23.	K 293	On 04/11/2023 three new exit signs were installed. They are located on either side of the set of smoke doors by the Jefferson/Washington unit as well as the long exit/egress corridor leading to the lobby/greenhouse exit. The exit signs show the direction of travel to reach the nearest exit. All residents have the potential to be affected by this deficient practice. Facility wide audit was conducted to ensure appropriate exit signage is located in required locations. Regional Director of Maintenance to educate Director of Maintenance/Designee on exit signage location requirements. Director of Maintenance/designee to conduct weekly audits for 1 month then monthly for 2 months to ensure all signage in proper locations and illuminated. Results of audits to be reviewed by Administrator or Designee on monthly QAPI meeting for 3 months to ensure compliance.	

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	315320	A. BUILDING 01 B. WING ______	03/30/2023

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K 293	Continued From page 9 NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the facility failed to ensure a). smoke detection sensitivity testing was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. and .b) to provide an updated fire alarm system & testing inspection report as per NFPA 70 & 72. The deficient practice was identified for 2 of 2 inspection reports and was evidenced by the following: On 3/28/23 at 11:10 AM, the surveyor reviewed all related fire alarm documentation provided by the MD from the fire alarm vendor to determine if the sensitivity test was performed. The reports were dated 12/15/22 (Company Name #1 redacted)	K 345	Annual smoke detection sensitivity test and fire alarm system and testing inspection was completed on 06/30/2022. On page 2 of the annual inspection and test report all smoke detectors are shown to pass annual test. All smoke detectors were audited to ensure compliance. Inspections will continue to occur annually. Next inspection due to be completed by June 30, 2023. Regional Director of Maintenance to educate Director of Maintenance or Designee to ensure copy of Annual Fire Alarm and Testing Inspection report is filed in Maintenance log. Director of Maintenance/designee will conduct monthly audit for 3 months to ensure proper paperwork reports are filed in Maintenance log.	4/21/23

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	315320	A. BUILDING **01** B. WING ______	**03/30/2023**

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K 345	Continued From page 10 and 6/30/22 (Company Name #2 redacted). The reports provided did not indicate any information on the testing of the smoke detector for sensitivity. An interview was conducted with the MD and RPOD during document review who both indicated they were not sure if the required sensitivity test for the facility smoke detectors were performed. The MD contacted the facility fire alarm vendor to see if sensitivity report was performed, and no further documentation was provided. On 3/28/23 at 11:40 AM, during document review the surveyor reviewed all fire alarm documentation from the fire alarm vendor. The inspection reports were dated 12/15/21 and 6/30/22 were inspected on a semi-annual basis. The current date of 3/28/23 indicated the last inspection was conducted almost 9-months ago. The fire alarm system utilizes sealed lead acid batteries as a backup and requires the semi-annual inspection as per NFPA 70 & 72. An interview was conducted with the MD during document review, and he stated that he was informed that the fire alarm inspection was only conducted on an annual basis, no further information was provided. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code Exit conference on 3/29/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	Administrator or Designee to review results of audits of Annual Fire Alarm and Testing Annual Inspection report in Maintenance log during monthly QAPI meeting for 3 months to determine compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING ___	**03/30/2023**

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K 353	Continued From page 11	K 353		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to a.) annually inspect 2 of 2 private property fire hydrants as per NFPA 25 and b). to ensure that their automatic sprinkler system was inspected/tested at the required 5-year interval in accordance with the National Fire Protection Association (NFPA) 25. This deficient practice was evidenced by the following: On 3/28/23 at approximately 11:30 AM, the surveyor reviewed all related documentation from the fire sprinkler vendor. The reports did not	K 353	Electronic Security Solutions has been contracted to perform the annual inspection private property fire hydrant as well as to perform the 5 year automatic sprinkler system test/inspection. All residents have the potential to be affected. All fire hydrants on private property assessed for inspection compliance. Regional Director of Maintenance in serviced Director of Maintenance on the importance of performing the annual test on 2 of 2 private property fire hydrants as well as then need to perform the	4/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING 01 B. WING	03/30/2023

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K 353	Continued From page 12 indicate any annual inspection of the two (2) private fire hydrants on the facility's property as required by NFPA 25. The MD and RPOD both indicated that the annual fire hydrant inspection requirement was not performed, and no further documentation was provided. During document review, the surveyor reviewed all fire sprinkler inspection reports dated: 1/31/22, 4/28/22, 7/28/22, 10/28/22, and 1/30/23. The inspections did not indicate the fifth-year internal observation of the fire sprinkler pipe investigation was completed. The MD and RPOD both stated that they were unsure if the inspection was completed and could not provide any further information from the fire sprinkler vendor indicating so. NFPA 25 requires an internal inspection of the fire sprinkler system piping every five years; this needs to be conducted to inspect for the presence of foreign organic material that can cause obstructions to pipe and sprinklers. The Licensed Nursing Home Administrator was notified of the findings at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 25	K 353	inspection/test on the automatic sprinkler system every 5 years. Director of Maintenance to audit annual inspection report of 2 of 2 fire hydrants as well as report five year test/inspection on automatic sprinkler system monthly for 3 months to ensure appropriate documentation is logged in Maintenance log for compliance. Director of Maintenance or Designee to bring reports from annual test of 2 of 2 private property fire hydrants as well as 5 year automatic sprinkler system test/inspection and audit results to monthly QAPI meeting x3 months for Administrator or Designee to check for compliance.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K 363		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING ____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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K 363	Continued From page 13 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/29/23,	K 363	1) Applewood doors #13, 23,30,41 –	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING ______	**03/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 14 in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in 16 of 38 resident room doors observed and was evidenced by the following: During the building tour on 2/29/23 from 9:15 AM to 2:00 PM, the surveyor in the presence of the MD and RPOD toured the facility and observed the following: Resident Room doors: Applewood wing: #13 door did not latch #23 door did not latch #23 door did not latch #30 door did not latch #41 door did not latch #45 door stuck into frame Washington wing: #12 top of door warped #15 top of door warped #16 top of door warped and loose hardware #18 door did not latch #19 door did not latch #24 door did not latch	K 363	were repaired to latch properly. #45 repaired to not stick to frame. Washington doors #12, 15 were repaired. #16 loose hardware repaired. #18, 19, 24 were repaired to latch properly. Jefferson doors #26, 32-adaptive chair and wheelchair were removed. #36 was repaired. #43 was repaired to not stick to frame and to latch properly.2) All resident room doors to be inspected to ensure that all resident rooms close completely to properly confine fire and smoke products and to properly defend occupants in place All residents have the potential to be affected. All resident room doors to be inspected to ensure that all resident rooms latch properly. Director of Maintenance or Designee to inspect resident room doors weekly for four weeks and then monthly for two months to ensure that all resident rooms latch properly when being closed. Results of this inspection should be brought by Director of Maintenance or Designee monthly to Administrator or Designee. Administrator or Designee to review audit results during monthly QAPI meeting for 3 months to ensure compliance.	

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COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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K 363	Continued From page 15 Jefferson wing: #26 door hitting an adaptive chair #32 door hitting resident wheelchair #36 door stuck into frame #43 door stuck into frame and did not latch At the time of observations, the surveyor interviewed the MD and RPOD, who both confirmed the above findings. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 522 SS=F	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 3/29/23 in the presence of the Maintenance Director (MD)	K 522	A cover plate was placed over exposed wires in mechanical rooms on Applewood,	4/21/23

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K 522	Continued From page 16 and Regional Plant Operations Director (RPOD), it was determined that the facility failed to provide combustion air from the outside to fuel fired HVAC units. This deficient practice was evidenced for 3 of 3 mechanical rooms by the following: 1). On 3/29/23 at 11:48 AM, the surveyor observed in the Applewood unit mechanical room that the back wall was provided with a make-up air ventilation system. The MD and RPOD indicated the system was not in operation as the electric motors had exposed wires and seemed to be disconnected and inoperable at the time of observation. The door to the mechanical door did not close freely as the make-up air was being taken from the occupied exit/egress corridor and resident rooms to now supply air to the HVAC system. 2). On 3/29/23 at 12:08 PM, the surveyor observed in the Washington unit mechanical room that the back wall was provided with a makeup air ventilation system. The MD and RPOD indicated the system was not in operation as the electric motors had exposed wires and seemed to be disconnected and inoperable at the time of observation. The MD indicated the HVAC system was out of service at the time of observation and will be replaced. 3). On 3/29/23 at 12:54 PM, the surveyor observed in the Jefferson unit mechanical room that the back wall was provided with a make-up air ventilation system. The MD and RPOD indicated the system was not in operation as the electric motors had exposed wires and seemed to be disconnected and inoperable at the time of observation. The door to the mechanical door did	K 522	Jefferson and Washington. A door closer was put on doors on mechanical rooms in Applewood and Jefferson to ensure doors close freely and no longer take air from the occupied exit/egress corridor to supply air to the HVAC system. All residents have the potential to be affected. Facility wide audit conducted to ensure vented air from outside only. Regional Director of Maintenance to inservice Director of maintenance on the requirement to ensure that all exposed wires are covered and that mechanical doors should close freely and not take up make up air from the occupied exit/egress corridor and resident rooms to supply air to the HVAC system. Director of Maintenance or Designee to check for proper closure of mechanical room doors on all unit for 4 weeks and then monthly thereafter for 2 months. Director of Maintenance or Designee to report findings of audit to Administrator or Designee at monthly QAPI meeting for 3 months to determine compliance.	

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	315320	A. BUILDING 01 B. WING	03/30/2023

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K 522	Continued From page 17 not close freely as the make-up air was being taken from the occupied exit/egress corridor and resident rooms to now supply air to the HVAC system. An interview was conducted with the MD and RPOD who both stated that they were unsure about the operation of the make-up air systems in the three (3) mechanical rooms observed and agreed 2 of 3 rooms when the doors were closed slowly were taking air from the atmosphere of the occupied area. The Licensed Nursing Home Administrator was informed of the findings at the LSC exit conference on 3/29/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.5.2.2 (1) (c) they shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area.	K 522		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712		4/21/23

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K 712	Continued From page 18 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and document review on 3/28/23, in the presence of the Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 10 of 12 fire drills and was evidenced by the following: A review of the facility fire drill reports revealed method for the simulation of emergency fire conditions were not varied and specific to location for 10 of 12 fire drills. The drills should include date; type of alarm transmission: pull, smoke or page; specific location, what was the topic of the drill; and how do staff respond with no specific location? The reports identified the following: 3/25/22 smoke, laundry, page 4/15/22 smoke and flame due to electrical fire, Washington unit where? 5/23/22 smoke, rehab 6/22/22 smoke, rehab, page 8/21/22 smoke and fire due to electrical fire, Applewood 9/25/22 smoke, Jefferson, page, where? 10/19/22 smoke in hall, Jefferson unit, from what? 11/28/22 smoke, dietary, what happened? 12/13/22 smoke, Washington, page only, where? 1/29/23 electrical fire, Washington west, room 49, area of room? 2/27/23 smoke and flame due to electrical fire	K 712	Regional Maintenance Director in serviced Crocker fire safety director on 04/05/2023 on noted deficient drills on 3/25/22, 4/15/22, 5/23/22, 6/22/22, 8/21/22, 9/25/22, 10/19/22, 11/28/22, 12/13/22, 1/29/23, 2/27/23, 3/27/23 on the importance of conducting fire drills with at expected and unexpected times, at least quarterly on each shift, varying activation types and simulation of specific emergency fire conditions and specific locations. All residents have the potential to be affected. Audit conducted on all fire drills to ensure compliance. Maintenance Director or Designee to audit future drills to ensure fire drills are held at expected and unexpected times, at least quarterly on each shift, with varying activation types and simulation of specific emergency fire conditions and specific locations. Fire drill audits will be done monthly for 3 months by Director of Maintenance/designee to ensure compliance. Director of Maintenance or designee to report findings of fire drill audits to Administrator or Designee at monthly QAPI meeting for 3 months to determine compliance.	

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	315320	A. BUILDING **01** B. WING ______	03/30/2023

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K 712	Continued From page 19 Where? 3/27/23 smoke, faulty heater, Washington room 42, page An interview was conducted with the MD after documentation review, where he stated and confirmed the findings that current fire drills included the transmission of a fire alarm signal and simulation of emergency fire conditions were not identified, varied, and specific to areas for 10 of 12 fire drills documented on the forms. In addition, 5 of 12 alarm activations were page; no fire alarm pull stations were activated and no smoke detectors were activated. The Licensed Nursing Home Administrator was informed of the finding's at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4	K 712		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914		4/28/23

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K 914	Continued From page 20 manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and documentation review on 3/29/23, in the presence of the facility's Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 31 of 50 resident rooms observed by the following: On 3/29/23 from approximately 9:30 AM to 1:30 PM, the surveyor, MD, and RPOD observed resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection in the following resident rooms: Applewood unit: #12, #14, #22, #31, #33, #36, #37 Jefferson unit: #11, #12, #13, #14, #16, #17, #18, #19, #26, #27, #28, #29, #33, #34, #35, #36 Washington unit: #11, #17, #18, #19, #31, #33, #37, #38 A review of the last annual electrical inspection from the facility vendor dated 12/30/21, did not indicate any testing of resident room outlets.	K 914	All electrical receptacles in Applewood resident's room #'s 12,14, 22, 31, 33, 36,37 were tested for grounding, polarity and blade tension. Jefferson room #'s 11,12,13,14,16,17,18,19,26,27,28,29,33,34,35,36 were tested for same. Washington room #'s 11,17,18,19,31,33,37,38 were tested for same. All residents with less than hospital grade electrical receptors in their rooms have the potential to be affected. Receptacles in all resident rooms were tested by Maintenance director/designee to ensure compliance. Regional Director of Maintenance in serviced Director of Maintenance on the importance of annual testing of electrical receptacles in residents' rooms that are less than hospital grade. Director of Maintenance or Designee to audit all electrical receptacles with less than hospital grade electrical receptors weekly for 4 weeks and then monthly for 2 months and then annually thereafter to ensure all required testing is being performed timely. Director of Maintenance or Designee to	

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K 914	Continued From page 21 The MD and RPOD indicated that the facility did not have any electrical testing log on-site at this time. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.2(e) NFPA 99	K 914	report findings to Administrator or Designee at quarterly QAPI meetings x4 meetings to determine compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		4/21/23

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	315320	A. BUILDING 01 B. WING ______	03/30/2023

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K 918	Continued From page 22 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documents on 3/28/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was identified for 1 of 1 generator logs provided by the MD and the evidence was as follows: On 3/28/23 at 10:25 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the Maintenance Director was performing weekly generator testing, but did not indicate on the provided document when he was conducting the monthly load testing that would include the required transfer times. An interview was conducted with the MD and RPOD, during document review and they stated that currently the transfer time was not provided on the current document. They stated that the	K 918	Generator log was updated to show that the generator will start to transfer power to the building within 10 seconds during monthly load testing. All residents have the potential to be affected. All generator logs were audited by maintenance director to ensure appropriate documented transfer times on generator logs Regional Director of Maintenance in serviced Director of Maintenance that all monthly generator load testing must show that the generator will start to transfer power to the building within 10 seconds. Director of Maintenance or Designee to audit documention in updated log that the generator will start to transfer power to the building within 10 seconds during monthly load testing monthly for 3 months. Director of Maintenance or Designee to report finding of audits to administrator at monthly QAPI meetings for 3 months to ensure compliance.	

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	315320	A. BUILDING **01** B. WING	**03/30/2023**

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K 918	Continued From page 23 current document needed to be updated and required a separate column for identifying monthly load testing and transfer times. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 3/29/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315320	A. Building 01 - MAIN BUILDING 01 B. Wing	5/12/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix Reg. # NFPA 101 LSC K0211	Correction Completed 04/21/2023	ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 04/21/2023	ID Prefix Reg. # NFPA 101 LSC K0291	Correction Completed 04/17/2023
ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 04/21/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 04/21/2023	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 04/28/2023
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 04/21/2023	ID Prefix Reg. # NFPA 101 LSC K0522	Correction Completed 04/21/2023	ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 04/21/2023
ID Prefix Reg. # NFPA 101 LSC K0914	Correction Completed 04/28/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 04/21/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/30/2023	