STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS CENSUS: 131 SAMPLE SIZE: 33 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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the care of a resident with a [redacted], in accordance with the care plan and nursing professional standards of clinical practice. This deficient practice was identified for 1 of 1 resident reviewed for [redacted] (Resident #22) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey included, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching,	F 658	F658: Based on observation, interview, and record review, it was determined that the facility failed to ensure the care of a resident with a [redacted], in accordance with the care plan and nursing professional standards of clinical practice. PLAN OF CORRECTION: CORRECTIVE ACTIONS: 1) MD Order for [redacted] Checks was obtained for Resident # 22. Resident□s [redacted] check reports were requested from the [redacted] Office and filed in residents record. IDENTIFICATION OF OTHER RESIDENTS WHO ARE AT RISK BY DEFICIENT PRACTICE:	3/20/20

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

Electronically Signed | 03/08/2020

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F 658	Continued From page 1 health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey included, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 02/11/20 at 11:01 AM, during the initial tour of the facility, the surveyor observed Resident #22 seated in a wheelchair at the resident's bedside and was accompanied by his/her resident representative (RR). The RR stated that the resident was hospitalized in [redacted] and had a [redacted] inserted [redacted]). The RR stated that he/she conducted the [redacted] (a way for an [redacted] on the resident on the [redacted] each month in the resident's room. The RR showed the surveyor a device located on the resident's window sill. The RR stated the device was held to the resident's [redacted] and the device communicated the resident's [redacted] function directly to the cardiologist.	F 658	1) All residents who have [redacted] are at risk of being affected by this deficient practice. SYSTEMIC CHANGES: 1) Unit Managers will generate a list of resident s with [redacted] in each unit. The list will be updated by the Unit Manager or designee whenever there are changes; e.g. Admission/Readmission of a resident with a new pacemaker. 2) The medical records of all residents with [redacted] will be reviewed to ensure that proper MD orders for [redacted] are in place and the results are filed in the Medical Records. 3) All nurses were re-in-serviced on Facility□s Policy re: Caring for Residents with [redacted]. Emphasis was made in ensuring the presence of MD Orders for [redacted] and that the results of [redacted] are obtained and filed in each resident□s chart. MONITORING OF CORRECTIVE ACTIONS TO ENSURE COMPLIANCE: 1) Unit Manager or designee will audit the Medical Records of all Residents with [redacted] in their respective units on a MONTHLY basis x 6 months. Audit will include the following: ¿ Checking for the presence of MD Orders for [redacted] and ¿ Ensuring that [redacted] results are filed in the appropriate resident□s chart. Any issues identified will be rectified immediately. 2) Unit Managers will report the monthly	

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F 658	Continued From page 2 The surveyor reviewed the Admission Record (an admission summary) which indicated that Resident #22 had diagnoses which included the presence of a [redacted]. A review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated [redacted] revealed that the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident was [redacted]. A review of the resident's Care Plan (CP) revealed an entry dated [redacted], and revised on [redacted]. The entry detailed the resident had a [redacted] related to [redacted]. Further review of the CP revealed the resident required [redacted]. There were no specifics regarding the [redacted] documented in the CP. On 02/13/20, the surveyor reviewed Resident #22's medical record (MR) in the presence of the Unit Manager (UM #2) who stated that the resident's [redacted] was monitored at the [redacted] office and not at the facility. She further stated that she lost the phone number to the [redacted] office but wanted to phone the office for copies of the [redacted] results. Further review of the MR revealed a consult from the [redacted] office, dated [redacted] that specified the facility should call the office for results. The UM #2 stated she would follow-up as the RR scheduled all resident doctor's appointments and provided the resident with transportation to the appointments.	F 658	Audit results to the Director of Nursing and Administrator and will be presented in the QAPI Meeting on a quarterly basis.	

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F 658	Continued From page 3 On 02/18/20 at 9:04 AM, the surveyor interviewed Resident #22 who was seated in a wheelchair in the resident's room. A device was observed on the window sill and was plugged into a nearby electrical outlet. The device was stored inside a blue box that was labeled with the trade name of a [redacted] manufacturer. The resident stated that all the nurses were aware that he/she had the device and the RR provided all required care for the device which included phoning the doctor for the [redacted] function test. On 02/18/20 at 10:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that Resident #22 didn't have a [redacted] LPN #1 further stated that the RR was very involved with the resident and took the resident to all appointments. On 02/19/20 at 10:52 AM, the surveyor interviewed UM #2 who phoned the [redacted] office in the presence of the surveyor and obtained a [redacted] result that was conducted on [redacted] The UM #2 stated that she wasn't aware that the resident had a device at the facility that would read the [redacted], and that she observed the device in the resident's room for the first time that morning. UM #2 further stated that she became aware of the device when the Director of Nursing (DON) informed her of it that day. She then stated that the RR was trained by the [redacted] office to do the [redacted] tests and that he/she would come to the facility to do the tests. At that time, UM #2 also stated that the [redacted] tests were completed by the RR on the [redacted] each month. UM #2 stated that	F 658		

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F 658	Continued From page 4	F 658		

the resident's [redacted] was inserted on [redacted]. UM #2 provided the surveyor with a copy of the resident's Care Plan. The surveyor reviewed an entry that was initiated on [redacted] which specified [redacted]" and the entry was revised on [redacted]. UM #2 could not provide information regarding the [redacted] and prior to 0[redacted], there was no order for [redacted]. According to UM #2, normally, the process would have been to obtain an order for [redacted] when the [redacted] was initially inserted. UM #2 stated that she just thought that the [redacted] were being done at the [redacted] office during scheduled appointments and were managed by the RR.

A review of Resident #22's Order Summary Report, dated [redacted] revealed [redacted] at the [redacted] center, the RR sets up the appointment.

On 02/19/20 at 11:18 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) for a copy of Resident #22's discharge instructions from the hospital after the resident had the [redacted] inserted. The ADON stated that a readmission note, dated [redacted], did not mention the [redacted] placement. The facility was unable to provide the surveyor with documented evidence for physician's orders for the [redacted] and care of the [redacted].

On 02/19/20 at 12:02 PM, the surveyor interviewed the RR who stated that he/she was the resident's Power of Attorney and that he/she maintained responsibility for assisting Resident #22 to set up the [redacted]

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F 658	Continued From page 5 device around [redacted]. The RR stated that he/she was trained at the [redacted] office, which the resident visited every three months, and that the [redacted] were conducted by him/her at the facility on the [redacted] each month. The RR stated the cardiology office provided him/her with a check list to do the [redacted] and he/she did not alert the facility that he/she was performing the [redacted] On 02/19/20 at 1:53 PM, the surveyor interviewed UM #2 who stated that she spoke to the RR who stated that she did not have to worry about the [redacted] because she took care of it. UM #2 stated that she told the RR that the facility was responsible for the resident and the facility was required to remain informed about the resident's care. On 02/19/20 at 2:29 PM, the surveyor interviewed the DON who stated that the RR handled the [redacted] follow-up care and provided the resident's transportation. She further stated that there was no physician order in place for the RR to check the [redacted] at the facility. The DON stated the facility has not inspected the [redacted] device for electrical safety as required. The Regional Nurse stated that the monthly [redacted] conducted by the representative at the facility were considered a diagnostic test. She further stated that the existing order for [redacted] to check the [redacted] at office visits was not appropriate for the care and assistance that the resident received from his/her representative at the facility with the [redacted]. She	F 658		

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F 658	Continued From page 6 further explained that resident office visits were scheduled quarterly. The surveyor reviewed the facility policy, Care of a Resident with a [redacted], updated 10/2019, which revealed, under Monitoring, that the [redacted] will be monitored remotely through the telephone or an Internet connection. The resident's [redacted] will provide instructions on how and when to do this. The policy revealed, under Documentation, that for each resident with a [redacted], the following would be documented in the medical record: 1. The name, address, and telephone number of the [redacted] order for [redacted] type of [redacted]; and date last check was done. 2. When the [redacted] was monitored by the physician, document the date and results of the [redacted] surveillance, including: how the resident's [redacted] was monitored (phone, office, Internet); type of [redacted]; functioning of the [redacted]; frequency of utilization; and battery life. NJAC 8:39-11.2 (a), (d)	F 658		
F 684 SS=D	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	F 684		3/20/20

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F 684	Continued From page 7 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) notify the physician of an injury sustained by a resident, b.) obtain a physician's order for treatment, and c.) ensure a Registered Nurse assessed an injury sustained by a resident. This deficient practice was identified for Resident #27, 1 of 2 residents reviewed for pressure ulcers, and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Administrative Code, Title 13, Law and Public Safety, Chapter 37, New Jersey Board of Nursing, under 13:37-6.5 Non-Delegable Nursing Tasks, includes: "A registered professional nurse shall no delegate the physical, psychological, and social assessment of the patient, which requires professional nursing judgment, intervention, referral, or modification of care."	F 684	F684: Based on observation, interview, and record review, it was determined that the facility failed to: a.) notify the physician of an injury sustained by a resident, b.) obtain a physician's order for treatment, and c.) ensure a Registered Nurse assessed an injury sustained by a resident. PLAN OF CORRECTION: IMMEDIATE CORRECTIVE ACTIONS: 1) MD was made aware of the injury sustained to resident #27 and MD Orders for treatment were obtained, transcribed in the TAR and carried out by nursing staff. IDENTIFICATION OF OTHER RESIDENTS: 1) All residents can be affected by this deficient practice. SYSTEMIC CHANGES: 1) All nurses were re-in-serviced on Facility□s Policy and Protocol in Caring for Residents who sustain injuries. Focus of the Re-education was on the following points: a.) Physician Notification when a resident sustains an injury. b.) Obtaining a physician's order for appropriate treatment, if applicable. c.) Assessment of the resident□s injury by a Registered Nurse	

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F 684	Continued From page 8 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 02/11/20 at 9:31 AM, during the initial tour of the facility, the surveyor observed Resident #27 seated in a wheelchair next to the bedside inside the resident's room. The surveyor observed that the resident had a non-adherent (non-stick) dressing on the [redacted]. The non-adherent dressing was dated [redacted] and a band-aid was noted on the resident's [redacted]. At that time, the surveyor interviewed the resident who stated the injury occurred when he/she self-propelled the wheelchair passed the former roommates' bed and banged both [redacted] on his/her wheelchair which caused blood to squirt from the [redacted] During this observation, the surveyor observed a bed next to the entrance to the room that was placed laterally against the inside wall with an air mattress pump affixed to the foot of the bed, as was described by the resident. The resident stated that his/her former roommate's bed was not placed against the wall at the time of the injury and stated that the air mattress pump affixed to the foot of the bed made it difficult to pass by in his/her wheelchair. According to Resident #27's Admission Record	F 684	MONITORING OF CORRECTIVE ACTIONS: 1) Unit Managers or designee will conduct random audits of 2 incidents per unit per monthly X 3 months to ensure compliance with Physician Notification of any Injury; MD Orders for Treatments (if applicable) are obtained; and that assessment of resident□s injury was assessed by a Registered Nurse. 2) Audit Results will be reported to the Director of Nursing on a monthly basis and presented to the QAPI Committee on a quarterly basis.	

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F 684	Continued From page 9 (an admission summary), the resident's diagnoses included [redacted] A review of an Annual Minimum Data Set (MDS), an assessment tool used to facilitate resident care), dated [redacted], revealed the resident had a Brief Interview for Mental Status Score of [redacted] which indicated that the resident was [redacted] intact and was self-sufficient in wheelchair with locomotion on and off the unit with supervision of one person. Further review of the MDS revealed that the resident required extensive assistance of one staff member to transfer from a chair to a standing position and to walk within the room. On 02/12/20 at 12:08 PM, the surveyor interviewed Resident #27 who stated that on [redacted], the facility requested and obtained a written report from the resident that detailed how the resident's skin injuries occurred approximately two weeks prior. The surveyor observed a scabbed area on the resident's [redacted] that was previously covered with a band-aid and a non-adherent dressing on the [redacted] dated [redacted]. The surveyor reviewed a Progress Note (PN), dated [redacted] at 7:08 AM, which revealed that Licensed Practical Nurse (LPN #7) documented that Resident #27 had an opened [redacted]) noted to the [redacted] and the resident stated that he/she didn't know how it happened as the resident stated when he/she awoke it was already	F 684		

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F 684	Continued From page 10 there. LPN #7 initiated a [redacted] treatment with [redacted] ointment [redacted] was cleansed with [redacted]), then covered the area with a non-adherent dressing x 5 days. Further review of the PN revealed that there was no documented evidence that a Registered Nurse or the resident's Attending Physician or Nurse Practitioner was notified of the resident's injury. On 02/14/20 at 10:00 AM, the Assistant Director of Nursing (ADON) provided the surveyor with a narrative [redacted] incident report, initiated by Unit Manager #1 and dated [redacted] at 6:30 AM with a revision date of [redacted] at 6:38 PM, that pertained to Resident #27's injury. The nursing description portion of the [redacted] report revealed that the 11-7 Certified Nursing Assistant (CNA) called the Unit Nurse (LPN #7) and reported that the resident's [redacted] was bleeding. The Unit Nurse (LPN #7) assessed the resident and it appeared to be an open [redacted]. The resident description portion of the [redacted] report revealed that at the time of the incident, the resident was unable to recall what happened an upon investigation, the resident verbalized that he/she [redacted] on the resident's air mattress pump while trying to leave the room. The immediate action taken revealed that first aid was administered (site cleansed with [redacted] and a clean, dry dressing was applied) and the Medical Doctor (MD) and family were contacted. Treatment was initiated and the air mattress pump was moved. The agencies/people notified section revealed no notifications found. The document did not specify that [redacted] ointment was rendered during first aid treatment	F 684		

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F 684	Continued From page 11 as detailed within the PN and that the physician and family were notified. The document further revealed that there was no documentation that a RN assessed the resident's [redacted] A review of the February 2020 Treatment Administration Record (TAR) reflected an entry, dated [redacted]) Apply to [redacted] topically one time a day for open [redacted] days. Cleanse open [redacted], pat dry, apply [redacted] then cover with non-adherent dressing x [redacted] On 2/19/20 at 10:14 AM, the surveyor interviewed the Director of Nursing (DON) who stated that an assessment was required to be completed by a Registered Nurse. She further stated if it was a small [redacted], she trusted her LPNs to do an assessment but if it was a big one, they were required to call. The DON stated that she expected LPN #7 to initiate the treatment first and then call the doctor since the [redacted] ointment was available over the counter. The DON further stated that she would have to check the facility protocol to see if it was appropriate to place a [redacted] treatment order in the computer without first speaking with a physician and she was unable to furnish documented evidence that this was permissible. On 02/19/20 at 9:30 AM, the DON furnished the surveyor with a second handwritten Accident/Incident Report, dated [redacted] at 6:30 AM, that was completed by LPN #7. A review of the document revealed that LPN #7 did not document notification of Resident #27's attending	F 684		

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F 684	Continued From page 12	F 684		

physician or family representative of the resident's injury in the required fields on the report. Further review of the document indicated that LPN #7 applied [redacted] to the [redacted] and covered the area with a dressing.

On 02/19/20 at 9:57 AM, the surveyor interviewed LPN #7 in the presence of UM #1, DON, and survey team. LPN #7 stated that the CNA asked LPN #7 to check Resident #27's [redacted] because it was bleeding. LPN #7 checked the resident's [redacted] and observed a [redacted] on the resident's [redacted]. LPN #7 stated he applied [redacted] ointment to Resident #27's [redacted] without a physician's order because the [redacted] was considered house-stock and that was a nursing judgment. He further stated that at least he was able to initiate the treatment. LPN #7 stated that he then placed an order into the computer system for Resident #27's [redacted] treatment per house protocol without first notifying the physician or obtaining a physician's order.

During an interview with the surveyor on 02/19/20 at 10:03 AM, UM #1 stated that she obtained the 24-Hour Summary and there was a call out to the doctor. She further stated that the Advanced Practice Nurse was notified and believed that she came into the facility that day. UM #1 stated that she didn't document those interventions because she was very busy that day.

The surveyor reviewed the 24-Hour Summary, dated [redacted] at 7:08 AM, which detailed that Resident #27 had an open [redacted] noted to the [redacted]. The resident didn't know how it happened and stated that it was already there when he/she woke up. Treatment initiated with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	02/20/2020

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COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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F 684	Continued From page 13 [redacted] ointment post [redacted] cleans then cover with non-adherent dressing [redacted] days. A second entry was noted on the 24-Hour Summary, dated [redacted] at 1:00 PM, which indicated that the open [redacted] on Resident #27's [redacted] continued with treatment and the dressing was clean and dry. On 02/19/20 at 3:24 PM, the surveyor interviewed the Regional Nurse (RN) who stated that a skin assessment form was not completed on the date of the injury as required. She further stated that a RN was responsible to assess a skin injury in accordance with professional standards of practice but that was not specified within the facility policy. The RN stated that a RN or LPN Supervisor could assess a skin injury assessment performed by an LPN but that was not done as LPN #7 failed to notify the house supervisor at the time of the resident's injury. A review of the facility's Medication and Treatment Orders policy, updated 10/19, revealed that orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. NJAC 8:39-11.2(b)	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		3/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	02/20/2020

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COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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F 695	Continued From page 14 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility nursing staff failed to obtain a physician order for [redacted] This deficient practice occurred for 1 of 4 residents reviewed for respiratory care, Resident #291, and was evidenced by the following: During the initial tour of the subacute unit on 02/11/20 at 10:04 AM, the surveyor observed Resident #291 lying in bed, awake and alert. The resident wore a [redacted] that was connected to a [redacted] that was set at [redacted]). Resident #291 stated that he/she used [redacted] at home at [redacted]. On 02/12/20 at 11:06 AM, the surveyor observed Resident #291 lying in bed, awake and alert. The resident wore a [redacted] that was connected to an [redacted] that was set at [redacted]. The resident stated that at home he/she used [redacted] but could adjust to [redacted] if needed. The resident stated he/she did not change the [redacted] levels on the [redacted] while at the facility. According to the Admission Record (an	F 695	F695: Based on observation, interview, and record review, it was determined that the facility nursing staff failed to obtain a physician order for [redacted]. PLAN OF CORRECTION: IMMEDIATE CORRECTIVE ACTIONS: 1) MD order for [redacted] Use for Resident 291s was obtained and recorded in the resident□s Medical Records. IDENTIFICATION OF OTHER RESIDENTS: 1) All residents who use [redacted] are at risk of being affected by this deficient practice. SYSTEMIC CHANGES: 1) Unit Managers generated a list of residents who use [redacted] in each unit. The list will be reviewed and updated by the Unit Manager or designee on a weekly and PRN. 2) The medical records of all residents who use Oxygen were reviewed to ensure that proper MD orders for [redacted] Use were in place. 3) All nurses were re-in-serviced re: the need to obtain MD Orders for [redacted] Use	

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	315265	A. BUILDING _____ B. WING _____	02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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F 695	Continued From page 15 admission summary), Resident #291 was admitted to the facility with diagnoses that included [redacted]). A review of the most recent Minimum Data Set (an assessment tool), dated [redacted]0, revealed Resident #291 was [redacted]y intact, needed the assistance of one person for mobility and received [redacted] therapy. A review of progress notes, dated [redacted] through [redacted], revealed varied documentation of the [redacted] levels that were administered to Resident #291 which included the following: On 01/31/20 at 14:55 (2:55 PM), a Registered Nurse (RN #1) documented the resident was administered [redacted]. On 02/01/20 at 06:39 AM, a Licensed Practical Nurse (LPN #4) documented the resident was administered [redacted]. On 02/01/20 at 14:05 (2:05 PM), LPN #5 documented the resident was administered [redacted] On 02/09/20 at 18:14 (6:14 PM), RN #2 documented the resident was administered [redacted] On 02/12/20 at 15:01 (3:01 PM), LPN #6 documented the resident was administered [redacted]. On 02/14/20 at 11:12 AM, LPN #1 documented the resident was discharged to home on	F 695	when a resident requires it. MONITORING OF CORRECTIVE ACTIONS TO ENSURE COMPLIANCE: 1) Unit Manager or designee will audit the Medical Records of all Residents who use [redacted] on a MONTHLY basis x 6 months. Audit will focus on checking the presence of MD Orders for [redacted] Use. Any issues will be rectified immediately. 2) Unit Managers will report Audit results to the Director of Nursing and Administrator on a monthly basis and will be presented to the QAPI Committee on a quarterly basis x 6 months.	

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	315265	A. BUILDING _____ B. WING _____	02/20/2020

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COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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F 695	Continued From page 16 [redacted].	F 695		

During an interview on 02/14/20 at 11:48 AM, LPN #1 stated that Resident #291 was discharged home on [redacted]. LPN #1 stated that residents on [redacted] would have a physician's order (PO) in the Electronic Medical Administration Record (EMAR) for the amount of [redacted] to be [redacted] and the [redacted]. At that time, in the presence of the surveyor, LPN #1 was unable to locate a physician's order in the EMAR for Resident #291's [redacted]. LPN #1 stated that a physician's order for [redacted] was needed for a resident on [redacted]

A review of the Order Summary Report, dated [redacted] failed to [redacted] oxygen.

During an interview with the Director of Nursing (DON) on 02/18/20 at 2:15 PM, the DON stated when a resident was admitted on [redacted], a physician's order (PO) was entered into the computer, and the nurses would follow that order. The DON stated there should have been a PO for Resident #291's [redacted] because [redacted] was considered a medication.

During an interview on 02/20/20 at 8:30 AM, the Medical Director (MD) stated Resident #291 was dependent on [redacted] and [redacted] at home. The MD stated the resident's hospital transfer sheet indicated that Resident #291 was on [redacted] upon admission and the nurse must have skipped that order when the admission orders were entered into the computer. The MD further stated a physician order was needed for a resident who required [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	02/20/2020

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F 695	Continued From page 17 A review of the facility's [redacted] Administration policy, updated 10/2019, revealed under the preparation section, to verify that there was a physician's order for the [redacted] and review the physician's order or facility protocol for [redacted] administration. NJAC 8:39-27.1(a)	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		3/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	02/20/2020

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F 880	Continued From page 18 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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	315265	A. BUILDING _____ B. WING _____	02/20/2020

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F 880	Continued From page 19 Based on observation, interview, and record review, it was determined that the facility failed to maintain appropriate infection control practices for hand hygiene and cleaning equipment during [redacted] and [redacted] administration. This deficient practice was identified for 1 of 4 nurses observed on 1 of 3 units during the medication pass for Resident #27, 1 of 1 resident reviewed for [redacted] administration and was evidenced by the following: On 02/14/20 at 11:16 AM, in the presence of License Practical Nurse (LPN #3), the surveyor prepared to inspect Medication Cart #1 on the [redacted] . The surveyor observed Resident #27 seated in a wheelchair in the doorway to the resident's room, adjacent to the medication cart. Resident #27 requested that LPN #3 check his/her [redacted] and administer the scheduled [redacted] at that time, as the resident planned to go to lunch. LPN #3 removed a [redacted] from a clear plastic bag located inside the top drawer of the medication cart, and placed the [redacted] on top of the medication cart. She did not clean the [redacted] at that time. She obtained [redacted], alcohol prep pads and some tissues and entered the resident's room. LPN #3 placed the tissues on top of the resident's roommate's dresser as a barrier between the top of the dresser and the [redacted] supplies without first sanitizing the surface of the dresser. Without performing hand hygiene, LPN #3 applied gloves, cleansed Resident #27's [redacted] with an [redacted]	F 880	F880: Based on observation, interview, and record review, it was determined that the facility failed to maintain appropriate infection control practices for hand hygiene and cleaning equipment during [redacted] and [redacted] administration. PLAN OF CORRECTION: IMMEDIATE CORRECTIVE ACTIONS: 1) LPN#3 was immediately counseled re: Proper Infection Control Practices for Hand Hygiene and Cleaning equipment during [redacted] and [redacted] Administration. IDENTIFICATION OF OTHER RESIDENTS: 1) All residents are at risk of being affected by this deficient practice. SYSTEMIC CHANGES: 1) All nurses were re-in serviced on Proper Infection Control Practices for Hand Hygiene and Cleaning equipment during [redacted] and [redacted]. MONITORING OF CORRECTIVE ACTIONS: 1) Facility□s Infection Preventionist will conduct Skills/Competency Evaluations on Proper Hand Hygiene and Cleaning Equipment during [redacted] and [redacted] Administration on 3 nurses per month x 6 months. 2) Skills/Competency Evaluation Results will be reported to the Director of Nursing and Administrator on a monthly basis and	

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	315265	A. BUILDING _____ B. WING _____	02/20/2020

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COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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F 880	Continued From page 20 [redacted], and placed a [redacted] resident's [redacted] onto the [redacted] and then inserted the [redacted] into the [redacted] LPN #3 reviewed the [redacted] result displayed on the [redacted] and then discarded the [redacted] and [redacted] into the [redacted] container (hard plastic container used to [redacted] located on the side of the medication cart. The remainder of the supplies were discarded into the trash can located on the outside of the mediation cart. Without cleaning the [redacted], LPN #3 placed it back into the clear plastic bag, that was located on top of the medication cart, and then placed it back inside the medication cart drawer. She then removed her gloves, disposed of them in the trash can. LPN #3 did not perform hand hygiene. Without performing hand hygiene, LPN #3 accessed a computer that was located on top of the medication cart. She then removed a [redacted] and proceeded to withdraw the desired amount of [redacted] using an [redacted]. LPN #3 then applied gloves and administered the [redacted] to Resident #27 in the [redacted] area. After discarding the used [redacted] in the [redacted] container, LPN #3 then removed and disposed of her gloves. She utilized a hand wipe to cleanse her hands prior to charting the [redacted] administration into the computer. When interviewed at that time, LPN #3 stated that the [redacted] was cleaned after she utilized it last, and stated that was in the morning.	F 880	will be presented in the QAPI Meeting on a quarterly basis.	

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	315265	A. BUILDING _____ B. WING _____	02/20/2020

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COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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F 880	Continued From page 21	F 880		

She stated she was not required to clean it prior to each use. She further stated that she should have cleaned the [redacted] before she stored it away, and "that was my mistake." LPN #3 then proceeded to do the following: applied gloves, removed the [redacted] from the plastic bag, obtained a sanitizer cloth, and wiped the [redacted] three times on the front, back and tip [redacted] or [redacted]) of the [redacted]. She then placed the [redacted] back into the plastic bag immediately, and stated that the dry time for the [redacted] was 30 seconds. LPN #3 removed her gloves and cleansed her hands with hand sanitizer.

As the interview continued, LPN #3 stated that she had washed her hands prior to the surveyor's arrival, and obtained the needed supplies, applied gloves and checked Resident #27's [redacted]. She stated that she should have washed her hands after she obtained the resident's [redacted].

LPN #3 stated that her hands were clean and that was why she didn't wash her hands, but instead used a wipe to perform hand hygiene after the [redacted] was administered as handwashing was only required if hands were visibly soiled.

On 02/14/20 at 11:50 AM, the surveyor interviewed Unit Manager (UM #1) who stated that nursing was required to perform handwashing for 30 seconds, use hand sanitizer or hand wipes prior to gathering the supplies for [redacted] administration. UM #1 stated that the [redacted] should have been clean already when it was contained inside the plastic bag

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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F 880	Continued From page 22 located inside the medication cart. She further stated that the [redacted] should be wiped with a sanitizer wipe and allowed to dry for one minute prior to use. UM #1 stated if supplies were placed on the bedside table the surface should have been cleaned prior to placing the supplies on top of the tissue utilized as a barrier. UM #1 also stated that hand hygiene was required with hand sanitizer or wipes, prior to applying gloves and after glove removal. UM #1 stated that the nurse was required to apply gloves and wipe down the [redacted] and allow it to dry. Gloves were then to be removed prior to using the computer. On 02/18/20 at 3:06 PM, the surveyor interviewed the Director of Nursing (DON) who stated that an in-service on [redacted] monitoring was provided to nursing staff approximately three weeks ago. She further stated that in order to disinfect the [redacted], the staff were required to wipe the front and back of the [redacted] with an approved sanitizer wipe. After the [redacted] was wiped with the sanitizer, it should sit and dry for two minutes. On 02/19/20 at 3:08 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who served as the facility's infection preventionist. The ADON stated that nursing should dispose of both [redacted] and [redacted] inside the [redacted] containers located on the medication carts. She further stated that if nursing disposed of discarded [redacted] or [redacted] inside the trash cans located inside the resident's rooms, it could pose a risk of [redacted] exposure to both confused residents and or unknowing staff members. The ADON stated that the facility always required that [redacted] and [redacted] to be	F 880		

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COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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F 880	Continued From page 23 discarded into the [redacted] container. The ADON stated that handwashing was required before all procedures and after glove removal. The ADON stated that disinfectant wipes were used to clean the [redacted] and could not recall the drying time required before the [redacted] was placed in a plastic bag for storage. The surveyor reviewed the facility's [redacted]) policy, revised 10/2019, which revealed to always ensure that [redacted] intended for reuse were cleaned and disinfected between resident uses and handle the [redacted] as a used [redacted]. The procedure steps included the following: Wash hands. Don (apply) gloves. Place [redacted] monitoring device on clean field. Place a new [redacted] and disposable platform on the spring-loaded [redacted] device. Wipe the area to be [redacted] with an alcohol wipes [sic.]. Obtain the [redacted] sample, following the manufacturer's instruction for the device. Discard [redacted] and platform into the [redacted] container. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts and/or devices after each use. Remove gloves, and discard into receptacle. Wash hands. Replace [redacted] monitoring device in storage area after cleaning. Review of the facility's undated "Cleaning and Disinfecting the [redacted]" policy revealed to always ensure that [redacted] intended for reuse were cleaned and disinfected between resident uses. The [redacted] Monitoring System may only be used for testing multiple patients when standard precautions and the	F 880		

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	315265	A. BUILDING _____ B. WING _____	02/20/2020

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F 880	Continued From page 24 manufacturer's disinfection procedures were followed. The policy included: Cleaning: Wear appropriate protective gear such as disposable gloves. Open the towelette container and pull out one towelette and close the lid. Wipe the entire surface of the [redacted] 3 times horizontally and 3 times vertically using 1 towelette to clean blood and other body fluids. Dispose of the used towelette in a trash bin. Disinfecting: The [redacted] should be cleaned prior to disinfection. Open the towelette container and pull out one towelette and close the lid. Wipe the entire surface of the meter three (3) times horizontally and 3 times vertically to remove blood-borne pathogens. Dispose of the used towelette in a trash bin. Allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth. Disinfectant Brand Name [redacted]. After disinfection, the user's gloves should be removed and thrown away. Wash hands before proceeding to the next patient. Review of the facility's Handwashing/Hand Hygiene Policy, updated 10/2019, revealed to wash hands with soap (antimicrobial or non-antimicrobial) and water when hands were visibly soiled. Use an alcohol based hand rub containing at least 62% alcohol; or soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents; before preparing or handling medications; after contact with a resident's intact skin; after contact with blood and body fluids; and after removing gloves.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 25 NJAC 8:39-19.4(a) (1) and 27.1(a)	F 880		