STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING _____ B. WING _____	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
COMPLETE CARE AT ARBORS	1750 ROUTE 37 WEST TOMS RIVER, NJ 08757

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F 000	INITIAL COMMENTS Survey CENSUS: 74 SAMPLE: 19+2 closed 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure the the call bell was within reach of the residents. The deficient practice was identified for 4 of 7 residents (Residents #63, Resident #28, Resident #11, and Resident #70) reviewed for the Environmental Task. The deficient practice was evidenced by the following: On 4/20/22 at 10:08 AM during the initial tour, surveyor #1 observed Resident #63 lying in bed. At that time, the surveyor observed the call bell on the ground behind the bed headboard out of reach from the resident.	F 558	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Upon notification of the deficient practice, the call bells of Resident #63, Resident #28, Resident #11 and Resident #70 were repositioned to ensure that they were within reach of the residents. There were no negative outcomes identified from the deficient practice. ¿ The Nursing Staff assigned to Residents #63, #28, #11 and #70 were counseled and re-in-serviced re: Facility□s Policy related to Call Lights, with emphasis on the procedure to Always	6/24/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/27/2022

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F 558	Continued From page 1 On 4/20/22 at 10:37 AM during the initial tour, surveyor #1 observed Resident #28 lying in bed. At that time the surveyor observed the call bell behind the bed headboard out of reach from the resident. On the same date and time, surveyor #1 observed Resident #11 lying in bed. At that time, the surveyor on observed the resident's call bell attached to the call bell wall input out of reach from the resident. On 4/21/22 at 12:02 PM, surveyor #2 observed Resident #70's call bell on the floor under the bed. On 4/22/22 at 11:46 AM, surveyor #2 observed Resident #70's call bell on the floor behind the headboard of the bed. On 4/25/22 at 11:16 AM, surveyor #2 observed Resident #70's call bell hanging over the top of the NJ Exec. Order 26:4.b.1. During an interview with the surveyor on 4/27/22 at 9:41 AM, the Charge Nurse said that when the staff provided care to Resident #63 and Resident #11, they forgot to attach the call bells in reach of the residents. During an interview with the surveyor on the same date at 9:46 AM, the Certified Nursing Assistant assigned to Resident #63 and Resident #11 said she did not touch the call bells yet. A review of the facility policy titled, "Call Lights" updated 1/2022, revealed under, "Procedures" number 6., "Always position call light conveniently for use and within the reach of the resident."	F 558	position call light conveniently for use and within the reach of the resident. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by the same deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ All Staff were re-in-serviced regarding Facility□s Policy related to Call Lights and ensuring that call bells are positioned conveniently for use and within the reach of each resident. Inservice training will continue to be provided during orientation of all new staff. IV. MONITORING OF CORRECTIVE ACTIONS ¿ The Unit Managers or designees will conduct observation audits on 5 residents per unit per week x 4 weeks, then monthly x 6 months thereafter, to ensure that call bell are positioned within reach of the residents. ¿ Any issues will be rectified immediately and reported to the Director of Nursing ¿ Audit Findings will be submitted to the QAPI Committee monthly and will be	

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F 558	Continued From page 2 NJAC 8:39-31.8(c)	F 558	incorporated in the Facility QAPI Program x 6 months for on-going compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	F 584		6/24/22

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F 584	Continued From page 3 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure equipment was in good repair by A.) providing fall mats (safety mats that are placed on the floor along the side of the bed) that had rips along the seams exposing the foam interior and B.) failed to ensure medication carts and Emergency carts were free of dust and debris on the wheels and shelves. The deficient practice was identified for 2 out of 7 residents (Residents #63 and #73), 3 medication carts, and 2 emergency carts reviewed for the Environmental Task. The deficient practice was evidenced by the following: On 4/20/22 at 10:09 AM during the initial tour of the facility, surveyor #1 observed Resident #63 in bed. At this time, the surveyor observed a [EX Order 26 § 4b] next to Resident #63's bed. The [EX Order 26 § 4b] had a rip along the seam exposing the foam interior. On the other side of the bed was another [EX Order 26 § 4b]. Surveyor #1 observed dried, yellow matter and stains on the surface of the [EX Ord]. On 4/28/22 at 10:04 AM, surveyor #1 observed Resident #73 in bed. At this time, the surveyor observed a [EX Order 26 § 4b] next to Resident #73's bed. The [NJ Exec. Order 26] had a rip along the seam exposing the foam interior.	F 584	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The [NJ Exec. Order 26:4.b.1] for Resident #63 and Resident #73 were replaced with new [NJ Exec. Order 26:4.b.1] ¿ The 3 Medication Carts (Medication Carts #3 and #4 on Rosewood Unit and Medication Cart #2 on the Evergreen Unit) were immediately checked and cleaned by the Housekeeping Department and Maintenance staff to ensure that they were free of dust and debris on the wheels. The Emergency Carts on the Evergreen Unit and Rosewood Unit were immediately cleaned by the Housekeeping Department to ensure that the shelves were free of dust and debris. ¿ The Nursing Staff, Housekeeping and Maintenance Staff were in-serviced regarding ensuring that the Medication Carts and Emergency Carts are clean and free of dust and debris on the wheels and shelves. There were no negative outcomes	

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F 584	Continued From page 4 On the same date at 10:07 AM, surveyor #1 observed Resident #63 in bed. The [EX Order 26 S 4b] was folded against the wall. The [EX Order 26 S 4b] had ripped corners and a piece of the exterior partially detached from the fabric surface. During an interview with the surveyor on 4/28/22 at 12:47 PM, the Director of Nursing said there is no facility policy on broken equipment. During an interview with the surveyor on 4/28/22 at 1:32 PM, the Administrator confirmed that [NJ Exec] [EX Order 26] should not have rips and should not be folded against the wall when a resident is in bed. A review of facility policy titled, "Falls and Fall Risk, Managing" updated on 10/2019 did not specifically address fall mats. B.) On 04/22/22 at 11:11 AM, surveyor #2 observed the following: 1. Medication cart #3 on Rosewood Unit had hair and thread/fabric strands wrapped around the wheels of the cart 2. Medication cart #4 on Rosewood Unit had hair and thread/fabric wrapped around the wheels of the cart. 3. Medication cart #2 on the Evergreen Unit had hair and thread/fabric wrapped around the wheels. 4. The Emergency Cart on the Evergreen Unit had an accumulation of dust on the second shelf support bracket. There was also as debris accumulated in the corner of the 2nd shelf. 5. The Emergency Cart on the Rosewood Unit had with debris and brown stain on top shelf and accumulation of dust debris on support brace on	F 584	identified from the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by the same deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ All Nursing, Housekeeping and Maintenance personnel were in-serviced on ensuring that all equipment and devices are in good repair, specifically: (a) Ensure that NJ Exec. Order 26:4.b.1 that are placed on the floor along the side of the bed) provided to appropriate residents are clean, intact and do not have rips; and (b) Ensure that medication carts and Emergency carts are free of dust and debris on the wheels and shelves. IV. MONITORING OF CORRECTIVE ACTIONS ¿ The Unit Managers or designee will conduct observation audits of all [NJ Exec. Orde] [NJ Exec. Orde] in each unit once a week x 4 weeks; then monthly x 3 months thereafter, to ensure that [NJ Exec. Order 26:4.b.1] provided to appropriate residents are clean, intact and do not have rips. ¿ The Director of Environmental Services or designee will conduct	

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F 584	Continued From page 5 the 2nd shelf. During an interview with the surveyor on 04/28/22 at 1:42 PM, the Administrator said that absolutely the Emergency Carts should be cleaned by housekeeping. She also said they were looking to get new carts. The Administrator went on to say that Housekeeping cleans outside of medication carts and maintenance periodically looks at the wheels for anything stuck and are on a cleaning schedule. NJAC 8:39-31.4(a)	F 584	observation audits of all Medication Carts and Emergency Carts in the Units weekly x 4 weeks, then monthly x 3 months thereafter, to ensure that they are clean, free of dust and debris on the wheels and shelves. ¿ Any issues will be rectified immediately and reported to the Administrator. Audit Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program x 3 months for on-going compliance.	
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 maintain professional standards of nursing practice by not following a physician's order for 1 of 19 sampled residents, (Resident #52). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of	F 658	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Upon notification of the deficient practice, Resident #52 was referred to the NJ Exec. Order 26:4.b.1 to comply with Physician□s Order. Resident was NJ Exec. Order 26:4.b.1 and started on NJ Exec. Order 26:4.b.1 , in accordance with Physician□s Order.	6/24/22

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F 658	Continued From page 6 casefinding; 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." According to the admission record, Resident #52 was admitted to the facility with diagnoses including, but not limited to, EX Order 26 § 4b1 [redacted]. A review of the most recent Minimum Data Set (MDS) an assessment tool, dated 3/1/2022, identified the resident as having a Brief Interview for Mental Status of [redacted]/15, indicating that the resident EX Order 26 § 4b1 . During an interview with the surveyor on 4/25/2022 at 11:24 AM, Resident #52 revealed that they were to NJ Exec. Order 26:4.b.1 however, the resident voiced, "I don't want to do it without anyone there. No one comes in to watch me". A review of the resident's physician orders, revealed an order dated 3/31/2022 at 1:33 PM, may NJ Exec. Order 26:4.b.1 [redacted] on 4/14/22 and NJ Exec. Order 26:4.b.1 [redacted]. A review of Resident #52's care plan, medication administration record (MAR), and treatment administration record (TAR) did not include the physician's order for the NJ Exec. Order 26:4.b.1 [redacted]. During an interview with the surveyor on	F 658	There were no negative outcomes noted on Resident #52 as a result of the deficient practice. ¿ Involved Nurses were counseled and in-serviced regarding the importance of following physician□s orders and in double-checking to make sure that physician□s orders are carried out as prescribed. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents who have Physician□s Orders have the potential to be affected by the same deficient practice. Unit Managers generated a list of Physician□s Orders in the past month to ensure that no other residents were affected the same deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ All Nurses were in-serviced on the professional standards of nursing practice regarding the need to follow physician's orders. Emphasized the need for them to follow facility□s system in ensuring that Physician□s Orders are followed, transcribed or documented in the Medical Record, and carried out accordingly. Any non-compliance may lead to disciplinary action.	

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F 658	Continued From page 7 04/25/2022 at 1:35 PM, the Rehabilitation Director (RD) said they are made aware of potential for therapy services by nursing. When asked if Resident #52 is currently receiving services, the RD said they are NJ Exec. Order 26:4.b.1 [redacted] During an interview with the surveyor on 4/25/2022 at 1:55 PM, Unit Manager #1 (UM #1) stated for therapy consultations they (the nurses) will complete a paper therapy screen or therapy will initiate therapy, "through an electronic task". The Surveyor asked how therapy is initiated upon direct request from a physician and UM #1 responded, "Honestly, I have to ask. I don't know if I ever had that happen". The Surveyor requested UM #1 to review physician order dated 3/31/22 at 1:33 PM UM #1 confirmed therapy "should have received the order". UM #1 also confirmed that nursing is responsible to ensure orders are fulfilled. During an interview with the surveyor on 4/28/2022 at 12:41 PM, the Director of Nursing (DON) said there are no policies in place for reconciliation of physician's orders. The DON explained the procedure is 11pm to 7am staff "will print out the orders from the day and given to the unit managers in the AM. The unit manager will then review the orders to make sure they are all completed". NJAC 8:39-11.2(B)	F 658	IV. MONITORING OF CORRECTIVE ACTIONS ¿ The Unit Managers or designee will conduct Medical Record Review audits of 3 residents per Unit per week x 4 weeks; then monthly x 3 months thereafter, to ensure that new Physician□s Orders in the past month are followed and carried out, as prescribed by MD. ¿ Any identified issues will be rectified immediately and reported to the Director of Nursing. Audit Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program x 3 months for on-going compliance.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		6/24/22

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F 759	Continued From page 8 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure that it was free of a medication error rate of five percent or greater by failing to ensure three medications were given within sixty minutes before or after the scheduled administration time. The deficient practice was observed for 1 of 7 residents (Resident #5) during the Medication Administration Task. The deficient practice was evidenced by the following: On 4/25/22 at 9:34 AM on the Rosewood Unit, the surveyor observed Licensed Practical Nurse (LPN) #1 prepare Resident #5's medication for administration. At that time, LPN #1, removed one EX Order 26 § 4b1 EX Order 26 § 4b1 and place them in the medication cup. At that time, the surveyor observed the Electronic Medical Administration Record (EMAR) on the medication cart computer with LPN #1. The EX Order 26 § 4b1 AM. LPN #1 then crushed the medications and	F 759	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ LPN #1 was counseled and in-serviced regarding Facility Policy related to "Proper Medication Administration. Emphasized that medications must be administered within one (1) hour of their prescribed time, unless otherwise specified. Resident #5 has not been adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents with medications have the potential to be affected by the same deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ All Nurses were in-serviced on the Standards of Practice and Facility Policy related to "Proper Medication Administration. Emphasized that	

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F 759	Continued From page 9 added pudding to the medication cup. During an interview with the surveyor at that time, LPN #1 revealed that she started her shift at 8:00 AM after acknowledging the scheduled medication times. LPN #1 then entered the resident room and NJ Exec. Order 26:4.b.1 [redacted] During an interview with the surveyor on 4/28/22 at 1:32 PM, the Director of Nursing (DON) confirmed that the EX Order 26 § 4b1 [redacted] were given outside of the administration time. A review of the EMAR "Administration History" revealed that the EX Order 26 § 4b1 was scheduled for 7:30 AM and the administration was documented on 4/27/22 at 9:37 AM. The EMAR "Administration History" further revealed that the EX Order 26 § 4b1 [redacted] were both scheduled for 8:00 AM and the administration was documented on 4/27/22 at 9:37 AM. A review of a facility policy titled, "Administering Medications", updated on 10/2021, revealed under "Policy Interpretation and Implementation" number 3., "Medication must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)." The policy further revealed under number 5., "The individual administering the medication must check the label against the Physician's order to verify the right resident, right medication, right dosage, right time..." N.J.A.C.8:39-29.2(d)	F 759	medications must be administered within one (1) hour of their prescribed time, unless otherwise specified. IV. MONITORING OF CORRECTIVE ACTIONS ¿ The Pharmacy Consultant or designee will conduct Observation of Medication Administration Audits on 2 nurses weekly x 1 month, and monthly thereafter x 6 months. Results of Med Pass Observations will be reported to the Director of Nursing and Administrator on a monthly basis and reported in the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and or/action plans.	

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F 812	Continued From page 10	F 812		
F 812 SS=D	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 other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 4/25/2022, at 3:15 PM, the Surveyor observed the following in the Rosewood Nourishment Room: 1. On the refrigerator door, located on the bottom shelf, one opened 24 ounce (oz) jar of kosher pickles was observed with resident's name and	F 812	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The refrigerator in the Rosewood Nourishment Room was immediately cleaned by the Food Service Department. All opened food containers and supplements were discarded. ¿ The Coffee machine and Juice Machine were immediately cleaned by Housekeeping.	6/24/22

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F 812	Continued From page 11 room number identified on lid. No "use by" date observed. Located on the same shelf, one opened 8 oz jar of sliced olives with resident's name and room number. No "use by" date observed. Throughout the bottom of the shelf, dried liquid was observed. 2. On the refrigerator door, located in the beverage hold, one TwoCal HN 8 oz Vanilla Carton, opened with no date identified, and One Lyons Ready Care 8 oz carton, opened with no date identified. 3. On the bottom of the refrigerator, located under the crisper bins, of dried liquid was observed. 4. Coffee machine was observed to have coffee splatter behind dispensers. The grate above the drainage area was observed to have dried coffee residue. 5. Juice machine was observed to have spatter behind the dispensers and significant amount of thickened juice under the grate in the drain area. 6. Located in the top left cabinet, 4 individual (Name) cereal containers with expiration date of 2/10/2022. In the same area, 4 individual (Name) cereal containers with expiration date of 4/3/2022. During an interview with the surveyor on 4/26/2022 at 3:33 PM, the Food Service Director (FSD) confirmed the opened items are to be dated and contents are to be used within three days. The FSD advised that Food Services are responsible for the maintenance, cleaning, and inspection of cabinets and refrigerator. The FSD further stated that "housekeeping or nursing" is responsible for the juice machine.	F 812	¿ All expired cereals were immediately discarded. ¿ The Nursing and Housekeeping Staff in the Rosewood Unit, and Food Service Department personnel were in-serviced on the importance of discarding potentially hazardous food and in maintaining sanitation in a safe and consistent manner to prevent food borne illness. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents with who can eat food and drink fluids have the potential to be affected by the same deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ All Nursing Staff, Housekeeping Staff and Food Service /Dietary staff were in-serviced on the following: (a) Handling of potentially hazardous food; (b) Maintaining sanitation in a safe and consistent manner to prevent food borne illness; (c) Review of each Department□s assignments and responsibilities in cleaning appliances in the Nourishment Rooms. IV. MONITORING OF CORRECTIVE ACTIONS	

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F 812	Continued From page 12 The FSD confirmed the following: 1. Ready Mildly Thickened Lemon Flavored was opened and was undated and should be dated. 2. Ready Moderately Thickened Lemon Flavored that was opened with date of 4/20/2022. The FSD said should be discarded since it was opened for more than three days. 3. Opened jar of kosher pickles should be discarded as it does not have an opened date. 4. Opened jar of sliced olives should be discarded as it does not have an opened date. 5. TwoCal HN 8oz Vanilla, should be discarded as it does not have an opened date. 6. Ready Care 8oz, should be discarded as it does not have an opened date. A review of a facility policy titled Foods Brought by Family/Visitors, version 2.0, revealed the following under Policy Statement; 7b. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. 8. The nursing staff will discard perishable foods on or before the "use by" date. 9. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger "for example, mold growth, foul odor, past due package expiration dates). During an interview with the surveyor on 4/28/2022, at 1:45 PM, the Administration and Director of Nursing (DON) confirmed that housekeeping is responsible for cleaning the coffee or juice machine. NJAC 8:39-17.2(g)	F 812	¿ The Unit Manager or Designee will conduct observation audits of each Unit□s Nourishment Room once a week x 4 weeks, then monthly thereafter x 6 months. Audit will focus on the proper handling/disposal of potentially hazardous food and Maintaining sanitation in a safe and consistent manner to prevent food borne illness ¿ Any identified issues will be rectified immediately and reported to the Administrator. Audit Findings will be submitted to the QAPI Committee monthly for trending and will be incorporated in the Facility QAPI Program x 6 months to ensure on-going compliance.	

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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: (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:	F 880		6/28/22

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F 880	Continued From page 14 (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: Based on observation, interview, record review and other pertinent facility documents, it was determined that the facility failed to ensure that A.) staff implemented appropriate hand hygiene after direct patient care by not performing hand hygiene for a minimum of 20 seconds, B.) failed to ensure medical waste was properly disposed of by staff leaving a NJ Exec. Order 26:4.b.1 on a resident's (Resident #426) bedside table and C.) failed to ensure a NJ Exec. Order 26:4.b.1 was properly cleaned for reuse according to the	F 880	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ LPN #2 was immediately counseled and in-serviced on Proper Hand Hygiene. Infection Preventionist conducted an Observation Audit on LPN #2 to verify her competency in performing Proper Hand Hygiene. ¿ LPN #2 was educated regarding the	

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F 880	Continued From page 15 manufacturer's instructions. The deficient practice was identified for two residents (Resident #374 and Resident #426) during the Medication Administration Task and 1 of 2 residents (Resident #46) investigated for EX Order 26 § 4b1. The deficient practice was evidenced by the following: A.) On 4/25/22 at 8:28 AM, after medication was administered to Resident #374, surveyor #1 observed Licensed Practice Nurse (LPN) #2 prepare to perform hand hygiene using soap and water in the resident room bathroom. At that time, surveyor #1 started an electronic timer to verify that a minimum of 20 seconds was used to lather the hands with soap, prior to rinsing. LPN #2 began to rinse her hands with water at 14 seconds. On the same date at 9:13 AM, LPN #2 removed her gloves and prepared to perform hand hygiene using soap and water in the resident room bathroom. At that time, surveyor #1 started an electronic timer to verify that a minimum of 20 seconds was used to lather the hands with soap, prior to rinsing. LPN #2 began to rinse soap off her hands at 2 seconds. The handwashing process performed including lathering with soap and rinsing totaled 17 seconds. B.) On 4/25/22 at 9:21 AM, in Resident #426's room, surveyor #1 observed a NJ Exec. Order 26:4.b.1 on the bedside table adjacent to hard candies. The NJ Exec. Order contained NJ Exec. Order 26:4.b.1. After administering medication to Resident #426, LPN #2 disposed of the NJ Exec. Order 26:4.b.1	F 880	proper disposal of a used Jackson-Pratt drain, which is considered medical waste, so it should be disposed off in a red bag. Nurse placed it in a clear plastic bag that she tied then discarded in the resident□s trash can next to the resident□s bed. The medical waste was subsequently discarded in a Red Bag. ¿ Nursing Staff were in-serviced on the proper cleaning of a urinary drainage leg bag for reuse according to the manufacturer's instructions. No residents were adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by deficient practices related to Infection Control. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ All Nursing Staff were in-serviced on the following: (a) Proper Hand Hygiene; (b) Proper Disposal of medical waste; and (c) Proper cleaning of a urinary drainage leg bag for reuse according to the manufacturer's instructions. ¿ DPOC (DIRECTED PLAN OF CORRECTION): Under the guidance of the Infection Prevention and Control Officer, and in collaboration with the IP, Medical Director, Governing Body and the QAPI committee, the following were	

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F 880	Continued From page 16 LPN #2 tied the bag and placed it into the resident's trash can next to the bed. During an interview with surveyor #1 on 4/25/22 at 9:25 AM, LPN #2 said during hand hygiene she counts a full thirty seconds and then rinses her hands in water. During an interview with surveyor #1 on 4/26/22 at 12:14, the Infection Prevention Nurse (IPN) said leaving the NJ Exec. Order 26:4.b.1 on the bedside table was incorrect and considered NJ Exec. Order 26:4.b.1 A review of a facility policy titled, "Handwashing/Hand Hygiene" revised on 1/2019, revealed under "Policy Interpretation and Implementation" subsection, "Washing Hands" number 1., "Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds." A review of a facility policy titled, "Waste Disposal" revised on 1/2019 revealed under "Policy Interpretation and Implementation" number 1, subsection "b." revealed, "Disposal of all infectious and regulated waste shall be in accordance with applicable federal, state, and local regulations. C.) According to electronic medical records, Resident #46 had a medical history consisting of, but not limited to, EX Order 26 § 4b1 [redacted].	F 880	completed and/or updated: o A Root Cause Analysis was completed by the QAPI Committee, which included the following reasons on why the deficiency occurred. The nurses were nervous and lacked understanding/knowledge regarding disposal and cleaning of these specific medical supplies. o An Infection Prevention and Intervention Plan has been implemented based on the findings of the Root-Cause Analysis. This was incorporated in the QAPI Program with Corrective Actions and a PIP (Performance Improvement Plan) to ensure on-going compliance. This was discussed in the QAPI Meeting on June 13, 2022 and updated on June 17, 2021. The facility□s Long-Term Care Infection Control Self-Assessment was updated to reflect the status of the facility. ¿ The Directed In-Service Training Programs have been initiated and will be completed as directed by the NJ-Department of Health. Education will be on-going with all new hires. The In-Service Trainings include the following: o Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist o CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out!	

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F 880	Continued From page 17 On 4/25/2011 at 12:23 PM, surveyor #2 observed the Resident #46 in the dining room independently eating lunch. Resident #46 was dressed in sweatpants and a NJ Exec. Order 26:4. was not visible; however, the sweatpants had no wetness or soilage observed. During an interview with surveyor #2 on 4/26/2022 at 11:14 AM, Licensed Practical Nurse #3 (LPN) confirmed that Resident #46 had physician's orders for a NJ Exec. Order 26:4 during the day and NJ Exec. Order 26:4.b.1 at night. LPN #3 stated that the policy is for the NJ Exec. Order 26:4. to be changed once weekly but can be changed as needed if soiled and/or malfunction. On 4/27/2022 at 11:32 AM, surveyor #2 obtained an unopened facility leg bag package. Surveyor #2 reviewed the manufacturer instructions which revealed under number 4, "To keep leg bag clean, rinse daily with 3 parts water and two parts white vinegar when not in use". During an interview with surveyor #2 on 4/27/2022 at 1:08 PM, the Director of Nursing (DON) was questioned about cleaning the leg bag. The DON responded, "They can rinse the bag and ensure to clean the tip". Surveyor #2 asked if the bag is cleaned with product and the DON said no. Surveyor #2 requested that DON read #4 of the Manufacturer Instructions. Upon reading the instructions, the DON stated, "I see what you are saying". When asked if the facility is following the Manufacturer Instructions, the DON responded, "As you can see with me just reading it, I was unaware. I have always just rinsed it". A review of a facility policies titled Urinary Leg	F 880	https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff o CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces https://youtu.be/t7OH8ORr5Ig Provide the training to: Frontline staff o CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtu.be/xmYMUly7qiE Provide the training to: Frontline staff o Nursing Home Infection Preventionist Training Course Module 5 □ Outbreaks https://www.train.org/cdctrain/course/l081803/ Provide the training to: Topline staff and infection preventionist o Nursing Home Infection Preventionist Training Course Module llB - Environmental Cleaning and Disinfection https://www.train.org/main/course/l0818l5/ Provide the training to: All staff including topline staff and infection preventionist o Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/l08l806/ Provide the training to: All staff including topline staff and infection preventionist o Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ Provide the training to: All staff including	

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F 880	Continued From page 18 Drainage Bags, and Emptying a Urinary Drainage Bag and did not include instructions regarding cleaning of urinary or leg bags. N.J.A.C. 8:39-19.4(n) N.J.A.C. 8:39-19.3(a) N.J.A.C. 8:39-19.4(l)	F 880	topline staff and infection preventionist o Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Provide the training to: All staff including topline staff and infection preventionist o Nursing Home Infection Preventionist Training Course Module IIA - Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/108l814/ Provide the training to: Topline staff and infection preventionist IV. MONITORING OF CORRECTIVE ACTIONS ¿ The Infection Preventionist or Designee will conduct Observation Audits on the following to ensure Compliance with Infection Control and Prevention Program: (a) Proper Hand Hygiene Audit on 3 employees per week x 4 weeks, then 3 employees per month x 6 months. (b) Proper Disposal of Medical Waste Audit: Observe 1 Nurse per week x 4 weeks, then 1 Nurse per month x 6 months. (c) Proper cleaning of a urinary drainage leg bag for reuse according to the manufacturer's instructions: Observe 1 Nurse per week x 4 weeks, then 1 Nurse per month x 6 months. ¿ Any identified issues will be rectified	

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F 880	Continued From page 19	F 880	immediately and reported to the Administrator. Audit Findings will be submitted to the QAPI Committee monthly for trending and will be incorporated in the Facility QAPI Program x 6 months to ensure on-going compliance.	

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	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: Based on interview and review of other facility documentation, it was determined that the facility failed to maintain the total number of required staff as mandated by the state of New Jersey. This was evident for 1 of 14-night 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, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse,	S 560	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls being made by the shift supervisor to fill the shift. Facility has documented evidence to reflect facility□s Recruitment and Retention Efforts in its relentless attempts to comply with the staffing ratios. No residents have been adversely affected. II. IDENTIFICATION OF RESIDENTS	6/24/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/27/22

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S 560	Continued From page 1 licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One 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. A review of the Nurse Staffing Report for weeks of 4/3/2022 and 4/10/2022 revealed the following, The facility was deficient in total staffing for residents on 1 of 14-night shifts as follows: -04/16/22 had 4 total staff for 75 residents on the overnight shift, required 6 total staff. During an interview with the surveyor on 4/26/22 at 9:16 AM, when questioned whether she was familiar with the minimum staffing requirements for nursing homes the Staffing Coordinator (SC) said yes, she is familiar with minimum staffing requirements. She went on to say the number of residents and staff we are supposed to have is 1 CNA for 7-8 residents on 7AM-3PM shift, 1 CNA for 10-12 residents on 3PM-11PM shift and 1 CNA for 14-15 residents on the 11PM-7AM shift. The SC stated, Yeah, we meet the requirements,	S 560	WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by this situation. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ Facility□s Recruitment and Retention Strategies and Efforts to comply with the State□s Staffing Ratios have been in progress, which include but are not limited to the following: o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage referrals from current staff o Offering daily and weekend bonuses to attract overtime or Per Diem staff shifts o Aggressively running ads in various social media o Flexible shifts and schedules o Increased wages to be well above state minimum o Increased expedience getting staff on board by offering Orientation every week with a schedule utilizing other sister facilities o Working with C.N.A. schools to recruit new graduates and to send Temporary Nurse□s Aides for certification o Currently have contracts with multiple staffing agencies IV. MONITORING OF CORRECTIVE ACTIONS ¿ Staffing Coordinator or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061537	A. BUILDING: _____ B. WING _____	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
COMPLETE CARE AT ARBORS	1750 ROUTE 37 WEST TOMS RIVER, NJ 08757

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S 560	Continued From page 2 we are using an agency now." The SC said, We are supposed to have 32 staff in a 24-hour period for the building. During a follow-up interview on 4/28/2022 at 9:36 AM, the SC stated, "I need 6 nurses and 10 CNA's for 7AM-3PM shift, 4 nurses and 8 CNA's for 3PM-11PM shift, and 2 nurses and 5-6 CNAs for the 11PM-7AM shift." During an interview with the surveyor on 4/28/2022 at 1:42 PM, the Director of Nursing said, yes, I do know about total numbers of staff required in a 24-hour period based on the facility census.	S 560	provide weekly reports to the Director of Nursing and Administrator regarding all efforts made to try to comply with the State□s Staffing Ratios. Reports will be submitted to the QAPI Committee monthly X 3 months then quarterly thereafter. ¿ Director of HR will submit monthly reports to document status of all recruitment efforts. Director of HR will report monthly to the QAPI Committee X 3 months then quarterly thereafter.	

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
315333 Y1	A. Building B. Wing Y2	8/2/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS	1750 ROUTE 37 WEST 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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0658	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	06/24/2022	LSC	06/24/2022	LSC	06/24/2022
ID Prefix F0759	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	06/24/2022	LSC	06/24/2022	LSC	06/28/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
5/11/2022	☐ 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
061537 Y1	A. Building B. Wing Y2	8/2/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS	1750 ROUTE 37 WEST 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 06/24/2022	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
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

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	
5/11/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING **01** B. WING _____	C **05/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
COMPLETE CARE AT ARBORS	**1750 ROUTE 37 WEST** **TOMS RIVER, NJ 08757**

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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		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 5/11/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 1-story building that was built in 90's, It is composed of Type V unprotected. The facility is divided into 10- smoke zones. The generator does approximately 33% of the building. 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 120 certified beds. At the time of	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/27/2022

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K 000	Continued From page 1 the survey the census was 80.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the	K 161		6/24/22

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K 161	Continued From page 2 construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on interviews and record review on 5/11/22, the facility failed to provide an acceptable construction type and wall-ceiling assembly in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1. This deficient practice was evidenced by the following: An interview was conducted on 5/11/22, at 10:30 AM, with the Maintenance Director and assistant Maintenance staff. They were unable to confirm the building construction type. They could not provide portable, accurate LSC (Life Safety Code) floor plans identifying smoke barrier walls, firewalls, shafts, hazardous areas, and exits for the life safety code survey. The findings were verified by the Maintenance Director and Assistant Maintenance staff at the time of record review. The Maintenance Director provided a generic floor plan indicating floor wings and resident room numbers only. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/11/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1.	K 161	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " no residents were affected by this deficient practice. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE " All residents have the potential to be affected MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: " After extensive review of Facility papers and old documents, we were able to find the LSC (Life Safety Code) floor plan. " The floor plan was placed in the Life Safety binder, as well as in the Emergency Preparedness Manual.	

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K 161	Continued From page 3	K 161	" Maintenance Director educated on the requirement to have the LSC floor plan. MONITORING OF CORRECTIVE ACTIONS: " The maintenance director/designee will audit the Life Safety and the Emergency Preparedness books to ensure the plans are accessible. The audit will be done weekly for 4 weeks and then monthly for 3 months. " Audit Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program x 4 months for on-going compliance.	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 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 documentation review on 5/11/22, in the presence of the Maintenance Director and Assistant Maintenance staff, it was determined that the facility failed to inspect fire doors Annually in accordance with S&C 17-38-LSC. This deficient practice was evidenced for 6 of 6	K 211	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Annual inspection was immediately completed for all fire doors.	6/24/22

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K 211	Continued From page 4 fire doors observed by the following: At 10:00 AM, the surveyor reviewed all provided documentation from the Maintenance Director. The annual fire door inspection documentation was not provided for the facility's fire door assemblies. An interview was conducted with the Maintenance Director and Assistant Maintenance staff, during the document review, where they stated that currently no further documentation could be provided on fire door inspections (Annual) for the last 12-months. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/11/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 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	K 211	" no residents were affected by this deficient practice. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE " All residents have the potential to be affected MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: " Maintenance Director was educated on the fire door inspection requirements. " Annual Fire Door inspection checklist was provided to the Maintenance Director. MONITORING OF CORRECTIVE ACTIONS: " The Fire doors will be audited monthly for 3 months and then yearly thereafter. " Audit Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program x 3 months for on-going compliance.	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING	K 331		6/24/22

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K 331	Continued From page 5 Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, in the presence of the facility's Maintenance Director and assistant Maintenance Staff on 5/11/22, it was determined that the facility failed to ensure that the fixed interior wall surfaces have a flame spread rating of Class A or B. This deficient practice was evidenced for 6 of 6 corridors and was evidenced by the following: During a tour of the facility on 5/11/22, the surveyor observed in exit corridors, carpet on the lower section of the walls. The carpet measured approximately 36 inches up from the floor. The Maintenance Director and Assistant Maintenance Staff was asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface. No documentation was provided as of the Life Safety Code exit conference. The Administrator was notified of the findings at the Life Safety Code exit conference on 5/11/22. There were no further documents provided.	K 331	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " no residents were affected by this deficient practice. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE " All residents have the potential to be affected MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: " After extensive review of Facility papers and old documents, we were able to find the original Finish Schedule. On the finish schedule it has the manufacturer information and model information for the carpet accents on the	

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K 331	Continued From page 6 N.J.A.C. 8:39-31.2(e) N.J.A.C. 8:39-31.1(c) NJAC 101 2012 edition Life Safety Code 10.2.3* and 10.2.8.1	K 331	wall, with the Fire and Smoke Rating as Class 1 (highest Fire and Smoke rating). " Maintenance Director was educated on the Fire and Smoke rating requirements MONITORING OF CORRECTIVE ACTIONS: " The Finish Schedule will be kept in the Maintenance office together with the Life Safety Binder. It will be audited by the maintenance director/designee that it□s accessible and in the correct location monthly for 3 months. " Audit Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program x 3 months for on-going 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	K 918		6/24/22

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K 918	Continued From page 7 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 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 observation and interview on 5/11/22, it was determined that the facility did not ensure a remote manual stop station for 1 of 1 generators, was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: On 5/11/22, the Surveyor, Maintenance Director and assistant Maintenance staff, observed the exterior diesel generator. There was no remote manual stop station to prevent inadvertent or unintentional operation for the emergency generator observed.	K 918	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " no residents were affected by this deficient practice. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE " All residents have the potential to be affected	

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COMPLETE CARE AT ARBORS	**1750 ROUTE 37 WEST** **TOMS RIVER, NJ 08757**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 8 An interview was conducted during the observation with the Maintenance Director and assistant Maintenance staff, where they stated that at the time of observation, the exterior generator was observed to not have a remote manual stop station. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/11/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: " a service company was contracted on 5/11/2022 to install the remote manual stop station. Installation was completed on 6/8. MONITORING OF CORRECTIVE ACTIONS: " Once installed, the function of the remote manual stop station will be checked during the monthly generator tests done by the Maintenance Director or designee. " Audit Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program x 3 months for on-going compliance.	

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
315333 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/2/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS	1750 ROUTE 37 WEST 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0161	06/24/2022	LSC K0211	06/24/2022	LSC K0331	06/24/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	06/24/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
5/11/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO