STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING _____ B. WING _____	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD BRICK, NJ 08723**

(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: 05/10/22 CENSUS: 114 SAMPLE: 25 + 31= 56 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. During a Recertification Survey conducted on 05/10/22, it was determined that effective 04/26/22, the facility was found to be in wide-spread system failure resulting in Immediate Jeopardy (IJ) cited at F886 at a scope and severity of L. The Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 04/26/22, including the Immediate Jeopardy Template. The Facility failed to: - ensure a system was in place to immediately initiate COVID-19 testing upon the identification of a single positive staff case of COVID-19 - ensure a system was in place to ensure the facility is following the most current guidance related to infection control The facility submitted an acceptable removal plan on 04/28/22. The survey team verified the removal plan as implemented during an onsite visit conducted on 04/29/22.	F 000		

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

Electronically Signed | 06/03/2022

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

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F 000	Continued From page 1	F 000		
F 558 SS=E	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, record review, and review of facility documentation, it was determined that the facility failed to respond to a resident call light in a timely manner to provide assistance to a resident who required toileting assistance. This deficient practice was identified for 1 of 25 residents reviewed (Resident #34) and was evidenced by the following: On 04/25/22 at 9:35 AM, two surveyors were at the nursing station on the EX Order 26.4B1 Unit EX Order 26.4 when we heard screaming in the hallway. The call light for Resident #34's room was activated and sounded at the nursing station. The surveyors proceeded down the hallway and observed Resident #34 was sitting on the bed and EX Order 26.4B1 . At that time, Resident #34 summoned the surveyors to come into the room. The surveyors entered the room and asked	F 558	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-558 -- S/S: E □ Reasonable Accommodations Needs/Preferences I. CORRECTIVE ACTION S ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Director of Nursing (DON) met with Resident #34 to discuss resident□s concerns related to prompt call light response to obtain assistance in toileting. Care Plan was updated to include a plan of care to address the individualized	6/13/22

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F 558	Continued From page 2 Resident #34 if he/she needed something. Resident #34 stated, "I have been here for [redacted] had never had two (staff) assist with the EX Order.26.4B1." The resident stated that [his/her] call light had been on since 8:00 AM because he/she needed to use the bathroom. and the CNA turned off the light at 8:30 AM, and the Certified Nursing Assistant (CNA) entered the room and indicated that she was waiting for another staff to assist and "[The CNA] was still not here to assist". On 04/25/22 at 9:40 AM, the surveyor interviewed the Temporary Nursing Assistant (TNA) assigned to Resident #34. The TNA revealed that she was aware that Resident #34 needed to use the bathroom and the TNA stated she had informed the resident that she would return to assist after she had collected the breakfast trays, and that she could not locate the EX Order.26.4B1) Lift to transfer the resident. The TNA informed the surveyor that she had returned to the room at 9:30 AM and had apologized to the resident. The TNA stated the resident was very upset and was unable to understand why he/she had to wait that long to use the bathroom. The TNA added that there was only one [redacted] for the unit and she could not locate it. The surveyor inquired to the TNA what other approaches could have been used to assist Resident#34, and the TNA indicated that she could have offered Resident #34 a bedpan since Resident #34 was still in bed. On 04/25/22 at 12:00 PM, the surveyor interviewed Resident #34 while Resident #34 was sitting in a wheelchair in the room. When asked if the facility staff answered the call light promptly when he/she needed assistance, Resident #34 stated, "Sometimes it seems like it takes forever	F 558	toileting needs of Resident #34. All Nursing Staff and IDCP (Interdisciplinary) Team were in-serviced on the updated care plan of Resident #34 to ensure compliance. ¿ All staff were counseled and in-serviced on the Facility□s Policy regarding Call Lights. Emphasis was made on ensuring that Staff will promptly respond to call lights for residents who require toileting assistance. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents who are able to use the call light and ask for assistance in toileting have the potential to be affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All staff were in-serviced on the facility□s policy on Call Lights, with emphasis on ensuring timely response to call lights and providing alternate options to accommodate resident□s toileting needs, if applicable. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Unit Managers/ Supervisors or designee will perform 1 Observation Audit in each unit daily x 2 weeks, then once a week x 3 months. Audit will focus on staff□s timely response to call lights to	

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F 558	Continued From page 3 for staff to come. Resident #34 stated that he/she needed help with being transferred and called for assistance. Resident #34 informed the surveyor that one time he/she alerted 911 because he/she needed to be changed and could not get the staff to assist in a timely manner. Resident #34 stated that this morning he/she activated the call light around 8:00 AM and was not assisted until 9:45 AM. When asked about the time, he/she pointed to the clock in the room to indicate that was how he/she knew the time. On 04/25/22 at 12:25 PM, the surveyor interviewed the Food Service Director (FSD) and requested any logs for the meal cart delivery. The FSD indicated that the Units do not sign when the trays arrived on the unit. However, he provided a log for the time that the trays left the kitchen. According to the log provided, the first cart left the kitchen for the 200's Unit at 7:20 AM, and the last cart scheduled at 7:40 AM. Resident #34's tray was on the second delivery and arrived on the Unit around 7:45 AM. Resident #34 stated to the surveyor that he/she activated the call light around 8:00 AM. Subsequent observations on 04/27/22 and 05/03/22 at 7:50 AM confirmed that Resident #34 received the breakfast tray around 8:00 AM. On 04/25/22 at 12:54 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM), regarding the incident with the call light. The LPN/UM stated that her expectation was for call light to be answered in a timely manner. When asked to elaborate she indicated a reasonable time would be within 15 minutes. She added that staff could have been in other rooms providing care or they forgot to turn off the call light. The surveyor asked the LPN/UM if Resident #34 had	F 558	provide assistance. Findings will be submitted to the Director of Nursing weekly and will be reported to the QAPI Committee monthly during the duration of the audits.	

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F 558	Continued From page 4	F 558		

prior issues with the call light or expressed concerns over his/her needs not being met in a timely manner and the LPN/UM stated, "No".

On 04/25/22 at 2:55 PM, the surveyor interviewed the Director of Nursing (DON) regarding if any call light audits completed. The DON stated that the system at the facility was not programmed to register when call lights were activated and deactivated by staff. The DON added that the call light was visible on the panel at the nursing station.

On 04/26/22 at 11:15 AM, the surveyor reviewed the paper call light audits for the prior two months that were provided by the DON. The DON stated that on a daily basis she asked the Unit Managers to document call lights responses and the Unit Managers provided these logs. The facility did not have the ability to confirm the time call lights were activated or when the requested care was provided.

On 04/26/22 at 11:45 AM, the surveyor reviewed Resident #34's electronic medical record which revealed the following:

Resident #34 was admitted to the facility with diagnoses which included but, was not limited to, EX Order 26.4B1 [redacted] The Admission Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care dated EX Order 26.4B1, revealed that Resident #34 scored EX Order 26.4B on the Brief Interview for Mental Status which indicated the resident was EX Order 26.4B1. The MDS further revealed

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F 558	Continued From page 5 the functional status for bed mobility, dressing, and personal hygiene was coded as the resident required [NJ Exec. Order 26:4.b.1] from staff. Resident #34 also required the use of a [EX Order 26] ([EX Order 26.4B1]) for transfer to the bathroom. The following Progress Notes entries revealed: [NJ Exec. Order 26:4.b] at 15:43:15 [3:43 PM] Note Text: This writer was informed of resident calling 911 for assistance. On arrival to resident's room, observed resident seated at edge of bed and [EX Order] [EX Order 26.4B1] not being attended to in a timely fashion. [He/She] mentioned that [he/she] was [EX Order] and [EX Order 26.4B1] [he/she] called police. This writer informed [him/her] that 911 is for emergency calls only and that we are here to assist in every way possible. This writer, nurse, & CNA immediately performed care and safely transferred [him/her] to the bathroom with use of [EX Order.26.4B1] equipment. Kept clean and dry with day clothes on; then transferred into [him/her] w/c [wheelchair]. Resident was content afterwards. 12/08/21 at 17:09 [5:09 PM] Health Status Note Note Text: Residen[EX Order.26.4B1] self to nurses station and informed this writer that the CNAs are not being mean or saying thing to [him/her] that are negative but that they are being [EX Order.26.4B1] to [him/her]. Writer asked [him/her] what that meant and [he/she] replied "they are just not as talkative to me as they could be." When writer was re assuring resident that the CNAs were busy and that they did say hello to [him/her] when [he/she] came out of [his/her] room, resident then became [EX Order 26.4B1] and [EX Order 26.4B1] at this righter [EX Order 26] [EX Order 26.4B1]." Resident then went to	F 558		

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activities. At 3:10 PM resident came to this writer and stated [EX Order 26.4B1] ." This writer informed resident that we will send a CNA to [him/her] as soon as we can. Resident was informed that [his/her] CNA was on a break and would be back in a few minutes. Resident then stated '[EX Order 26.4B1] ." Resident waited about 10 minutes and began [EX Order 26.4B1] for [his/her] aid. Writer informed [his/her] that her CNA had just come back from break and that she was getting her supplies to take resident to the bathroom. Resident then screamed "I have been sitting here for 40 minutes." Writer informed [him/her] of the time and that it was 10 minutes. At that time resident stopped yelling and CNA assisted resident into the bathroom.

12/13/21 at 14:59 [2:59 PM] Behavior Note Note Text: Resident continues on [EX Order 26.4B1], last dose given, [EX Order 26.4B1] [EX Order 26.4B1] noted after lunch, Wanted to be [EX Order.26.4B1] "Immediately" upon returning from MDR. Resident was made aware aware that the CNAs were [EX Order.26.4B1] other residents and will assist [him/her] when care was completed, that [he/she] should go to [him/her] room to be [EX Order.26.4B1]. Resident #34 began to raise [his/her] voice and did not want to wait. Two CNAs approached Resident #34 with the [NJ Exec. Order 26:4.b.1] for transfers and took [him/her] to her room to be [EX Order.26.4B1]. No further episodes noted.

The surveyor could not locate the incident that occurred in the presence of the surveyor on 04/25/22 in the Electronic Progress Notes. On 04/27/22 at 12:15 PM, after surveyor inquiry to the DON, the DON provided the surveyor a

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F 558	Continued From page 7	F 558		

grievance form dated [NJ Exec. Order 26:4.b]. The form revealed that the LPN/UM reported that Resident #34 was [EX Order.26.4] about waiting to be [EX Order.26.4B1] and get care. On 05/03/22 at 12:53 PM, the administrator provided an individual Education Record for the TNA who was assigned to Resident #34 which addressed Residents care and preferences.

A review of the Agency-Self Study Orientation Packet for the TNA provided by the facility on 04/27/22 at 2:39 PM, revealed the following under "Customer Service/Culture of Caring/ Effective Communication: If you cannot help, ask a supervisor or another person to help. (The TNA acknowledged that she could not assist Resident #34 at 8:30 AM when she collected the breakfast tray and that she did not report to the Unit Manager her conversation with Resident #34 who mentioned that he/she had been waiting for awhile to use the bathroom.) A review of the facility's CNA/TNA main duty was to carry out assignments for resident care including but not limited to answer call light promptly.

On 05/03/22 at 10:30 AM, the surveyor interviewed the DON regarding any entries into the medical record regarding Resident #34's concerns regarding a delay in care. The DON indicated that she was not aware of any prior entries in the clinical record regarding Resident #34 concerns with delay in services. (Resident #34 had 3 prior documented incidents with the call lights/ needed assistance to use the bathroom: [NJ Exec. Order 26:4.b] at 15:43, [NJ Exec. Order 26:4.b] at 15:10 PM and [NJ Exec. Order 26:4.b] at 14:59 PM. The facility did not initiate a care plan to assist the direct staff to meet Resident #34's [EX Order.26.4B1] needs in a timely manner. Resident #34 had a BIMS of [EX Orde] there

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F 558	Continued From page 8 was no documentation in the medical record to indicate that the Interdisciplinary Team met with Resident #34 and addressed the above issues). On 05/03/2022 at 11:00 AM, the DON provided a copy of the call lights policy. The listed procedures documented, "Answer all call lights in a prompt, calm, courteous manner. All staff, regardless of assignment must answer call lights. Turn off call light. Call-light should not be turned off until request is met. Respond to request or, if unable to do so, refer request to appropriate staff member immediately". On 05/04/2022 at 10:27 AM, the DON indicated that she met with Resident #34 to discuss the concerns and a care plan was developed. The DON stated, "I was surprised there was no care plan in place. Our expectations would be to put a care plan to address the issues".	F 558		
F 656 SS=E	NJAC 8:39-27.1 (a) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		6/13/22

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F 656	Continued From page 9 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and review of facility documentation, it was determined the facility failed to ensure a comprehensive person-centered care plan was developed with measurable objectives and individualized interventions for 2 of 25 sampled residents (Residents #34, #62) and was evidenced by the following: 1. On 04/21/22 at 9:30 AM, the surveyor	F 656	F-656: Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) = (S/S = E) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Care Plan of Resident #34 was updated to address the individualized	

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F 656	Continued From page 10 observed Resident #34 sitting in a wheelchair in the room watching television. On 04/25/22 at 9:35 AM, two surveyors were at the nursing station and heard [redacted] from the hallway. The surveyors proceeded to the hallway and we both observed Resident #34 sitting on the bed and was upset. Resident #34 asked the surveyors to come to to the room. The surveyors entered the room and asked Resident #34 if he/she needed something. Resident #34 stated, "I have been here for [redacted] had never had two (staff) assist with the [redacted]. The resident stated that [his/her] call light had been on since 8:00 AM because he/she needed to use the bathroom. Staff then turned off the light at 8:30 AM and the Certified Nursing Assistant (CNA) entered the room and indicated that she was waiting for another staff to assist. [The CNA] was still not here to assist". On 04/25/22 at 9:40 AM, the surveyor interviewed the Temporary Nurse Assistant (TNA) assigned to Resident #34. The TNA confirmed that the [redacted]) was not available to assist Resident #34 to the bathroom in a timely manner. The surveyor reviewed the medical record for Resident #34 which revealed the following: Resident #34 was admitted to the facility with diagnoses which included, but were not limited to, [redacted] The Admission Minimum Data Set (MDS), an	F 656	toileting needs of Resident #34. The IDCP Team reviewed resident's Comprehensive Care Plan to ensure that it individualized and person-centered with measurable objectives and individualized interventions. ¿ The Care Plan of Resident #62 was reviewed and updated by the IDCP Team to include a plan of care to address resident's [redacted] behavior and to ensure that it is a comprehensive person-centered care plan with measurable objectives and individualized interventions. 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. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ The members of the IDCP Team were in-serviced on the facility's policy on "Care Planning", which includes the policy statement that the Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Director Of Nursing or Designee will conduct 2 Care Plan Audits weekly x 4 weeks, then 2 Care Plan Audits monthly x 3 months. Audits will focus on verifying	

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COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD BRICK, NJ 08723**

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F 656	Continued From page 11 assessment tool used by the facility to prioritize care, revealed that Resident #34 scored [redacted] on the Brief Interview for Mental Status which indicated an [redacted]. Functional status for bed mobility, transfer were coded as requiring [redacted] from staff. Resident #34 also required a [redacted] to the bathroom. On 04/25/22 at 9:45 AM, two surveyors observed the Licensed Practical Nurse/Unit Manager (LPN/UM) enter Resident #34's room with the [redacted] to assist the resident. On 04/25/22 at 10:12 AM, the surveyor interviewed the LPN/UM and inquired about the process for the call bell response. The LPN/UM stated that the call bell should be answered in a timely manner and resident's needs should be met promptly. The surveyor inquired regarding what promptly meant, and the LPN/UM stated 15 minutes. The LPN/UM further stated that she had only one [redacted] because the other one was broken. She stated there were three residents on the unit who required the [redacted]. She stated that she was not aware that Resident #34 had the light on since 8:00 AM this morning and she acknowledged that she observed the call light after breakfast but was unsure of the time. On 04/25/22 at 11:22 AM, the surveyor conducted a second interview with the TNA who cared for Resident #34 that day. The TNA stated that Resident #34 did not [redacted] and she confirmed that Resident #34 requested to use the bathroom when she delivered the breakfast tray. She stated she informed Resident #34 that she would return after breakfast to assist him/her.	F 656	the completion of a Comprehensive Person-centered Care Plan with measurable objectives and individualized interventions for each resident. Results of audits will be reported to the Administrator and presented in the monthly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plans for on-going compliance	

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F 656	Continued From page 12 Resident #34 informed then the TNA that he/she had been waiting for a little while. The TNA stated that another staff was using the [NJ Exec. Order 26:4.a], and that there was only one [NJ Exec. Order 26:4], so she could not assist Resident #34 in a timely manner. On 04/25/22 at 12:25 PM, during an interview with the Food Service Director (FSD), the FSD revealed that the units did not have signed acknowledge receipts of the meals carts. The FSD then provided the log when the meal carts left the kitchen. According to the log, The 200's Unit received the first breakfast cart at 7:20 AM and the second cart left the kitchen at 7:40 AM. Resident #34's breakfast tray was on the second cart and observations on 04/27/22 and 05/03/22 at 7:50 AM, confirmed that Resident #34 received the breakfast tray close to 8:00 AM. On 04/25/22 at 12:45 PM, the surveyor conducted another interview with the TNA. She indicated that Resident #34 informed her that she needed to use the bathroom when she collected the breakfast tray. The TNA stated that she was aware that he/she needed to use the [NJ Exec. Order 26:9] but the TNA could not locate the [NJ Exec. Order 26:4]. She stated she would have to use the [NJ Exec. Order 26:4.b.] instead. When asked if there was any other approach that could have been used, she stated clearly, "the fact that [he/she] was in bed, I could have offered the bedpan." The TNA indicated that she was assisting with breakfast trays and could not assist Resident #34 when he/she requested to use the bathroom. On 04/25/22 at 12:54 PM, during an interview with the LPN/UM regarding other approaches that could have been used to assist the resident with his/her needs, she indicated the following: "The	F 656		

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F 656	Continued From page 13	F 656		

TNA could have borrowed a [redacted] from another unit. Could have ask a Physical Therapy staff to assist with transfer." The LPN/UM told the surveyor that the TNA could have offered the bedpan and stated "I don't know why she did not offer the bedpan." The LPN/UM stated that she was not made aware of the resident request to use the bathroom earlier. The LPN/UM stated that she had an open door policy, if she was aware she would assist or could have advise the TNA of other approaches that could have been used to assist Resident #34. The surveyor then asked the LPN/UM if delivering/collecting meals trays took precedence over toileting needs. The LPN/UM stated "No, however, as a CNA we were trained that when we start passing breakfast tray we had to continue. It is not norm [normal] and we are not trained that way." The LPN/UM added that the TNA took an online course and was not sure if they trained for the State certification yet. "They do get trained here. They get a sign in sheet".

The surveyor asked the LPN/UM if Resident #34 had prior incidents regarding delay in answering the call light or meeting his/her toileting needs and she stated, "No".

On 04/26/22 at 10:30 AM, the surveyor conducted a review of Resident #34's electronic clinical record. A review of the Progress Notes from [redacted] to present revealed the following entries:

[redacted] at 14:31 [2:31 PM] Behavior Note, Note Text: Resident continues on med [medication] changed for dc' d [discontinued] [redacted]. No ill effect noted. Fair appetite. Compliant with meds. CNA came to resident's room this morning for care and since she's a new one, resident stated,

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F 656	Continued From page 14 "I don't want somebody to do me that's new." Another CNA was in the room and stated that she's gonna [going] to help the other staff. Resident refused and stated that the other aid is doing another resident's flower. This writer explained to the resident that we will try to get somebody to help her. In the meantime, lunch tray came in and resident agreed to wait after lunch. When this writer went to the room after lunch, resident stated that [he/she] called the police and they are coming. Supervisor made aware and came to the unit and talked to the resident. Resident stated [he/she] called the police because [he/she] NJ Exec. Order Care rendered to resident this time with the supervisor and this writer helping. 12/8/21 at 17:09 [5:09 PM], Health Status Note, Note Text: Resident NJ Exec. Order 26:4.b.1 self to nurses station and informed this writer that the CNAs were not being mean or saying thing to [him/her] that are negative but that they are being "breezy" to [him/her]. Writer asked [him/her] what that meant and [he/she] replied "they are just not as talkative to me as they could be." When writer was re assuring resident that the CNAs were busy and that they did say hello to [him/her] when [he/she] came out of [his/her] room, resident then became NJ Exec. Order 26:4.b.1 at this writer 'NJ Exec. Order 26:4.b.1." Resident then went to activities. At 3:10 PM resident came to this writer and stated "I need to go to the bathroom." This writer informed resident that we will send a CNA to [him/her] as soon as we can. Resident was informed that [his/her] CNA was on a break and would be back in a few minutes. Resident then stated "I can wait a few minutes." Resident waited about 10 minutes and began NJ Exec. Order 26:4.b.1 for [his/her] aid. Writer informed	F 656		

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F 656	Continued From page 15 [him/her] that [his/her] CNA had just come back from break and that she was getting her supplies to take resident to the bathroom. Resident then screamed "I have been sitting here for 40 minutes." Writer informed her of the time and that it was 10 minutes. At that time resident stopped yelling and CNA assisted resident into the bathroom. 12/13/21 at 14:59 [2:59PM], Behavior Note, Note Text: Resident continues NJ Exec. Order 26:4.b.1, last dose given, NJ Exec. Order 26:4.b.1. Respirations [redacted] noted. No NJ Exec. Order 26:4.b.1. Increased [redacted] noted after lunch, Wanted to be toileted "Immediately" upon returning from MDR. Resident was made aware aware that the CNAs were toileting other residents and will assist [him/her] when care was completed, that [he/she] should go to [his/her] room to be toileted. Resident #34 began to raise [his/her] voice and did not want to wait. 2 CNAs approached Resident #34 with the NJ Exec. Order 26:4.b.1 for transfers and took [him/her] to [his/her] room to be toileted. No further episodes noted. The surveyor could not locate the incident that occurred in the presence of the surveyor on 04/25/22 in the Electronic Progress Notes. On 04/27/22 at 12:15 PM, after surveyor inquiry to the DON, the DON provided the surveyor a grievance form dated [redacted]. The form revealed that the LPN/UM reported that Resident #34 was upset about waiting to be toileted and get care. On 05/03/22 at 12:53 PM, the administrator provided an individual Education Record for the TNA who was assigned to Resident #34 which addressed Residents care and preferences.	F 656		

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F 656	Continued From page 16 On 04/25/22 at 2:45 PM, the surveyor reviewed Resident #34's plan of care. There was [NJ Exec. Order 26:4] plan in place regarding a toileting program, or any approaches that could assist the direct care staff to better meet Resident #34's toileting needs. On 04/29/22 at 8:59 AM, the surveyor reviewed Resident #34's Kardex. After surveyor inquiry interventions to toilet Resident prior to breakfast was added on [NJ Exec. Order 26:4.b]. 2. On 04/22/22 at 7:43 AM, the surveyor observed Resident #62 in bed. Resident #62 reported that he/she had a horrible night, and stated " I dreamed all night". On 04/25/22 at 10:15 AM, the surveyor observed Resident #62 in activity holding a doll. During the tour on 04/20/22 at 10:30 AM, the surveyor observed Resident #62 in bed. The bed was in a low position and a tab alarm was noted on the chair. A record review of Resident #62 clinical record was conducted on 04/22/22 which revealed the following: According to the Admission Face Sheet, Resident #62 was admitted to the facility with diagnoses which included but not limited to unspecified [EX Order 26.4B1] 02/19/22 at 19:41 [7:41 PM], a Behavior Note revealed: Resident (referring to Resident #62) noted to [NJ Exec. Order 26:4.b.1] in and out of other resident rooms easy to redirect [NJ Exec. Order]	F 656		

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[redacted] in place.

Another entry dated [redacted] at 19:50 [7:50 PM], indicated the following: Resident #62 is on [redacted] [redacted] and received responsive and noted [redacted] self to and from the unit. Resident #62 is [redacted]. Was redirected several times resident wheeled [him/herself] at the front lobby looking for [his/her] room. Resident requires x 1 assist with care and x 1 with transfers. Resident is able to feed self with set-up help... At this time resident is in bed with eyes close. [redacted] in place. Will continue to monitor.

On [redacted] at 18:56 [6:56 PM], Behavior Note: Note Text: Resident [redacted] in wheelchair throughout unit since beginning of shift. Resident [redacted] down 40 hallway pushed on exit door alarm sounded. Able to redirect without difficulty. Staff assist to bed.

On [redacted] at 18:19 [6:19 PM], Behavior Note: Note Text: Resident was [redacted] around on and off the unit. Also found in one of other resident bathroom [redacted], alarm going off. Resident is [redacted] and required [redacted]. At this time resident is being monitored. Will continue to monitor.

On [redacted] at 16:41 [4:16 PM], Note Text: Observed this resident [redacted], found pt [Patient], in another room using someone bathroom. [redacted]. Redirection given. Shower given . . No apparent distress noted. will monitor .

A review of Resident #62's most recent quarterly Minimum Data Set (MDS) with an Assessment

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F 656	Continued From page 18 Reference Date (ARD) of EX Order.26.4B1, indicated some EX Order 26.4B1 deficit. Resident #62 scored EX Order.26.4B on the Brief Interview for Mental Status (BIMS) which indicated a EX Order 26.4B1 EX Order 26.4B1 . A review of Resident #62's comprehensive care plan initiated EX Order 26.4B1 with no revision date, documented there was no care plan of individualized interventions for the EX Order.26.4B1 behavior. There was no documentation regarding assessments and the facility's rationale for not proceeding with care planning for the documented EX Order 26.4B1 . A review of Resident #62's Admission MDS with an ARD of EX Order.26.4B1, Section V. CAA (Care Area Assessment) Summary, documented cognition EX Order 26.4B1 EX Order.26.4B1 , EX Order 26.4B1 meds (medications) were triggered in the CAA and the interdisciplinary team (IDT) indicated a care plan for those areas was developed. On 04/26/22 at 9:13 AM, during an interview with the surveyor, the LPN/UM regarding indicated that she was not aware of any behaviors for Resident #62 exhibited. On 05/03/22 at 9:56 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who cared for Resident #62. The CNA confirmed the resident EX Order.26.4B1 The CNA added that Resident #62 EX Order.26.4B1 at times but was easily redirected. On 05/03/22 at 1:03 PM, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) was made aware of the above concerns. The DON stated that she was not aware of any EX Order.26.4B1 behavior. The	F 656		

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F 656	Continued From page 19 surveyor referred to the nursing entries in the resident's medical record, and the DON stated that a care plan should have been in place to address the [redacted] behavior. On 05/04/22 at 10:32 AM, the DON provided a care plan for the [redacted] behavior developed on [redacted], after surveyor inquiry, with directives for the direct care staff to follow. The facility policy entitled, Care Planning" updated 10/21 provided by the LNHA on 05/03/22 at 11:37 AM, included but was not limited to the policy statement, "Our facility's Care Planning/ Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident." The policy was not being followed.	F 656		
F 880 SS=F	NJAC:8:39-11.2 (2) 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,	F 880		6/22/22

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F 880	Continued From page 20 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: (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	F 880		

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F 880	Continued From page 21 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 interview, and review of facility documentation, it was determined that the facility failed to: 1.) immediately conduct contact tracing to identify residents and staff who had close contact with a NJ Exec. Order 26:4.b.1 staff member, 2.) conduct contact tracing to identify residents and staff who had close contact with a NJ Exec. Order 26:4.b.1 resident, 3.) ensure an NJ Exec. Order 26:4.b.1 Certified Nurses Aide (CNA) #1 notified a supervisor of symptoms prior to her shift on NJ Exec. Order 26:4.b.1, when she proceeded to deliver direct care for nine of 27 residents on the EX Order 26.4B1 unit, and assisted with care for other residents, 4.) ensure that NJ Exec. Order 26:4.b.1 staff, CNA #1 was tested prior to the start of their shift per facility policy, and 5.) follow the Centers for Disease Control and Prevention (CDC), Federal, State, and County guidance to prevent exposure and mitigate the spread of NJ Exec. Order 26:4.b.1 . This deficient practice was identified on 2 of 3 resident units (EX Order 26.4B1) and was evidenced by the following: Reference F 886L	F 880	F-880: INFECTION CONTROL PRACTICES SCOPE and SEVERITY = F I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Upon notification of the deficient practice, facility immediately conducted Broad-Based Testing (Facility-wide) for all staff and residents in order to identify any other NJ Exec. Order 26:4.b.1 cases. All yielded NJ Exec. Order 26:4.b.1. No new cases were identified, including the residents and staff who worked in the EX Order 26.4B1 and EX Order 26.4B1 Units. ¿ The Infection Preventionist and Department Heads were in-serviced on the following: 1) IMPLEMENTATION OF PROMPT CONTACT TRACING: Perform contact tracing to identify all high-risk exposures in staff and close contact encounters in patients/residents. o Immediately conduct contact tracing to identify residents and staff who had	

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F 880	Continued From page 22 1.) On 04/20/22 at 9:24 AM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) had informed the survey team that the facility was currently experiencing an outbreak of [NJ Exec. Order 26:4.b.1]. The survey team was informed there were NJ Exec. Order 26:4.b.1 cases, four cases on the [EX Order 26.4B1] unit and two cases on the [EX Order 26.4B1] unit. On 04/20/22 at 3:00 PM, the DON provided the survey team with the facility line listing which included nine names. The first name listed was a staff CNA #1, assigned to the [EX Order 26.4B1] unit. The line listing indicated CNA #1 had a [NJ Exec. Order 26:4.b.1] degrees Fahrenheit, [NJ Exec. Order 26:4.b.1] that included [NJ Exec. Order 26:4.b.1]n and [NJ Exec. Order 26:4.b.1] the [NJ Exec. Order 26:4.b.1] onset was [NJ Exec. Order 26:4.b.1], and the NJ Exec. Order 26:4.b.1) was collected on [NJ Exec. Order 26:4.b.1], with a [NJ Exec. Order 26:4.b.1]" result. The line listing further revealed five residents who resided on the [EX Order 26.4B1] unit, and two residents who resided on the [EX Order 26.4B1] unit as all having tested NJ Exec. Order 26:4.b.1. The line listing revealed the following: One staff member on the [EX Order 26.4B1] unit tested [NJ Exec. Order 26:4.b.1], with [NJ Exec. Order 26:4.b.1] results. Resident #56, on the [EX Order 26.4B1] unit tested [NJ Exec. Order 26:4.b.1], with [NJ Exec. Order 26:4.b.1] results. Resident #16, on the [EX Order 26.4B1] unit tested [NJ Exec. Order 26:4.b.1], with [NJ Exec. Order 26:4.b.1] results. Resident, unsampled, on the [EX Order 26.4B1] unit tested [NJ Exec. Order 26:4.b.1], with [NJ Exec. Order 26:4.b.1] results. Resident #78, on the [EX Order 26.4B1] unit tested [NJ Exec. Order 26:4.b.1], with [NJ Exec. Order 26:4.b.1] results. Resident, #27, on the [EX Order 26.4B1] unit tested [NJ Exec. Order 26:4.b.1], with [NJ Exec. Order 26:4.b.1] results. Resident #260 on the [EX Order 26.4B1] unit tested [NJ Exec. Order 26:4.b.1], with [NJ Exec. Order 26:4.b.1] results.	F 880	close contact with a COVID-19 positive staff member, o Conduct contact tracing to identify residents and staff who had close contact with a symptomatic COVID-19 positive resident, 2) TESTING: Based on results of Contact Tracing, COVID-19 Testing will be done in accordance with CDC and NJ-DOH Guidance. Testing of residents and staff will be done based on Contact Tracing Approach or Broad-based Approach. 3) Educate and train staff to not to report to work when ill, even if they have mild symptoms consistent with COVID-19 4) Unvaccinated staff must be tested prior to the start of their shift per facility policy. 5) Follow the Centers for Disease Control and Prevention (CDC), Federal, State, and County guidance to prevent exposure and mitigate the spread of COVID-19 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. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All Staff were educated on the following: o Importance of PROMPT CONTACT	

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	315453	A. BUILDING _____ B. WING _____	05/10/2022

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F 880	Continued From page 23 Resident, unsampled, on the Subacute unit tested [redacted], with [redacted] results. On 04/21/22 at 9:30 AM, the DON provided the surveyor with nine contact tracing documents associated with the facility outbreak. A review of the contact tracing documents revealed there were no staff members identified and listed as exposed to an already identified [redacted] employee or resident. There was a blank contact tracing document provided for Resident #56 who resided on the [redacted] unit who had [redacted] per the facility line listing. The contact tracing document indicated the "Date of [redacted] was [redacted] per the facility, with a notation that "Resident Sits by [him/herself] in a Private Room" with no staff or residents listed as being exposed. 2.) On 04/21/22 at 11:52 AM, the surveyors interviewed the DON who stated that Resident #56 had been [redacted] that he/she "had no contacts", that he/she was in a "private room", and the facility did not conduct contact tracing. On 04/26/22 at 2:16 PM, the surveyors interviewed the DON who stated that Resident #56 required staff assistance. The DON stated that noone who had provided care for Resident #56 was tested for [redacted] The surveyor observed Resident #56 in the common areas on the following date/times: On 04/21/22 at 12:46 PM, the surveyor observed Resident #56 [redacted] and was [redacted] in the [redacted] unit activity area with other residents while in close proximity, less than 6 feet.	F 880	TRACING and Testing based on Contact Tracing results o Do Not report to work when ill, even if with mild symptoms consistent with COVID-19 o Unvaccinated staff must be tested prior to the start of shift per facility policy. ¿ System was established for the Infection Preventionist or Designee to check the NJ-DOH COVID-19 website (with links to CDC, Federal and State Guidance to prevent exposure and mitigate the spread of COVID-19) on a weekly basis to ensure knowledge of the latest guidance. This is documented in a Weekly Log to ensure compliance. ¿ 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 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. • Lack of Knowledge, Misinterpretation and Confusion on Current Guidance related to Contact Tracing and Testing Approach based on Contact Tracing • Human Factors: Distraction & Lack of Heightened Awareness of unvaccinated staff regarding mitigating the risks for COVID-19 transmission • Need to reinforce more education and Close Monitoring of Unvaccinated Staff – to ensure that they are compliant with the Facility's Policies regarding mitigating the	

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F 880	Continued From page 24 On 04/25/22 at 9:51 AM, the surveyor observed Resident #56 EX Order 26.4B1 and EX Order 26.4B1 in the EX Order 26.4B1 unit activity area with other residents in close proximity, less than 6 feet. On 04/27/22 at 8:37 AM, the surveyor observed Resident #56 in a chair on the EX Order 26.4B1 unit by the nurse's station. Resident #56 was not wearing a mask and was within 6 feet of an activity aide who was feeding another resident. On 04/28/22 at 8:29 AM, the surveyor observed Resident #56 on the EX Order 26.4B1 unit by the nurse's station, without a mask and was within 6 feet of two other residents. On 04/29/22 at 7:46 AM, the surveyor observed an activity aide transporting Resident #56 via wheelchair into a common area on the EX Order 26.4B1 unit. Resident #56 had been seated within 6 feet of two other residents. In total, the facility provided nine contact tracing documents that included two staff and seven residents. The contact tracing documents provided by the facility revealed that the facility failed to completely document the staff and residents who may have been identified as a close contact, and as NJ Exec. Order 26:4.b.1 staff and resident. On 04/25/22 at 1:53 PM, the surveyor interviewed the DON regarding what the process would be to identify close contacts, including residents and staff, for NJ Exec. Order 26:4.b.1. The DON stated that the process to identify residents exposed to a positive staff member would be to review the staff assignment for residents the staff had provided care for. The DON further stated that the process	F 880	risks for COVID-19 Infection • Need for IP and Topline Staff to stay updated with the most current CDC, Federal, State, and County guidance to prevent exposure and mitigate the spread of COVID-19. This will ensure that the facility is in compliance with the most recent regulations regarding COVID-19 Prevention and Management. 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. ¿ Completed the Directed In-Service Training Programs as directed by the NJ-Department of Health. Education will be on-going with all new hires. 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!: https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff o CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Provide the training to: Frontline staff o Nursing Home Infection Preventionist	

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F 880	Continued From page 25 to identify staff exposed to a positive resident would be to review the resident's staff assigned to provide care. The DON further stated that the facility would also rely on the screening process upon entry to help monitor staff, and that the NJ Exec. Order 26:4.b.1 staff would be NJ Exec. Order 26:4.b.1 twice weekly. 3.) On 04/26/22 at 9:31 AM, during an interview with two surveyors, CNA #1 who had NJ Exec. Order [redacted] stated she had NJ Exec. Ord[redacted] about 5:00 AM on NJ Exec. Order 26:4.b. CNA #1 stated she was not sure what her NJ Exec. Order 26:4.b.1 read because she did not take her NJ Exec. Order 26:4.b.1, but she knew she had NJ Exec. Order 2[redacted] because she was NJ Exec. Order [redacted] CNA #1 stated she took EX Order.26.4B1 prior to coming to work and that she had told the receptionist at the front desk that she NJ Exec. Order 26:4.b.1 [redacted] CNA #1 further stated that NJ Exec. Order 26:4.b.1 was her day to be administered the NJ Exec. Order 26:4.b.1, and that she was NJ Exec. Order 2[redacted] about 3:00 PM after the end of her shift. CNA #1 stated she had not been NJ Exec. Order 26:4.b.1 On 04/26/22 at 9:37 AM, during an interview with two surveyors, the Registered Nurse Unit Manager (RN UM) on the EX Order.26.4B1 unit stated she had not worked on NJ Exec. Order 26:4.b. [redacted]. The RN UM stated if a staff member did not feel well, they must report it to the front desk, be swabbed (administered a rapid COVID-19 test) and have their temperature taken again. The RN UM further stated if an employee felt sick or the employee knew they weren't "OK", the employee should tell us (facility). The RN UM stated if an employee tested positive for COVID-19, she inform the DON and Assistant Director of Nursing (ADON). The RN UM also stated if an employee took EX Order.26.4B1 prior to their shift, the employee	F 880	Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/1081803/ Provide the training to: Topline staff and infection preventionist o Nursing Home Infection Preventionist Training Course: Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/1081802/ Provide the training to: Topline staff and infection preventionist only o Nursing Home Infection Preventionist Training Course: Module 6A - Principles of Standard Precautions - https://www.train.org/main/course/108l804/ Provide the training to: All staff including 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 IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Director of Nursing, Assistant Director of Nursing or Designee will conduct a weekly audit x 3 months of all residents and/or staff members who tested positive for COVID-19 to ensure that the following are promptly implemented: (a) Contact Tracing to identify all high-risk exposures in staff and close contact encounters in	

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F 880	Continued From page 26 probably would not register as having a temperature upon screening. On 04/26/22 at 9:53 AM, during an interview with two surveyors, the front desk Receptionist was asked about to explain the screening process. The Receptionist stated she had worked on [NJ Exec. Order 26:4.b]. She stated she was educated on the process regarding if a staff member went to check in on the electronic kiosk used for screening, and then mentioned they were sick prior to the start of their shift, she would not let the staff member pass the lobby and she would immediately contact the supervisor. The receptionist further stated that no staff had reported to her they felt sick on [NJ Exec. Order 26:4.b.1] On 04/26/22 at 10:35 AM, during an interview with the survey team, CNA #1 stated she had been a CNA since [NJ Exec. Orde] and had worked part time at the facility for [NJ Exec. Order 26:4]. CNA #1 stated she had been educated on the signs and symptoms of [NJ Exec. Order 26:4.b.1] such as a [NJ Exec. Order 26:4.b.1] CNA #1 further stated she was educated and knew to inform the supervisor before entering the facility if she had any symptoms. CNA #1 stated that on [NJ Exec. Order 26:4.b.], she woke up, did [NJ Exec. Order 26] took [EX Order.26.4B1] went back to sleep, and felt fine. She stated she then reported to work. CNA #1 stated her duties included resident care, assisting (other staff) with two person (resident) transfers, and that she would assist residents with eating. CNA #1 further stated that [NJ Exec. Order 26:4.b.] was her regularly scheduled day to be [NJ Exec. Order 26:4.b.1] tested, and that the ADON RN Infection Preventionist (ADON RN IP) was the one who tested her at the end of her shift. CNA #1 stated she informed the ADON RN IP that she was [NJ Exec] that morning and felt ok "now". CNA	F 880	patients/residents, and (b) COVID-19 Testing of all individuals who were identified as exposed based on Contact Tracing (in accordance with CDC and NJ-DOH Guidance) Results of audits will be reported to the QAPI Committee monthly. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. ¿ Infection Preventionist or Designee will conduct audits of COVID-19 Testing of all unvaccinated staff on a weekly basis x 3 months to ensure that: (a) they are screened for COVID-19 symptoms prior to the start of their shift. If staff is not feeling well, staff will not be allowed to work, and (b) they are tested prior to the start of their shift per facility policy. Results of audits will be reported to the QAPI Committee monthly. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. ¿ Administrator or Designee will conduct audits of the Weekly Log completed by the Infection Preventionist or Designee to reflect that he/she checked the NJ-DOH COVID-19 website (with links to CDC, Federal and State Guidance related to COVID-19 in Long-Term care). This will be done on a weekly basis x 3 months to ensure on-going compliance. Results of audits will be reported to the QAPI Committee monthly. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. ¿ COMPLETION DATE: 6/22/2022	

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F 880	Continued From page 27 #1 stated nobody inquired to her regarding any questions about her day on [redacted], or who she had contact with during her shift at any time, after she had NJ Exec. Order 26:4.b.1 . On 04/26/22 at 12:55 PM, during an interview with the surveyors, the ADON RN IP and DON were asked about contact tracing. The DON replied that a review would be completed to find out who any identified close contacts would be, and that would be completed as a team with the unit managers. The DON stated then interviews would be completed with the staff and the residents. The DON continued to state that if the COVID-19 positive person was a staff member, that they would find out when the staff member had worked last, ask for their assignment, and also inquire if they helped on another assignment. She stated that information would determine who would be need to be tested for COVID-19 and on contact tracing. The DON added that the facility would use the CDC algorithm related to COVID-19 exposure. On 04/26/22 at 1:47 PM, during a follow up interview with the surveyors, the DON and ADON RN IP presented their copy of QSO-20-38-NH revised 03/10/22 to review. The DON stated the facility referred to and used that directive, and that it was important to identify close contacts quickly and to test for COVID-19 immediately. The DON stated she was aware CNA #1 was NJ Exec. Order 26:4.b.1 but could not explain why the identified close contacts were [redacted] until NJ Exec. Order 26:4.b.1), and not on [redacted] The DON stated she did not identify, or test staff because she was not aware if CNA #1 had been with any staff for 15 minutes. The DON stated she interviewed the RN UM and other aides on	F 880		

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F 880	Continued From page 28 the floor (EX Order 26.4B1 unit) and that she did not document the conversations with staff. The ADON RN IP stated that when she administered the NJ Exec. Order 26:4.b.1 to CNA #1 at the end of her shift, CNA #1 informed her at that time that she wasn't NJ Exec. Order 26:4.b.1 earlier in the day. The ADON RN IP next stated she informed the DON of CNA #1's NJ Exec. Order 26:4.b.1 result, and informed CNA #1 not to return back to work. The DON stated that on NJ Exec. Order 26:4.b.1, CNA #1's assignment was reviewed as a team, all staff and family were alerted of a NJ Exec. Order 26:4.b.1 t on NJ Exec. Order 26:4.b, and residents were routinely monitored for signs and symptoms of NJ Exec. Order 26:4.b.1 as normal on each shift. The DON stated that she could not answer if testing should have been done immediately because she had utilized a different directive to complete testing at 24 hours. The DON could not speak to why testing was not completed at 24 hours either. 4.) On 04/27/22 at 9:14 AM, the surveyor interviewed the ADON RN IP, in the presence of the survey team, regarding the facility testing prior to the outbreak of NJ Exec. Order 26:4.b. The ADON RN IP stated the facility was testing NJ Exec. Order 26:4.b.1d employees twice weekly and the employees would be swabbed prior to the start of their shift using a rapid test. The ADON RN IP stated that if she was not there to do the swabbing, then another nurse would test the NJ Exec. Order 26:4.b.1 employees prior to their shift. The ADON RN IP stated the importance of testing prior to the shift was because the employee may not have been symptomatic, may have NJ Exec. Order 26:4.b.1, and it would prevent the spread of the virus. The ADON RN IP stated that if a staff member tested positive prior to their shift, she would send the employee home. The ADON RN IP stated the NJ Exec. Order 26:4.b.1	F 880		

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F 880	Continued From page 29 employees knew that they needed to contact the supervisor to be tested prior to the start of their shift. The surveyor inquired as to how the [NJ Exec. Order 26:4.b] outbreak started, and the ADON RN IP stated it started with the [NJ Exec. Order 26:4.b.1] employee who [NJ Exec. Order 26:4.b.1]. The ADON RN IP further stated that CNA #1 was running late on [NJ Exec. Order 26:4.b.1] that CNA #1 wanted to start her assignment and that was the reason she (CNA #1) was not tested prior to the start of her shift. The surveyor inquired as to what should have been done after CNA #1 [NJ Exec. Order 26:4.b.1] ADON RN IP stated that when an employee [NJ Exec. Order 26:4.b.1], we should start testing the residents that he/she had close contact with. She further stated "I notified the DON that CNA #1 [NJ Exec. Order 26:4.b.1] for [NJ Exec. Order 26:4.b.1]. The ADON RN IP stated testing should be completed immediately and was regardless of the vaccination status of the residents. The ADON RN IP stated the exposed employees were not tested immediately. On 04/27/22 at 9:57 AM, the surveyors interviewed the ADON RN IP who stated that when an employee was due for testing, they were supposed to report before the shift started and that the employees knew to do that. The ADON RN IP stated CNA #1 had been running late that day ([NJ Exec. Order 26:4.b]) so CNA #1 came in and started working. The ADON RN IP further stated there was no documented disciplinary action with CNA #1. CNA #1 left at the end of her shift that day after. On 04/29/22 at 10:23 AM, during an interview with the surveyors, the DON and ADON RN IP informed the survey team they had completed recent contact tracing. The DON stated when	F 880		

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someone tested COVID-19 positive, the facility would look back 48 hours prior to identify residents and staff on the unit who may have had a close contact exposure. The DON acknowledged that no doctors or therapist were listed on the original contact tracing documents, and stated they should have been. The DON stated contact tracing should begin immediately, and completed within 24 hours. The DON further stated the supervisors would be responsible to begin the contact tracing, when either she or the ADON RN IP were not at the facility. The DON stated the supervisors were educated, however, she was not sure to what extent of the process they were aware of.

On 04/29/22 at 10:34 AM, the DON further stated a date completed or started was not required on the contact tracing documents because (I) "just know I (DON) did the contact tracing". The DON also revealed that since the facility had been following a prior "regulation" that referred to source control, staff including doctors and therapists were not included in the contact tracing.

On 04/29/22 at 10:41 AM, during an interview with the surveyors, the DON stated the facility was on day 28 of an outbreak from NJ Exec. Order 26:4.b.1 and she was unaware that the outbreak of NJ Exec. Order 26:4.b should be considered a new outbreak. The DON acknowledged she had been in contact with the local health department for guidance, and had been instructed to reference the new directive. The DON stated that since she had already started the contact tracing the prior way, she decided to keep following the prior directive.

5.) On 04/26/22 at 1:26 PM, the DON and IP

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F 880	Continued From page 31 provided the surveyor with the Executive Directive No. 21-012, dated November 24, 2021, The New Jersey Department of Health (NJDOH) Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel, dated February 17, 2022, and Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities, dated February 25, 2022. At that time, the surveyor inquired to the DON regarding using the QSO-20-38-NH guidance from CMS, that was referenced in the DOH email. The DON stated the facility used what they had and she stated she was "not sure" of the CMS QSO-20-38-NH, Revised 03/10/22. On 04/28/22 at 12:34 PM, the surveyor conducted a telephone interview with the Public Health Epidemiologist for the county the facility resided in. The surveyor inquired to the Epidemiologist regarding what the facility guidance should the facility followed for contact tracing and testing regarding the [NJ Exec. Order 26:4.b.i.] outbreak. The surveyor referenced the email between the epidemiologist and the facility dated [NJ Exec. Order 26:4.b.i] The epidemiologist stated that the QSO 20-38-NH guidance was what was referenced in the email and that should have been followed by the facility. The epidemiologist stated the facility should have identified using a broad based or close contact method, and the facility was responsible to complete COVID-19 testing immediately. The email also provided references for updates and resources with the link to CDC Releases Emergency Guidance for Healthcare Facilities to Prepare for Potential Omicron (a variant of COVID-19) surge. Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, Revised	F 880		

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	315453	A. BUILDING _____ B. WING _____	05/10/2022

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F 880	Continued From page 32 03/10/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. A review of the facility provided, "Policy and Procedure COVID-19 Pandemic Case Investigation and Contact Tracing", updated 3/2022, included but was not limited to: Objective - case investigation and contact tracing, ..by local and state health department, is a key strategy for preventing further spread of COVID-19. 3. Contact tracing Procedures - those who were exposed such as staff and residents who are in close contact 48 hours prior will be identified as close contacts and will be monitored closely. Contact tracing is generally recommended for anyone (e.g. HCP, patient, visitor) who had prolonged close contact with the COVID-19 case. A review of the facility provided, "Policy for Emergent Infectious Disease (COVID-19)" updated 03/01/22, included but was not limited to: Assumption - the local, state, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and skilled nursing center response related to a specific disease threat. This document contains recommendations ...Modifications should be made based upon the regulatory requirements. Testing of Residents 1. If testing capacity allows, facility-wide testing of all residents should be considered in facilities with suspected or confirmed cases of COVID-19. 3. If testing capacity is not sufficient for facility-wide testing, perform testing on units with symptomatic residents should be prioritized. Testing of nursing	F 880		

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F 880	Continued From page 33 home HCP (staff) - 1. If testing capacity allows, all HCP should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well. Testing related to (+) COVID-19 exposure and/or symptoms associated with SARS-CoV-2 1. Contact tracing approach - identifies all resident close contacts and staff high-risk exposures. All individuals with close contact and/or high-risk exposure should be tested. If testing reveals additional cases, contact tracing will continue to be performed. Testing of Residents and Staff as follows: 4. Routing testing: all staff testing must be completed prior to entering the facility and units to decrease exposure to the residents and staff. A review of the Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 03/10/22, included but was not limited to the definition of "Close contact " refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period. Guidance - To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive	F 880		

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F 880	Continued From page 34 individual. Testing during an outbreak revealed -that upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. Documentation of testing - that upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests. A review of the Policies and Practices- Infection Control Revised/Reviewed: 1/2019 revealed: Policy Statement: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and mange transmission of diseases and infections; 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infection in the facility, b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public, 3. The Quality Assurance and Performance Improvement Committee, through the Infection Control Committee, shall oversee implementation of infection control policies and practices, and help department heads and managers ensure that they are implemented and followed... A review of the Infection Prevention and Control Program Reviewed 3/2021 revealed: Policy Statement: 1. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral	F 880		

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F 880	Continued From page 35 part of the quality assurance and performance improvement program, 2. The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety, 1. Coordination and Oversight, a. the infection prevention and control program is coordinated and overseen by and infection prevention specialist (infection preventionist), 3. Surveillance, a. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications, 6. Outbreak Management, a. Outbreak Management, Outbreak management is a process that consists of: 1. determining the presence of an outbreak; 2. determining the presence of an outbreak, 3. preventing the spread to other residents, 4. documenting information about the outbreak, 5. reporting the information to appropriate public health authorities, 6. educating the staff and the public, 7. monitoring for recurrences, 8. reviewing the care after the outbreak has subsided; and recommending new or revised policies to handle similar events in the future, 9. Monitoring Employee Health and Safety, a. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers, including: 1. situations when these individuals should report their infections or avoid the facility (for example, the draining skin wounds, active respiratory infections with considerable coughing and sneezing, or frequent diarrhea stools)...	F 880		

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F 880	Continued From page 36 A review of the undated Job Description: Infection Control Preventionist revealed: Broad Function: The infection preventionist is responsible for the facility infection prevention and control program (IPCP), which is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. CMS definition: "Infection preventionist": term used for the person (s) designated by the facility to be responsible for the infection prevention and control program...Management of Nursing Department: Oversight of the IPCP, which included, at a minimum, the following elements, A system from preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangements based upon the facility assessment...and following accepted national standards, Establish a facility-wide system for the prevention, identification, investigation, and control of infections of residents, staff, and visitors, including surveillance designed to identify possible communicable diseases or infections before they spres, Conduct outbreak investigations, Maintain current knowledge of federal, state, and local regulations and ensure that the facility leaders are informed of appropriate issues, understand and comply with infection, control... A review of the Certified Nursing Assistant job description revealed the following: Job Summary, The purpose of this position is to assist the nurses in the providing of resident care primarily in the area of the daily living routine.; C. Carry out assignments for resident care including (but not	F 880		

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F 880	Continued From page 37 limited to): a. Bathing, b. Dressing, c. Grooming, d. Shaving, e. Feeding, f. Restorative nursing procedures, g. retraining; M. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty; Z. Follow established fire, disaster, safety, infection control, and evacuation policies and procedures...	F 880		
F 886 SS=L	NJAC 8:39-19.2(a); 19.4(a); 19.4(d)(f)(g) COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;	F 886		6/13/22

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F 886	Continued From page 38 (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, it was determined that the facility failed to ensure: 1.) a	F 886	F-886: COVID-19 TESTING SCOPE and SEVERITY = L	

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F 886	Continued From page 39 NJ Exec. Order 26:4.b.1 Certified Nurse Aide (CNA #1) notified the supervisor, prior to the start of her shift on [redacted] that she [redacted] 2.) immediate action was taken to initiate [redacted] testing upon the identification of a staff member (CNA #1) who provided resident care to 9 of 27 residents who resided on a [redacted] unit, and NJ Exec. Order 26:4.b.1 at the end of shift on [redacted] and resident testing for [redacted] was initiated on NJ Exec. Order 26:4.b.1), 3.) the facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, State guidance for infection control, and 4.) the facility's Outbreak Plan was followed to prevent exposure and mitigate the spread of NJ Exec. Order 26:4.b.1 [redacted]. The facility's system wide failure to immediately conduct NJ Exec. Order 26:4.b.1 upon the identification of a single new case of a [redacted] posed a serious and immediate risk to the health and well-being of all staff and residents who resided at the facility and who were placed at risk for contracting a NJ Exec. Order 26:4.b.1 and potentially [redacted]. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on [redacted] at 4:10 PM. The removal plan was verified as implemented by the survey team during an onsite visit conducted on 04/29/22 at 1:22 PM. The IJ situation began on [redacted], when a Certified Nurse Aide (CNA #1) reported to work while ill and proceeded to provide care for nine residents who resided on 1 of 3 resident units ([redacted] unit). The residents who were cared for by CNA #1 were tested for [redacted] on [redacted] which was [redacted] after they were	F 886	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The 9 residents (Residents #15, #40, #46, #65, #84, #60, #101, #20, and #47) who were found to have been affected by the deficient practice were all tested for [redacted] and all yielded [redacted] results. All 9 residents were also monitored for NJ Exec. Order 26:4.b.1 and all remained [redacted]. ¿ The involved Staff were counseled and re-educated on the following: (a) Not to report to work when [redacted] and (b) Ensure that unvaccinated staff gets tested for [redacted] prior to the start of the shift per facility policy. ¿ The Infection Preventionist and Department Heads were in-serviced on the following: o IMPLEMENTATION OF PROMPT CONTACT TRACING and TESTING: Based on results of Prompt Contact Tracing, COVID-19 Testing will be done in accordance with the most current applicable CMS, CDC and NJ-DOH Guidelines. Testing of residents and staff will be done based on Contact Tracing Approach or Broad-based Approach. o Following the Centers for Disease Control and Prevention (CDC), CMS, NJ-DOH and County guidance to prevent exposure and mitigate the spread of COVID-19. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE	

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F 886	Continued From page 40 identified as exposed. The evidence is as follows: Refer to 880F Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 03/10/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. On 04/20/22 at 9:24 AM, the surveyor conducted an entrance conference with the facility Administrator (LHNA) and Director of Nursing (DON). The DON stated the EX Order 26.4B1 unit currently had an outbreak of NJ Exec. Order 26:4.b.1. On 04/20/22 at 3:00 PM, the DON provided the surveyor with a line listing (LL) for the current facility outbreak. The surveyor reviewed the LL which revealed the following: There were two staff and seven residents listed on the LL. A Staff member, a CNA, who worked on the EX Order 26.4B1 unit, was the first NJ Exec. Order 26:4.b.1 case and had an Onset Date (symptomatic or specimen date, asymptomatic) of NJ Exec. Order 26:4.b. Asymptomatic had "N" (no) documented and the CNA had a temperature of NJ Exec. Order 26:4.b.1 Fahrenheit and a "Y" (yes) was indicated for NJ Exec. Order 26:4.b.1 and NJ Exec. Order 2. The NJ Exec. Order 26:4.b.1 Collection date was NJ Exec. Order 26:4.b.1. NJ Exec. Order 26:4.b.1 was NJ Exec. Order 26:4.b". The surveyor inquired to the DON if the outbreak had been reported to the Department of Health (DOH). The DON confirmed that she had reported the outbreak and the surveyor requested any communication the	F 886	AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All Staff were educated on the following: o Staff must not report to work when ill, even if with mild symptoms consistent with COVID-19 o Importance of PROMPT CONTACT TRACING and TESTING based on Contact Tracing results o Unvaccinated staff must be tested prior to the start of shift per facility policy. o Follow the Centers for Disease Control and Prevention (CDC), CMS, Federal, State, and County guidance to prevent exposure and mitigate the spread of COVID-19 IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Infection Preventionist or Designee will interview 5 unvaccinated Staff weekly x 4 weeks then Monthly x3 months to ensure that they confirm knowledge and compliance with the following: (a) Not reporting to work when feeling ill; (b) Get tested for COVID-19 prior to each shift and before going into any resident-care areas; and (c) Get tested for COVID-19 when exhibiting any signs and	

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F 886	Continued From page 41 facility had with the DOH regarding reporting the outbreak. On 04/21/22 at 8:30 AM, the facility provided the surveyor with an Outbreak Plan, Updated 03/01/2022. The Outbreak Plan revealed Assumptions, "Every disease is different. The local, state, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and skilled nursing center response related to a specific disease threat." On 04/21/22 at 9:19 AM, the DON provided the surveyor with an email dated [NJ Exec. Order 26:4.b] at 12:05 PM that revealed a "Subject: NJDOH Recommendations". The document revealed "Outbreak/Investigation Testing, CMS-certified facilities are to follow QSO-20-38-NH, upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately." The document also revealed "You must continue to follow NJDOH Guidance for infection prevention and comply with all applicable regulatory requirements set forth by NJDOH, CMS, or other regulatory agencies." On 04/21/22 at 9:30 AM, the DON provided the surveyor with eleven pages of contact tracing documents for the current outbreak, and the first page revealed: [NJ Exec. Order 26:4.b] Employee" CNA #1, "Date of Exposure [NJ Exec. Order 26:4.b.i], Current Shift 7-3 (7:00 AM-3:00 PM) and Shifts worked in last 48 hours, 2-[NJ Exec. Order 26:4.b.i] and [NJ Exec. Order 26:4.b]. Number of residents exposed, "9". The document revealed resident names (Resident #15, #40, #46, #65, #84, #60, #101, #20, #47), and a date that they had received a	F 886	symptoms that maybe COVID-related. Results of interviews will be reported to the QA Committee monthly x 3 months. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. ¿ The Director of Nursing, Assistant Director of Nursing or Designee will perform audits of 5 Staff testing result sheets weekly x 1 month, then 5 Staff testing result sheets monthly x 3 months to ensure testing was done timey and prior to shift. The results will be reported in the monthly QAPI meeting to ensure continued compliance. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. V. COMPLETION DATE: 6/13/2022	

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F 886	Continued From page 42 EX Order.26.4B1 "After Exposure 1- NJ Exec. Order 26:4.b.1" and all nine residents had NJ Exec. Order 26:4.b.1 documented. On 04/21/22 at 9:21 AM the surveyor, in the presence of another surveyor, interviewed the DON regarding the contact tracing process. The DON stated she would complete the contact tracing along with the facility Infection Preventionist (IP). The surveyor inquired to the DON regarding the facility COVID-19 testing process. The DON stated that the COVID-19 testing was completed twice weekly for all unvaccinated staff, and it depended on when the staff worked regarding when they were tested. The DON stated that the residents were tested depending on the contact tracing that was completed. The DON stated if they were not in an outbreak the residents would not be tested. The DON stated she was currently in the process of completing contact tracing for the current outbreak NJ Exec. Order 26:4.b.1 and was completing "some testing" on "some" of the residents. On 04/21/22 at 11:52 AM the surveyor, in the presence of another surveyor, conducted an additional interview with the DON regarding the facility contact tracing that was provided by the DON. The DON stated that CNA #1 worked on NJ Exec. Order 26:4.b.1 on the 7:00 AM to 3:00 PM shift. The DON stated that the CNA #1 was not feeling well toward the end of her shift, and she was tested for NJ Exec. Order 26:4.b.1 at that time. The DON stated that the CNA #1's temperature was taken and was NJ Exec. Order 26:4.b.1 degrees Fahrenheit. The DON stated she used a copy of the CNA #1's resident assignment for that day, and the day before (NJ Exec. Order 26:4.b.1 for the contact tracing. The surveyor inquired as to what other people were identified as exposed to the	F 886		

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	315453	A. BUILDING _____ B. WING _____	05/10/2022

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F 886	Continued From page 43 CNA #1. The DON stated the CNA #1 "had no close contact with any other people". The DON stated the facility tested all of the residents on the CNA #1's assignment for [NJ Exec. Order 26:4.b.1] at that time, and all of the residents were [NJ Exec. Order 26:4.b.] (Per the contact tracing documents the residents were tested on [NJ Exec. Order 26:4.b.1] which was [NJ Exec. Order 26:4.b.1] after being exposed to the CNA #1 [NJ Exec. Order 26:4.b.1] On 04/26/22 at 10:35 AM, the surveyor interviewed the CNA #1 in the presence of the survey team. The CNA #1 stated she worked at the facility for [NJ Exec. Order 26:4.b.1] and had been educated on signs and symptoms of [NJ Exec. Order 26:4.b.1] and was aware that she should tell her supervisor prior to coming to work if she was [NJ Exec. Order 26:4.b.1]. The CNA #1 stated that she did [NJ Exec. Order 26:4.b.1] on [NJ Exec. Order 26:4.b], she felt [NJ Exec. Orde], then took [EX Order:26.4B] ([NJ Exec. Ord]), fell back asleep and then came into work. She stated she did not report to her supervisor that she [NJ Exec. Order 26:4.b.1] on [NJ Exec. Order 26:4.b]. She stated she worked that day, cared for residents, and assisted other staff with their residents. She stated, "it was my regular day to get tested" and went to get tested at the end of her shift. The CNA #1 stated no one had interviewed her about what she had done on [NJ Exec. Order 26:4.b] and who she had contact with. 04/26/22 at 12:56 PM, the surveyor interviewed the DON and IP, in the presence of the survey team. The surveyor inquired regarding, who and when could be contact traced, and the time frame for the look back. The IP stated that the contact tracing was completed for 48 hours prior to the exposure to the positive COVID-19 staff. The contact tracing would include the assignment for who the staff member had cared for, and if the staff had helped with any other assignments. The	F 886		

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F 886	Continued From page 44 IP stated they would follow the CDC (Centers for Disease Control and Prevention) algorithm for exposure and the executive order from the DOH which entailed who should be tested. On 04/26/22 at 1:26 PM, the DON and IP provided the surveyor with the Executive Directive No. 21-012, dated November 24, 2021, The New Jersey Department of Health (NJDOH) Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel, dated February 17, 2022, and Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities, dated February 25, 2022. At that time, the surveyor inquired to the DON regarding using the QSO-20-38-NH guidance from CMS, that was referenced in the DOH email. The DON stated the facility used what they had, and she stated she was "not sure" of the CMS QSO-20-38-NH, Revised 03/10/22. On 04/26/22 at 1:47 PM the surveyor inquired to the DON and IP, in the presence of another surveyor regarding what would the definition of "immediately" be in regard to testing, and as referenced in the CMS QSO-20-38-NH, Revised 03/10/22. The DON stated immediately would be within 24 hours. The surveyor requested the documentation regarding the definition and the DON was unable to provide. The surveyor inquired to the DON regarding the date that any residents were tested regarding the [NJ Exec. Order 26:4.b.1] outbreak, which listed a testing date of [NJ Exec. Order 26:4.b.1] The DON confirmed the residents were tested on [NJ Exec. Order 26:4.b.1]. The DON stated she would go back to NJ Exec. Order 26:4.b.1 for the contact tracing. At 1:55 PM the DON stated that she spoke with the unit manager and obtained CNA #1's assignment that would be utilized for the contact tracing. At	F 886		

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F 886	Continued From page 45 that time, the surveyor inquired if there was any staff tested regarding the [NJ Exec. Order 26:4.b.1] outbreak. The IP stated that she did not test any staff related to the exposure from the [NJ Exec. Order 26:4.b.1] outbreak. The IP stated that CNA #1's [NJ Exec. Order 26:4.b.1] was completed at the end of her shift. The IP stated that the CNA #1's test was [NJ Exec. Order 26:4] and the IP inquired to the CNA #1 if she was feeling ill and the CNA #1 told the IP that she [NJ Exec. Order 26:4.b.1] and took [redacted] At 12:05 PM, the DON stated that as a team we went through the CNA #1's assignment on Monday [NJ Exec. Order 26:4.b.1] and we started to test residents for [NJ Exec. Order 26:4.b.1] at that time, she stated "I didn't put the times in", regarding the testing and "I didn't test immediately." The DON stated that the CNA #1 should have told us about her [NJ Exec. Orde] beforehand. On 04/27/22 at 9:14 AM, the surveyor interviewed the IP, in the presence of the survey team, regarding the facility testing prior to the outbreak of [NJ Exec. Order 26:4.b] . The IP stated the facility was testing un-vaccinated employees twice weekly and the employees would be swabbed prior to the start of their shift using a rapid test. The IP stated that if she was not there to do the swabbing, then another nurse would test the un-vaccinated employees prior to their shift. The IP stated the importance of testing prior to the shift was because the employee may not be symptomatic and may have COVID-19 and it would prevent the spread of the virus. If the staff member tested positive prior to the shift she stated she would send the employee home. The IP stated the un-vaccinated employee knows that they need to contact the supervisor to be tested prior to the start of their shift. The surveyor inquired as to how the [NJ Exec. Order 26:4.b.1] outbreak started, and the IP stated it started with the CNA #1, the	F 886		

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F 886	Continued From page 46	F 886		

NJ Exec. Order 26:4.b.1 employee. The IP further stated that the CNA #1 was running late on NJ Exec. Order 26:4.b.1 and that the CNA #1 wanted to start her assignment, and that was the reason she was not tested prior to the start of her shift. The surveyor inquired as to what should be done after the CNA #1 NJ Exec. Order 26:4.b.1. The IP stated that when an employee tested NJ Exec. Order 26:4.b.1 we would start testing the residents that he/she had close contact with. The IP stated, "I notified the DON that the CNA #1 NJ Exec. Order 26:4.b.1 The IP stated testing should be immediate for any close contacts, and it did not matter what the vaccination status of the residents were regarding testing for NJ Exec. Order 26:4.b.1 The IP stated the exposed employees were not tested immediately and NJ Exec. Order 26:4.b.1 exposed employees are tested within 24 hours of exposure.

On 04/28/22 at 12:34 PM, the surveyor conducted a telephone interview with the Public Health Epidemiologist for the county the facility resided in. The surveyor inquired to the Epidemiologist regarding what the facility guidance should the facility followed for contact tracing and testing regarding the NJ Exec. Order 26:4.b.1 outbreak. The surveyor referenced the email between the epidemiologist and the facility dated NJ Exec. Order 26:4.b.1. The epidemiologist stated that the QSO 20-38-NH guidance was what was referenced in the email and that should have been followed by the facility. The epidemiologist stated the facility should have identified using a broad based or close contact method, and the facility was responsible to complete COVID-19 testing immediately.

On 04/29/22 at 10:45 AM, the surveyor, in the presence of another surveyor, inquired to the

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F 886	Continued From page 47 DON if the DON read the email from DOH on 04/14/22. The DON stated that she read the directive from the DOH on 04/14/22 and since she had already started the contact tracing, she would follow the 03/10/22 directive moving forward. On 05/03/22 at 12:14 PM, the surveyor requested the [redacted] testing documentation for all 9 residents exposed to [redacted] or [redacted] and at 12:50 PM the DON provided nine Point of Care (POC) [redacted] reports for Resident #15, #40, #46, #65, #84, #60, #101, #20, and #47. The Date the tests were performed for all nine residents was [redacted] and the tests were untimed. On 05/04/22 at 10:12 AM, the surveyor, in the presence of the survey team, interviewed the DON and IP regarding the document that provides the guidance when an outbreak occurred. The DON and IP confirmed that the Outbreak Plan was the guiding document for any outbreak. A review of the facility provided, "Policy for Emergent Infectious Disease (COVID-19)" updated 03/01/22, included but was not limited to: Assumption - the local, state, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and skilled nursing center response related to a specific disease threat. This document contains recommendations ...Modifications should be made based upon the regulatory requirements. Testing of Residents 1. If testing capacity allows, facility-wide testing of all residents should be considered in facilities with	F 886		

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F 886	Continued From page 48 suspected or confirmed cases of COVID-19. 3. If testing capacity is not sufficient for facility-wide testing, perform testing on units with symptomatic residents should be prioritized. Testing of nursing home HCP (staff) - 1. If testing capacity allows, all HCP should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well. Testing related to (+) COVID-19 exposure and/or symptoms associated with SARS-CoV-2 1. Contact tracing approach - identifies all resident close contacts and staff high-risk exposures. All individuals with close contact and/or high-risk exposure should be tested. If testing reveals additional cases, contact tracing will continue to be performed. Testing of Residents and Staff as follows: 4. Routing testing: all staff testing must be completed prior to entering the facility and units to decrease exposure to the residents and staff. A review of the Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 03/10/22, included but was not limited to the definition of "Close contact " refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period. Guidance - To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should,	F 886		

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F 886	Continued From page 49 regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual. Testing during an outbreak revealed -that upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. Documentation of testing - that upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests. A review of the Policies and Practices- Infection Control Revised/Reviewed: 1/2019 revealed: Policy Statement: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and mange transmission of diseases and infections; 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infection in the facility, b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public, 3. The Quality Assurance and Performance Improvement Committee, through the Infection Control Committee, shall oversee implementation of infection control policies and practices, and help department heads and managers ensure that they are implemented and followed... A review of the Infection Prevention and Control	F 886		

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F 886	Continued From page 50 Program Reviewed 3/2021 revealed: Policy Statement: 1. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program, 2. The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety, 1. Coordination and Oversight, a. the infection prevention and control program is coordinated and overseen by and infection prevention specialist (infection preventionist), 3. Surveillance, a. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications, 6. Outbreak Management, a. Outbreak Management, Outbreak management is a process that consists of: 1. determing the presence of an outbreak; 2. determining the presence of an outbreak, 3. preventing the spread to other residents, 4. documenting information about the outbreak, 5. reporting the information to appropriate public health authorities, 6. educating the staff and the public, 7. monitoring for recurrences, 8. reviewing the care after the outbreak has subsided; and recommending new or revised policies to handle similar events in the future, 9. Monitoring Employee Health and Safety, a. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers, including: 1. situations when these individuals should report their infections or avoid the facility (for example,	F 886		

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F 886	Continued From page 51 the draining skin wounds, active respiratory infections with considerable coughing and sneezing, or frequent diarrhea stools) ... A review of the undated Job Description: Infection Control Preventionist revealed: Broad Function: The infection preventionist is responsible for the facility infection prevention and control program (IPCP), which is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. CMS definition: "Infection preventionist": term used for the person (s) designated by the facility to be responsible for the infection prevention and control program...Management of Nursing Department: Oversight of the IPCP, which included, at a minimum, the following elements, A system from preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangements based upon the facility assessment...and following accepted national standards, Establish a facility-wide system for the prevention, identification, investigation, and control of infections of residents, staff, and visitors, including surveillance designed to identify possible communicable diseases or infections before they spres, Conduct outbreak investigations, Maintain current knowledge of federal, state, and local regulations and ensure that the facility leaders are informed of appropriate issues, understand and comply with infection, control... A review of the Certified Nursing Assistant job description revealed the following: Job Summary,	F 886		

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F 886	Continued From page 52 The purpose of this position is to assist the nurses in the providing of resident care primarily in the area of the daily living routine.; C. Carry out assignments for resident care including (but not limited to): a. Bathing, b. Dressing, c. Grooming, d. Shaving, e. Feeding, f. Restorative nursing procedures, g. retraining; M. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty; Z. Follow established fire, disaster, safety, infection control, and evacuation policies and procedures... NJAC 8:39- 19.1(a); 19.2(a)(c)	F 886		

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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 DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility provided staffing, and a review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios per the required minimum staffing standards as mandated by the State of New Jersey. Reference: New Jersey State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	S-560 8:39-5.1(a) Mandatory Access to Care □ STATE□S STAFFING RATIOS 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. No residents have been adversely affected.	6/13/22

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

Electronically Signed | 06/03/22

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COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	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 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 PRN 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 provide weekly reports to the Director of Nursing and Administrator regarding all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656003	A. BUILDING: _____ B. WING _____	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... The facility was deficient in Certified Nurse Aide (CNA) staffing for residents on 7 of 14 day shifts. -04/03/22 had 11 CNAs for 116 residents on the day shift, required 15 CNAs. -04/04/22 had 12 CNAs for 116 residents on the day shift, required 15 CNAs. -04/09/22 had 12 CNAs for 113 residents on the day shift, required 15 CNAs. -04/10/22 had 10 CNAs for 117 residents on the day shift, required 15 CNAs. -04/11/22 had 14 CNAs for 117 residents on the day shift, required 15 CNAs. -04/12/22 had 14 CNAs for 117 residents on the day shift, required 15 CNAs. -04/15/22 had 14 CNAs for 117 residents on the day shift, required 15 CNAs. On 04/27/22 at 8:50 AM, a surveyor interviewed Resident #97 who stated 'can't blame the aids (CNAs) they don't have enough help.' The resident stated he/she couldn't remember any specific times and they had been in the facility for [NJ Exec. Order]. Resident #97 stated there were 2 times where he/she had to wait a long time but that he/she wouldn't say it was a dignity issue but that it was a time issue or staff issue. The resident stated the staff can't answer the call light timely if	S 560	efforts made to try to comply with the State□s Staffing Ratios. Reports will be submitted to the QAPI Committee monthly X 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656003	A. BUILDING: _____ B. WING _____	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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S 560	Continued From page 3 there was not enough staff and that he/she figured there were 15 to 20 residents per CNA at night. On 04/28/22 at 10:27 AM, review of the CNA staffing revealed 8 CNAs on the 7 AM - 3 PM shift, 10 CNAs on the 3 PM - 11 PM shift, and 14 on the 11 PM - 7 PM shift. During an interview with the surveyor at that time, the facility Staffing Coordinator stated the staffing was based on the facility census. The Facility Assessment Tool revealed: that the facility would provide adequate staffing to meet the residents' daily needs, preferences, and routines. The staffing would include the services of a registered nurse for at least eight consecutive hours a day, 7 days a week, a designated licensed nurse to serve as a charge nurse to serve as a charge nurse on each tour of duty and adequate staffing on each shift to ensure that our residents' needs are met by registered and licensed nursing staff, certified/state tested nursing assistants, and other support services. The Facility Assessment further indicated that the facility endeavors that in no event does the overall number of qualified staff provided to meet resident's needs would fall below the minimum daily average required by law. A review of the facility provided policy, "Staffing", updated 01/22, revealed the Policy Statement: "our facility provides sufficent numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment." Policy Interpretation and Implementation included but was not limited to 2. staffing numbers and the skill requiremets of	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 4 direct care staff are determined by the needs of the residents based on each resident's plan of care.	S 560		

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
315453 Y1	A. Building B. Wing Y2	8/9/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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 F0656	Correction	ID Prefix F0880	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.21(b)(1)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	06/13/2022	LSC	06/13/2022	LSC	06/22/2022
ID Prefix F0886	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80 (h)(1)-(6)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/13/2022	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	
5/10/2022	☐ 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
656003 Y1	A. Building B. Wing Y2	8/9/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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 06/13/2022	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 5/10/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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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 05/09/2022 and 05/10/2022 and Complete Care Shorrock 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 Occupancies. Complete Care Shorrock is a single story, Type V Un-Protected building that was built in January 1999. The facility is divided into 13 smoke zones.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the	K 222		7/15/22

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

Electronically Signed | 06/03/2022

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
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COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 222	Continued From page 1 rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 222	Continued From page 2 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview from 5/09/2022, it was determined that the facility failed to provide exit doors in the means of egress 1) Readily accessible and free of all obstructions or impediments to full instant use in case of fire or other emergencies, as per the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was identified in 3 of 11 exit discharge doors in the following locations, During the building tour starting at 9:30 AM, in the presence of the facility's Director of maintenance (DOM) the surveyor observed the three (3) exit discharge doors that required two actions in the following locations, 1) At 10:59 AM, exit discharge door next to resident room #128 had a sign posted on the door that read, "To exit in an emergency press red button and door can be opened in 15 seconds". The door was not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button and then push on bar. This is two actions to open the door. 2) At 11:15 AM, the exit discharge door next to	K 222	K0222 -- S/S: D -- NFPA 101 -- Egress Doors 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ No residents were directly affected by this deficient practice. ¿ The delayed egress doors by rooms 128,139 and 145 have been provided with a push bar that activates the delayed egress with one action and proper signage has been posted 2. INDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIOL TO BE AFFECTED BY THIS DEFITIANT PRACTICE ¿ All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ Maintenance Department was educated on the proper activation of egress doors and proper signage. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 222	Continued From page 3 resident room #139 had a sign posted on the door that read, "To exit in an emergency press red button and door can be opened in 15 seconds". The door was not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button and then push on bar. This is two actions to open the door. 3) At 11:15 AM, the exit discharge door next to resident room #145 had a sign posted on the door that read, "To exit in an emergency press red button and door can be opened in 15 seconds". The door was not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button and then push on bar. This is two actions to open the door. The DOM, confirmed the findings at the time of the observations. The Administrator (interim) was informed of these findings during the Life Safety Code survey exit conference on 4/21/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222	¿ The Maintenance Director or designee will perform observation audits of all delayed egress doors once a week x 1 month; and monthly thereafter x 3 months. Results of audits will be reported monthly to the QAPI Committee.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.	K 291		7/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

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K 291	Continued From page 4 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation on 05/09/2022, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 16 battery back up emergency lights independent of the building's electrical system and emergency generator function properly when tested, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: Starting at 9:20 AM, the surveyor toured the building with the facility's Director of Maintenance (DOM) and observed the following: 1. At 9:52 AM, during a test of the battery back up emergency light outside of designated exit discharge door next to the Ambulance entrance door was performed, the light did not function properly. 2. At 1:38 PM, a test of the battery back up emergency light outside the designated exit discharge door next to resident room 328 was performed, the light did not function properly. This findings was confirmed by the facility's DOM at the time of inspection. The surveyor informed the Administrator of the deficiency at the Life Safety Code survey exit conference on 05/10/2022 at 2:41 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	K0291 -- S/S: F -- NFPA 101 -- Emergency Lighting Bldg.: 02. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ No residents were affected by the deficient practice. ¿ Functioning emergency lighting was installed outside the ambulance exit and designated exit next to room 328. 2. INDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIOL TO BE AFFECTED BY THIS DEFITIANT PRACTICE ¿ All residents have the potential to be affected by the deficient practice. 3.What measures will be put in place or systemic changes to ensure the practice does not recur? ¿ The Maintenance Department was educated on ensuring functioning emergency exit lighting. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Maintenance Director or designee will perform inspections weekly x 1 month; then monthly x 3 months to ensure that the exit emergency lighting is functioning. Results of audits will be reported monthly to the QAPI Committee.	

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	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 293	Continued From page 5	K 293		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that illuminated exit signs were in 6 locations to clearly identify the exit access path. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 During a facility tour on 05/09/2022, the surveyor in the presence of the facility Director of Maintenance (DOM), observed the following locations that failed to to have illuminated exit signs to clearly identify the exit access route:	K 293	K0293 -- S/S: E -- NFPA 101 -- Exit Signage 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ No residents were affected by the deficient practice. ¿ Illuminated exit signage was placed in the center enclosed courtyard, corridor by room #220,corridor by room 230, corridor near room 236 and corridor near room #216, 2. INDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIOL TO BE AFFECTED BY THIS DEFITIANT PRACTICE ¿ All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does	7/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 6 1. At 9:58 AM, inside the enclosed center courtyard the surveyor observed two (2) illuminated exit signs. One illuminated exit sign above each of the two exit access doors leading out of the enclosed center courtyard. 2. At 10:03 AM, one (1) illuminated exit sign above the corridor double smoke doors next to Resident room #220. 3. At 10:17 AM, one illuminated exit sign above the corridor double smoke doors next to Resident room #230. 4. At 10:19 AM, one illuminated exit sign above the corridor double smoke doors next to Resident room # 236. 5. At 11;52 AM, one illuminated exit sign above the corridor double smoke doors next to Resident room # 216. The DOM confirmed the findings at the time of observations. The Administrator was informed of the findings during the Life Safety Code survey exit conference on 05/10/2022 at 2:41 PM. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293	not recur? ¿ Maintenance Department was educated on ensuring proper illuminated exit signage. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Maintenance Director or designee will perform observation audits of corridors and courtyard to ensure that they have the proper illuminated Signage once a week x 1 month; and then monthly thereafter x 3 months. Results of audits will be reported monthly to the QAPI Committee.	
K 331 SS=E	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING	K 331		7/15/22

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	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 331	Continued From page 7 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 and interview, the surveyor in the presence of the facility's Management on 05/09/2022, 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 8 of 12 corridors and 4 of 4 interior resident porch areas. This deficient practice was evidenced by the following: During a tour of the facility starting at 9:20 AM, the surveyor in the presence of the facility's Director of Maintenance (DOM) observed four (4) exit access corridors and two (2) interior resident porch area walls, post and rails on the Applewood Unit and in four (4) exit access corridors and two (2) interior resident porch area walls, post and rails of the Brighton Unit, carpet on the lower section of the walls and wood clapboard siding on the porch areas. The carpet measured approximately 30 inches up from the floor and the wood clapboard sideling measured approximately 20 feet long by 8 feet high along with wood post and rails in each of the 4 porch areas .	K 331	K0331 -- S/S: E -- NFPA 101 □ Interior wall and Ceiling Finish 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ No residents were affected by the deficient practice. ¿ The two interior resident porch area walls, post, and rails on applewood and Brighton units have been painted with a paint which is class A flame rating. After reviewing facility plans facility was able to locate documentation that the carpet on the lower part of wall is class 1 flame rating (highest level fire smoke rating). 2. Identification of residents who have potential to be affected by the deficient practice. ¿ All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ The Maintenance Department was educated on ensuring that affixed interior	

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	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 331	Continued From page 8 The DOM was asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface and the wood clapboard siding, post and rails. The DOM could not provide any documentation on the carpet and the wood siding. The Administrator was informed of the findings during the Life Safety Code survey exit conference on 05/10/2022 at 2:41 PM. 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 surfaces have flame spread rating . 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Maintenance Director or designee will perform inspections of all corridors to ensure that affixed interior wall surfaces have proper flame spread rating once a week x 1 month; and monthly thereafter x 3 months. Results of audits will be reported monthly to the QAPI Committee.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		7/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations on 5/09/2022, the surveyor in the presence of facility management, it was determined that the facility failed to install supervised smoke/ heat detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. This deficient practice includes the following: During the tour of the building, the surveyor in the presence of the facility's Director of Maintenance (DOM) at 9:30 AM, observed that the facility failed to provide supervised smoke/ heat detection in the following locations, 1. At 2:37 PM, an inspection inside the main electrical (where the main fire alarm and detection system panel is located) was performed. The surveyor observed no evidence of a supervised smoke/ heat detection system inside the room as required by code. 2. At 3:06 PM, the surveyor conducted an inspection inside the main kitchen. The surveyor observed no evidence of a smoke/ heat detector with-in 20 feet of the stove as required by code. The DOM confirmed the findings at the time of observations. The Licensed Nursing Home Administrator (LNHA) was informed of the findings during the Life Safety Code survey exit conference on 05/10/2022 at 2:41 PM.	K 341	K0341 -- S/S: E -- NFPA 101 -- Fire Alarm System - 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ No residents were affected by the deficient practice. ¿ Smoke/ heat detection system was installed in the main electrical room and kitchen. 2. Identification of residents who have potential to be affected by deficient practice ¿ All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ The Maintenance Department was educated on ensuring a proper smoke/heat detection System 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Maintenance Director or designee will perform inspections of the smoke heat detection system to ensure compliance once a week x 1 month; and monthly thereafter x 3 months. Results of audits will be reported monthly to the QAPI Committee.	

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K 341	Continued From page 10 Fire Safety Hazard. NJAC 8:39 -31.2 (a).	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. This deficient practice was identified in 5 of 3 observed resident shower areas and was evidence by the following:	K 351	K0351-- S/S: E -- NFPA 101 □ Sprinkler system installation 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ No residents were affected by the deficient practice. ¿ Proper sprinkler coverage was installed in Brighton unit mechanical room next to room #223, Brighton mechanical room next to room #230, Applewood	7/15/22

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K 351	Continued From page 11 During the entrance conference on 05/09/2022 at 9:12 AM, the surveyor requested the Licensed Nursing Home Administrator (LNHA) and Director of Maintenance (DOM) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. Starting at 9:20 AM, the surveyor in the presence of the LNHA and DOM conducted a tour of the building. During the tour, the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: 1. At 10:05 AM, the surveyor observed inside the Brighton Unit mechanical room next to resident room #223 had one fire sprinkler head in the room which was being blocked by metal duct and could not provide complete coverage to one side of the the 16 feet deep by 8 feet wide room. The surveyor informed the LNHA and DOM of these findings at the time of inspection. The LNHA and DOM confirmed the findings at the time of observation. 2. At 10:20 AM, the surveyor observed inside the Brighton Unit mechanical/ sprinkler control valves room next to resident room #230 had one fire sprinkler head in the room which was being blocked by metal duct and could not provide complete coverage to one side of the the 16 feet deep by 8 feet wide room. The surveyor informed the LNHA and DOM at the time of inspection. 3. At 10:52 AM, the surveyor observed inside the Applewood Unit mechanical/ sprinkler control valves room next to resident room #114 had one fire sprinkler head in the room which was being	K 351	mechanical room next to room 114 , Applewood mechanical room next to room #123and applewood Mechanical room next to room #117. 2. Identification of residents having the potential to be affected by the same deficient practice. ¿ All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ The Maintenance Department was educated on ensuring proper sprinkler coverage. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Maintenance Director or designee will perform inspections of Mechanical Rooms sprinkler coverage once a week x 1 month; and monthly x3 months. Results of audits will be reported monthly to the QAPI Committee.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 351	Continued From page 12 blocked by metal duct and could not provide complete coverage to one side of the the 16 feet deep by 8 feet wide room. 4. At 11:03 AM, the surveyor observed inside the People Under Investigation (PUI) on the Applewood Unit, mechanical room next to resident room #123 had one fire sprinkler head in the room which was being blocked by metal duct and could not provide complete coverage to one side of the the 16 feet deep by 8 feet wide room. 5. At 11:16 AM, the surveyor observed inside the Applewood Unit, mechanical room next to resident room #117 had one fire sprinkler head in the room which was being blocked by metal duct and could not provide complete coverage to one side of the the 16 feet deep by 8 feet wide room. The facility LNHA and DOM confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code survey exit conference on 05/10/2022 at 2:41 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		7/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING **01** B. WING _____	**05/10/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	**75 OLD TOMS RIVER ROAD** **BRICK, NJ 08723**

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K 353	Continued From page 13 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations on 05/09/2022, the surveyor in the presence of facility management, determined that the facility failed to maintain 3 of 4 sets of pressure gauges for the automatic sprinkler system in optimal condition as required by National Fire Prevention Association (NFPA) 25. This deficient practice was evidenced by the following: During the survey entrance at 9:12 AM, the surveyor made a request to the Licensed Nursing Home Administrator (LNHA) and Director of Maintenance (DOM) to provide a copy of the facility layout which identifies the various rooms and units in the facility. Later starting at 9:21 AM, in the presence of the DOM an inspection of the Applewood, Brighton, Evergreen, Meadows Units and Service corridor wings was performed. During the tour the surveyor inspected four (4) separate sprinkler control valves. The surveyor observed that the pressure gauges (one set of gauges on each unit) on the Applewood Unit, Brighton Unit and	K 353	K0353 -- S/S: E -- NFPA 101 -- Sprinkler System - Maintenance and Testing 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ No residents were affected by the deficient practice. ¿ The Pressure Gauges on the sprinkler control valves applewood Unit, Brighton Unit and Service corridor near the generator room have been replaced. 2. identification of residents having the potential to be affected by the same deficient practice. ¿ All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ The Maintenance Department was educated on ensuring proper Sprinkler System Maintenance .	

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K 353	Continued From page 14 Service corridor, near the generator room had manufacture dates 2014. NFPA 25 requires pressure gauges to be changed or re-certified every six (6) years. These pressure gages were over six (6) years old. The surveyor informed the LNHA of the deficiency at the Life Safety Code survey exit conference on 05/10/2022 at 2:41 PM. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 25	K 353	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Maintenance Director or designee will perform audits related Sprinkler Maintenance to ensure compliance once a week x 1 month; and monthly thereafter x 3 months. Results of audits will be reported monthly to the QAPI Committee.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations on 05/09/2022, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for Two (2) of Twelve (12) smoke barrier walls as evidenced by the following:	K 372	K372 -- S/S: D -- NFPA 101 □ Subdivision of building spaces □ Smoke Barrier. 1. What corrective action(s) will be accomplished for those residents found to	7/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 372	Continued From page 15 On 05/09/2022 starting at 9:20 AM with the facility's Director of maintenance (DOM), a tour of the building which included the Applewood, Brighton, Evergreen and Meadows Units was conducted. During the building tour, the surveyor observed the following smoke barrier walls failed to maintain the 1/2 hour fire rated construction as required by code in the following locations, 1) At 10:22 AM, the surveyor observed above the corridor double smoke doors, next to the Brighton units Resident living room an approximately 2" by 2" hole through the smoke barrier wall. 2) At 1:32 PM, the surveyor observed above the corridor double smoke doors, next to resident #321 had an approximately 3/4" in diameter hole with an electrical cable running through the hole. These penetrations were observed on both sides through the smoke barrier walls, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The findings were verified and confirmed by DOM during the observations. The Administrator was informed of the findings during the Life Safety Code survey exit conference on 05/10/2022 at 2:41 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 372	have been affected by the deficient practice? ¿ No residents were affected by the deficient practice. ¿ The hole above the double smoke doors, next to the Brighton unit and the hole above the corridor double doors next to room #321 have been sealed 2. Identification of other residents having the potential to be affected by the same deficient practice. ¿ All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ The Maintenance Department was educated on ensuring that penetrations above smoke doors are sealed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: ¿ The Maintenance or designee will perform inspections above the smoke doors once a week x 1 month; and monthly thereafter x 3 months Results of audits will be reported monthly to the	

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
315453 Y1	A. Building 01 - SHORROCK GARDENS B. Wing Y2	8/9/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHORROCK	75 OLD TOMS RIVER ROAD BRICK, NJ 08723

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	K0222	07/15/2022	LSC	K0291	07/15/2022	LSC	K0293	07/15/2022
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0331	07/15/2022	LSC	K0341	07/15/2022	LSC	K0351	07/15/2022
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0353	07/15/2022	LSC	K0372	07/15/2022	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	
5/10/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO