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 _____	C 07/16/2021

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 Complaints #: NJ142041 and NJ142281 Census: 125 Sample Size: 7 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ142281 Based on interviews and record reviews, it was determined that the facility failed to implement a resident-directed treatment consistent with physician orders, as evidenced by the facility's failure to ensure a physician's order for a [redacted] care consult was implemented for 1 resident (Resident [redacted] of 3 residents reviewed for physician orders. Findings included: 1. Resident [redacted] admitted to the facility on [redacted] for [redacted] after a	F 684	"This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law" F-684: Quality of Care CFR(s): 483.25 Corrective Actions Accomplished for	9/10/21

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

Electronically Signed | 08/25/2021

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F 684	Continued From page 1 hospital stay to treat [redacted] ([redacted] On [redacted], the resident discharged to home with [redacted]. Resident [redacted] had diagnoses including [redacted], [redacted] The admission Minimum Data Set (MDS), dated [redacted] revealed the resident's Brief Interview for Mental Status (BIMS) score was [redacted] which indicated the resident was [redacted]. The resident required extensive assistance with all activities of daily living (ADLs) except for eating, which required limited assistance. A review of Resident [redacted]s medical record indicated the resident admitted to the facility with [redacted]. A review of medical records indicated the resident received [redacted]" medication. A physician's order dated [redacted] indicated a [redacted] consultation was ordered to occur every Tuesday morning for "prophylactic [preventive]" measures. The physician's order indicated wound consultation visits were expected for [redacted]. A nurse's progress note dated [redacted] at 1:26 AM indicated Resident [redacted] had [redacted] which had been entered into the "consult" book. A review of records revealed a [redacted] consultation was not completed for Resident [redacted].	F 684	Residents found to be affected by the Deficient Practice: ¿ Residents #[redacted] was already discharged from the facility when the deficient practice was identified. Identifying other Residents who have the Potential to be affected by the Deficient Practice: ¿ A list of all residents with wounds was generated by the Unit Managers, based on review of the TARs/ MARs. The medical records of these residents were reviewed to ensure that any physician's order s for [redacted] care consults were implemented. Review results revealed that all physician's order s for [redacted] care consults were implemented properly. Measures or Systemic Changes to ensure that the Deficiencies will not Recur: ¿ All licensed nurses were in-serviced on facility's policy regarding implementation of resident-directed treatments, consistent with physician orders. Emphasis was made on ensuring that physician orders for [redacted] care consults are implemented properly. Monitoring the Continued Effectiveness of Corrective Actions: ¿ Unit Managers will conduct random chart audits of 3 residents with [redacted] to ensure that physician orders for [redacted] care consults are implemented properly. This will be done weekly x 1 month, then monthly x 6 months thereafter. ¿ Audit results will be submitted to the QAPI Committee monthly and will be	

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F 684	Continued From page 2 On 07/16/2021 at 1:46 PM, Medical Doctor (MD) #6 stated that Resident [redacted] was admitted to the facility after receiving care for [redacted] and [redacted] at a local hospital. MD #6 stated that because medications were failing to control the resident's [redacted], a special[redacted]" was applied to the resident's [redacted] while in the hospital to "[redacted] back into the resident's body. MD #6 stated the resident discharged from the hospital to the facility with no orders regarding the[redacted]. MD #6 stated the[redacted] were not to be removed by nursing staff. MD #6 stated the[redacted] should have been managed by a [redacted] specialist, and he had placed an order for a [redacted] consultation. MD #6 stated it was a mistake that the [redacted] specialist did not consult on the[redacted]; however, MD #6 stated the mistake was not "detrimental" to the resident. On 07/16/2020 at 2:35 PM, the Administrator (ADM) stated the QAPI (Quality Assurance and Performance Improvement) process was initiated upon learning of the failure to manage Resident [redacted]. On 07/16/2021 at 2:44 PM, the Director of Nursing (DON) stated that at the time Resident [redacted] was in the facility, the process was that a [redacted] consult order would be entered into a "[redacted]." The DON stated the consultant would then refer to the "[redacted]" to determine the residents that needed a [redacted] consultation. The DON stated that in this case, the [redacted] consultant overlooked Resident [redacted] name, and the resident was not seen by the [redacted] consultant. The DON was unsure when the facility became aware of the oversight but stated an investigation was started upon learning of the oversight. The DON stated the facility also	F 684	reassessed for further action to ensure on-going compliance.	

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F 684	Continued From page 3 changed the [redacted] consultant group they used. During the survey, two attempts were made to contact the [redacted] company and [redacted] nurse who cared for Resident [redacted] once they discharged to home; however, these attempts were unsuccessful. New Jersey Administrative Code § 8:39-27.1(a)	F 684		