STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 12/19/19 CENSUS: 85 SAMPLE SIZE: 18 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 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 follow a physician order to assess the [redacted] on Resident #3. This deficient practice was identified for 1 of 3 nurses during medication pass on 1 of 2 units [redacted] Unit) 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 states, "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	Residents affected by deficient practice: Resident #3 had weekly [redacted] taken by the LPN by assessing a [redacted] not taking the [redacted] as the physician order had specified. Resident #3 had an order for weekly [redacted] and [redacted]. The [redacted] was not taken as a result of being given a [redacted] medication. Identifying other Residents who could be affected by the deficient practice: All residents with an order for weekly [redacted] are at risk of the being affected.	1/6/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/30/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 responsibilities within the framework of 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." During observation of the medication pass on 12/16/19 at 8:50 AM, Resident #3's December 2019 Electronic Medical Record revealed an order, dated 02/26/19, to assess the resident's [redacted] and [redacted] weekly. The surveyor observed the Licensed Practical Nurse (LPN) assess the resident's [redacted] and then assess Resident #3's [redacted]) of the resident's [redacted] for 60 seconds. The LPN told the surveyor that the [redacted]" was 68 beats per minute. During an interview with the surveyor on 12/16/19 at 9:12 AM, the LPN stated that you take the [redacted] at the [redacted] and count for one full minute. During an interview with the Unit Manager on 12/16/19 at 9:55 AM, the Unit Manager stated that when a nurse assesses an [redacted], she would listen for one full minute using the [redacted] on the resident's [redacted]. During an interview with the Staff Development Registered Nurse (RN) on 12/16/19 at 10:05 AM, the RN stated that she teaches the nurses to assess the [redacted] by placing their [redacted] on the [redacted] of the [redacted] and to	F 658	Measures or systemic changes to ensure that the deficiencies will not recur: All resident MARs were reviewed, and orders were changed to read weekly [redacted] and [redacted]. Monitoring the continued effectiveness of the systemic change: All orders will be reviewed by the director of nursing or designee monthly for three months then quarterly for one year. All findings will be reported quarterly to the QAPI committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 2 count the [redacted] for 60 seconds. The RN further stated that this education was provided annually during nurse competencies. On 12/16/19 at 10:20 AM, the RN provided the surveyor with the In-Service Education packet which was presented at the Nurses' Meeting on 07/25/19. The surveyor reviewed the in-service materials which revealed that education was provided for [redacted]" The sign-in sheet for the 07/25/19 Nurses' Meeting further revealed that the LPN was in attendance. During an interview with the Director of Nursing (DON) on 12/16/19 at 10:55 AM, the DON stated that she expected the nurses to use a stethoscope to listen to the [redacted] on the resident's [redacted] for one full minute for an [redacted] and not to take the [redacted]. NJAC 8:39-27.1 (a)	F 658		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to routinely evaluate the status of the [redacted] for a resident with [redacted]	F 698	Residents affected by deficient practice: Resident #68 a [redacted] resident was missing an order for checking the [redacted] and there was not	1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 3	F 698		

This deficient practice was identified for 1 of 1 resident, Resident #68, reviewed for [redacted]) and was evidenced by the following:

On 12/18/19 at 10:38 AM, the surveyor was unable to interview Resident #68 because he/she had left the facility for a [redacted] treatment. The Licensed Practical Nurse (LPN) at the nurses' station stated that Resident #68 went out for [redacted] treatments on Monday, Wednesday and Friday.

Review of the face sheet revealed that Resident #68 was originally admitted to the facility on [redacted] and that he/she was diagnosed with [redacted] According to the Quarterly Minimum Data Set, an assessment tool used to facilitate care, dated [redacted], Resident #68 was received [redacted].

Review of the resident's current Interdisciplinary Care Plan for [redacted] included an intervention, dated 01/30/19, to [redacted], also know as an [redacted]

Review of the December 2019 Physician's Order Summary Report included an order, dated 12/13/19, to "[redacted] every shift."

consistent documentation of checks. LPN stated the [redacted] was checked on [redacted] days and assessed [redacted] by [redacted]

Identifying other Residents who could be affected by the deficient practice:

All residents receiving [redacted] are at risk of the being affected.

Measures or systemic changes to ensure that the deficiencies will not recur:

All resident MARs were reviewed, and orders were obtained to check [redacted] residents and the nurses were immediately educated by the facility educator on how to accurately assess [redacted]. All care plans were updated to reflect the checking for [redacted] every shift. Any discrepancies will be reported to the medical doctor.

Monitoring the continued effectiveness of the systemic change:

All orders, MARS and care plans will be reviewed by the director of nursing or designee monthly for three months then quarterly for one year. All findings will be reported quarterly to the QAPI committee. [redacted] education has been added to the annual nurse competencies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 4	F 698		

Review of the December 2019 Medication Administration Record (MAR) reflected the above order and included documentation that the nurse assessed the [redacted] each shift from 12/13/19 to 12/18/19. The surveyor also reviewed the resident's December 2019 Treatment Administration Record (TAR), which revealed that there was no documentation of the [redacted] on the TAR. There was no documentation of [redacted] in the resident's October and November 2019 MARs and TARs.

Review of the Nursing Progress notes from 10/01/19 to 12/18/19 revealed there were ten entries for documentation of the [redacted] as follows: one on 11/22/19; two on 12/03/19; three on 12/06/19; one on 12/07/19; two on 12/13/19; and one on 12/16/19.

On 12/18/19 at 1:18 PM, the surveyor interviewed the LPN who stated she usually cared for Resident #68. The LPN stated that she checked the resident's [redacted] and that she checked by using her [redacted]. The LPN stated that she also checked the [redacted] on the other [redacted] days after removing the [redacted]. The LPN stated that she documented her findings in the MAR. The LPN stated that she also documented the [redacted] in the resident's progress notes. The surveyor asked the LPN if she would check the [redacted] in any way other than by [redacted] and she replied, "No."

On 12/18/19 at 1:47 PM, the surveyor interviewed the Unit Manager (UM). The UM stated that she had been a [redacted] nurse. She stated that when checking the resident's [redacted], she would [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 5 [redacted] The UM stated that the staff would document in the TAR after checking for [redacted]. On 12/19/19 at 8:52 AM, at a meeting with the administrative staff, the Administrator stated, "We know the documentation for the [redacted] was off. We educated the nurse about the care of the [redacted]" She further stated that the facility had orders to check the [redacted] in [redacted] and that the resident was transferred to the hospital at that time. When the resident returned from the hospital, the orders to check for [redacted] were not resumed. The Director of Nursing (DON) stated, "Moving forward we will have the [redacted] checked. It should be documented in the MAR." On 12/19/19 at 9:03 AM, Resident #68 showed the surveyor the [redacted] Resident #68 stated that the nurses check the [redacted] everyday. Resident #68 stated, "[redacted]. Once in a while they listen to it with a [redacted]. They check it once a day on the day shift... no other shift." Review of the facility's "[redacted] Resident" policy, dated 02/01/09, included the statement, "Check every shift sheet and [redacted] (sic)." The DON acknowledged that there was a typographical error in that policy. She stated that the [redacted] should "absolutely" be checked every shift. NJAC 8:39-27.1 (a)	F 698		