STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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F 000	INITIAL COMMENTS COMPLAINT #: NJ00162301 CENSUS: 74 SAMPLE SIZE: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 162301 Based on observation, interviews, review of the medical records (MRs), and other facility documentation on 3/14/23, 3/16/23, and 3/21/23, it was determined that the facility failed to	F 600	COMPLETE CARE AT MONMOUTH: PLAN OF CORRECTION F-600 □ SS = E- Free from Abuse and Neglect CFR(s): 483.12(a)(1	5/21/23

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

Electronically Signed | 05/07/2023

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F 600	Continued From page 1 implement their policy titled "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" to prevent reoccurrence of a NJ Exec Order 26.4b1 by Resident #3 and to protect 2 of 2 sampled residents (Resident #1 and Resident #2). Approximately NJ weeks prior to NJ Exec Order 26.4b, Certified Nursing Assistant (CNA #1) witnessed Resident # 3 NJ ex order 26.4b1 Resident #1 NJ ex order 26.4b1 Resident #1 has diagnoses of NJ ex order 26.4b1 NJ ex order 26.4b1 . Although, according to CNA #1, the NJ ex order 26.4b1 NJ ex order 26.4b1 to the nurse, there was no indication that staff notified facility Administration at the time of the NJ ex order 26.4b. In addition, NJ ex order 26.4b1 Resident #3. Subsequently, NJ ex order 26.4b1 by Resident #3 was reported on NJ ex order 26.4 by CNA #1. On NJ ex order 26 CNA #1 heard Resident #3 in Resident #2's room saying to Resident #2 NJ ex order 26.4b1." Resident #2 NJ ex order 26.4b1 The CNA entered the room and observed Resident #3 NJ ex order 26.4b1 Resident #2 NJ ex order 26.4b1 while Resident #2 NJ ex order 26.4b1 . The US FOIA (b separated the residents and reported the event to the nurse who reported the incident to the US FOIA (B) (6) on NJ ex order 26. An investigation was initiated for the NJ ex order 26 incident. Resident #3 NJ ex order 26.4b1 and NJ ex order 26.4b1 Resident #1 and Resident #2 until NJ Exec Order 26. Resident #3 NJ ex order 26.4b1	F 600	) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Residents #1 and #2 were assessed by RN on NJ ex order 26.4b1, NJ ex order 26.4b1 . NJ Exec Order 26.4b1 or indications of NJ Exec Order 26.4b1 were noted on both Residents #1 and #2. ¿ US FOIA (b)(6) Resident #3 NJ ex order 26.4b1 . Evaluation was completed and Care Plan was updated for Resident #3. ¿ Resident #3 NJ ex order 26.4b1 which primarily has NJ Exec O and NJ Exec Order 26 residents. Resident #3 NJ ex order 26.4b1 NJ ex order 26.4b1, NJ ex order 26.4b1 ¿ Resident #3 was educated by the US FOIA (b)(6) on NJ ex order 26.4b1, and again, on NJ ex order 26.4b1 (for emphasis), that NJ ex order 26.4b1 ¿ NJ ex order 26.4b1 as follows: o Resident #1- NJ ex order 26.4b1 care plan was updated on NJ ex order 26.4. Resident #1 will be	

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NJ ex order 26.4b1) who determined that Resident #3 NJ ex order 26.4b1 at the time of the assessment on NJ ex order 26.

The facility's failure to report and initiate interventions to address the behavior displayed by Resident # 3 approximately NJ ex order 26.4b1 .

This deficient practiced was evidence by:

On NJ ex order 26.4b1 , the surveyor reviewed the MR of Resident #1, Resident #2, and Resident #3.

1. According to the "Admission Record (AR)", Resident #1 was admitted to the facility on NJ ex order 26.4b1 , with diagnoses which NJ ex order 26.4b1 to; NJ ex order 26.4b1

The Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b1 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of NJ ex which indicated cognition was NJ ex order 26.4b1

A Care Plan (CP), initiated on NJ ex order 26.4b1 , reflected that Resident #1 NJ ex order 26.4b1 The CP further included that Resident #1 NJ ex order 26.4b1

2. According to the AR, Resident #2 was admitted to the facility on NJ ex order 26.4b1 , with a diagnosis NJ ex order 2

NJ Exec Order 26.4 to all activities held on the first floor. Staff will redirect Resident #1 NJ ex orde NJ ex order 26.4b1 with Resident #3.

- o Resident #2 - NJ ex order 26.4b1 on NJ ex order 26.4b1 care plan was updated on NJ ex order 26.4b1
- o Resident #3 - NJ ex order 26.4b1 ; care plan was updated on NJ ex order 26.4b1

¿ Resident #3 NJ ex order 26.4b1

¿ Staff will prompt Resident #3 NJ ex orde .

¿ Resident #3 NJ ex order 26.4b1 .

¿ Staff will NJ ex order 26.4b1 Resident #3 NJ e

¿ Director of Nursing or Designee will review progress notes on Resident #3□s medical records daily x 1 week, then weekly x 4 weeks, then monthly x 2 months. This is to determine if Resident #3 has NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 that may require evaluation, intervention and support.

¿ The back elevator code was changed on 3/16/23 with education on 3/16/23 to all staff that the code will not be provided to Resident #3.

¿ Education was completed for all staff on NJ ex order 26.4 by the JS FOIA (B) re: Resident #3 NJ ex order 26.4b1 .

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F 600	Continued From page 3 The MDS, dated [redacted], revealed Resident #2 had a BIMS score of [redacted] which indicated a [redacted] and NJ ex order 26.4b1 [redacted] A CP, initiated on [redacted], included that Resident #2 had NJ ex order 26.4b1 and NJ ex order 26.4b1 . 3. According to the AR, Resident #3 was admitted to the facility on [redacted], with diagnoses [redacted] The MDS, dated [redacted] revealed Resident #3 had a BIMS of [redacted] which indicated NJ ex order 26.4b1 [redacted]. A CP, initiated and revised on [redacted] indicated that the resident NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 : NJ ex order 26.4b1 [redacted] Review of the investigation summary (IS) dated [redacted], revealed that on [redacted] at 3:30 pm, Certified Nursing Assistant (CNA #1) witnessed Resident #3 NJ ex order 26.4b1 to Resident #2. The [redacted] also reported that (date unknown) she witnessed the same, Resident #3 NJ ex order 26.4b1 [redacted] Resident #1. The IS further revealed that the CNA revised her statement "all she saw was Resident #3 [redacted] Residents #1 and #2 NJ ex order 26.4b1 [redacted] Furthermore, the IS	F 600	¿ Education was completed for all staff on 3/21/23 by the ADON re: Resident #1 NJ ex order 26.4b1 [redacted] Resident #1 NJ ex order 26.4b1 [redacted] Resident #3. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents in the facility□s 2nd floor Long Term Care Unit have the potential to be affected by the same deficient practice. Administrator, DON and Designees conducted observation rounds, staff interviews and review of medical records of all residents in the 2nd floor Long Term Care Unit to identify if there were residents who were affected by unwanted inappropriate touching by Resident #3. No residents were affected. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All staff were in-serviced on the regulations governing F-600 and Facility□s Policy regarding Abuse, Neglect, Mistreatment and Misappropriation of Resident Property-Reporting and Investigating." Emphasis was made on Proper Reporting, Prompt Investigation and Implementation of Interventions to prevent reoccurrence of any incident involving resident-to-resident	

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F 600	Continued From page 4 conclusion indicated that NJ ex order 26.4b1 from Resident #3 to Resident #2 and Resident #1. Resident #3 was educated NJ ex order 26.4b1 Additionally, if [he/she] NJ ex orde Included in the IS was CNA #1's statement, undated. NJ ex order 26.4b1 at 3:45 pm, the US FOIA (b was in the hallway and heard Resident #3 NJ ex order 26.4b1." The statement further indicated that the US FOIA (b witnessed Resident #3 NJ ex order 26.4 Resident #2 NJ ex order CNA #1 asked Resident #3 NJ ex order 2 Resident #2. Resident #3 NJ ex order 26.4b1 Included in the IS, Resident #1's written interview, undated, indicated that Resident #1 NJ ex ord "[Resident #3] NJ ex order 26.4b1 Resident #1 circled NJ ex order 2 NJ ex orde Resident #1 NJ ex order 26.4b1 Included in the IS was Resident #3's statement dated NJ ex order 26 , which indicated on: "NJ ex order 26.4b1 1. NJ ex order 26.4b1 [Resident#2] NJ ex order 26.4b1 NJ ex order 26.4b1 " "NJ ex order 26.4b1 2. NJ ex order 26.4b1 [Resident #1], NJ ex order 26.4b1	F 600	inappropriate touching. In-services on Facility□s Abuse and Reporting Policy will be on-going for new hires and on an annual basis. IV. MONITORING OF CORRECTIVE ACTIONS TO PREVENT REOCCURRENCE ¿ The Director of Nursing or Designee will conduct 3 random Staff interview Audits in the 2nd Floor Long-Term Care Unit to determine if staff observed any residents with behaviors of inappropriately touching other residents. This will be done weekly x 4 weeks; then monthly thereafter x 6 months. If staff identifies a resident with inappropriate touching behaviors, Administrator or Designee will be notified immediately. Medical Records will be reviewed for proper documentation, reporting, investigation, and management, as appropriate. Any issues will be addressed immediately by the Administrator/Designee. Results of the audits will be reported to the QAPI Committee monthly. The Administrator will be responsible for ensuring compliance monthly x 6 months. QAPI Committee will determine the need for further audits and/or action plans.	

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Included in the IS, an undated statement from the Unsampled Resident #4 (UR4), NJ ex order 26.4b1 .

UR4 indicated "on NJ ex order 26 at 3:30 pm [Resident #2] NJ ex order 26.4b1 [Resident #3] NJ ex order 26.4b1 [Resident #2] NJ ex order 26.4b1 NJ ex order 26.4b1 On NJ ex order 26.4b1 at about 3:30 pm [Resident #2] NJ ex order 26.4b1. NJ ex ord [unsampled Resident #4] NJ ex order 26.4b1 [Resident #2 and Resident #3]. [Resident #2] NJ ex order 26.4b1 . NJ ex order 26.4b1 When [Resident #2] NJ ex order 26.4b1 [Resident #3] NJ ex order 26.4b1 NJ ex order 26.4b1 [Resident #3] NJ ex order 26.4b1 - NJ ex order 26.4b1 [Resident #2]. NJ ex order 26.4b1 . [Resident #3] NJ ex order 26 [Resident #2]. NJ ex order 26.4b1 -[Resident #3] said - "NJ ex order 26.4b1

The surveyor conducted an interview with UR4 on 3/16/23 at 1:35 pm, the UR4 confirmed what was written on the IS. However, UR4 stated that "[Resident #2] NJ ex ord [Resident #3], NJ ex order 26.4b1 The UR4 further stated that NJ ex order 26.4b1 Resident #3 NJ ex order 26.4b1 Resident #2 because the NJ ex order 26.4b1

The CP for Resident #3, initiated and revised on NJ ex order 26.4 (NJ Exec Order 26.4b1 after the initial unreported

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incident), indicated that Resident #3 had a NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 when NJ Exec Order 26.4b1 them. Interventions which included but were not limited to; "assist me with developing more NJ Exec Order 26.4b1 methods of NJ Exec Order and NJ Exec Order 26.4b1 .Intervene as necessary to protect the NJ Exec Order and NJ Exec Order of NJ Exec Order 26.4b1 .Divert attention. Remove from situation and take to NJ Exec Order 26.4b1 as needed. Monitor NJ Exec Order 26.4b1 episode and attempt to determine underlying cause. Consider location, time of day, person involved, and situation. Document NJ Exec Order 26.4b1 and potential causes."

Review of Resident #3's NJ Exec Order 26.4b1 ," dated NJ Exec Order at 11:15 am, the NJ Exec Order 26.4b1 indicated that "Client was referred by US FOIA (b)(6) ..after she discovered that Client made NJ Exec Order 26.4b1 with a [male/female] resident without NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . Client reportedly NJ Exec Order [male/female] resident on the NJ Exec Order 26.4b1 [Male/Female] resident has NJ Exec Order 26.4b1 .According to staff, about a week prior Client NJ Exec Order 26.4b1 [male/female] residents who appeared to be NJ Exec Order 26.4b1 and NJ Exec Order [him/her] on the NJ Exec Order 26.4b1 as well. Client reported that [he/she] NJ Exec Order 26.4b1 [male/female] resident to NJ Exec Order [him/her]. Both [male/female] residents have NJ Exec Order 26.4b1 According to US FOIA (b)(6) Client has NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 prior to this incident. It is unclear whether Client was informed of LTCF's [Long Term Care Facility] policy on NJ Exec Order 26.4b1 after the first incident, but [he/she] was informed after the second incident. Client stated that [he/she] was NJ Exec Order 26.4b1 [he/she] was NJ Exec Order 26.4b1 and would not do it again...Client is NJ Exec Order 26.4b1 ...Client was seated in an NJ Exec Order 26.4b1 and reported

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being able to [redacted] to a [redacted] ..." The [redacted] further indicated that Resident #3 had [redacted] and with [redacted] and under "Clinical Impression: Client does not appear to be an [redacted] to himself/herself or others at the time of this assessment. Client appears to have been unaware of LTCF's policy on [redacted]. Client appeared to have the intention of [redacted] and/or [redacted] resident... [redacted] Recommendations: 1. Provide Client with policy on [redacted] with residents and educate [him/her] on terms. Educate Client on appropriate ways of showing [redacted] that are in line with policy. 2. Utilize line of sight supervision when Client is in [redacted] to other residents. Prompt Client to [redacted] when [redacted] 3. Encourage Client to come to staff to report if Client notices residents in [redacted] 4. [redacted] recommends staff training on "Managing [redacted] in Long-Term Care..."

There was no staff education regarding "[redacted] documented until [redacted].

Review of Resident #1's "[redacted] undated, written by [redacted] Nurse Practitioner (NP #1), indicated that Resident #1 [redacted]. The [redacted] described Resident #1 [redacted] The PE indicated that Resident #1 [redacted] The PE indicated "[redacted] [Resident #1] [redacted] [she/he] started pointing to writer [NP #1] [redacted]

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produced a facility pamphlet and pointed to a NJ Exec Order 26.4b1, made a NJ Exec Order 26.4b1 When asked if this resident had any NJ Exec Order 26.4b1 with her/him she/he NJ Exec Order 26.4b1 [his/her] [.] When asked if [she/he] at the facility [she/he] lifted hand ". The further indicated that Resident #3 was NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 regarding the incident. During the conversation with the Resident #1 NJ ex order 26.4b1.

Review of Resident #2's PE, dated , written by NP #1, indicated that Resident #2 Resident #3. The further indicated that Resident #2 NJ ex order 26.4b1 Resident #2 NJ ex order 26.4b1

Review of Resident #3's PE, dated , written by NP #1, indicated that Resident #3 ". The educated Resident #3 on NJ ex order 26.4b1

The MR for Resident #1 NJ ex order 26.4b1 NJ ex order 26.4b1 Resident #3.

The MR for Resident #2 NJ ex order 26.4b1 NJ ex order 26.4b1. Furthermore, the MR/CP did not indicate that interventions were put in place to protect Resident #2 NJ ex order 26.4b1

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[redacted] Resident #3 until [redacted].

The MR for Resident #3 NJ ex order 26.4b1 [redacted]

Resident #3 NJ ex order 26.4b1 [redacted]. The MR indicated that on [redacted] at 10:51 pm, Resident #3 NJ ex order 26.4b1 [redacted] The MR had no documented evidence that Resident #3 NJ ex order 26.4b1 [redacted]

During the tour of the unit on 3/14/23 from 10:05 am to 11:00 am, the surveyor observed Resident #2 NJ ex order 26.4b1 [redacted] The surveyor further observed that Resident #2 and Resident #3's NJ ex order 26.4b1 [redacted]

The surveyor attempted to interview Resident #1 on 3/14/23 and 3/16/23. The resident was given a NJ Exec Order 26.4b1 [redacted]. The surveyor used the computer and paper and marker to [redacted] to the resident. The surveyor wrote on paper "Resident #1 was asked [redacted] Resident #3 NJ ex order 26.4b1 [redacted] Resident [redacted] instead, Resident #1 NJ ex order 26.4b1 [redacted] Resident #1 [redacted] The surveyor asked another question. "When is your birthday?" Resident #1 NJ ex order 26.4b1 [redacted] When the surveyor began

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questioning about the NJ ex order 26.4b1 Resident #1 [redacted]

During an interview with the surveyor on 3/14/23 at 11:43 am, Resident #3 NJ ex order 26.4b1 [redacted] [Resident #3] NJ ex order 26.4b1 [redacted] Resident #3 further explained that "a few weeks ago, before the incident with Resident #2 [redacted] [Resident #1] NJ ex order 26.4b1 [redacted] Furthermore, the resident stated that he/she also NJ ex order 26.4b1 [redacted] Resident #2. Resident #2 NJ ex order 26.4b1 [redacted] Resident #3 stated that NJ ex order 26.4b1 Resident #2 and put Resident #3's NJ ex order 26.4b1 Resident #2 and [redacted] Resident #2 NJ ex order 26.4b1. Resident #3 revealed that NJ ex order 26.4b1 the [redacted] on [redacted] the administrator had said [redacted]

During an interview with the surveyor on 3/14/23 at 12:57 pm, CNA #1 revealed that on [redacted] around 3:45 pm, she heard a resident saying, NJ ex order 26.4b1 from Resident #2's room. [redacted] #1 entered Resident #2's room and witnessed Resident #3 [redacted] Resident #2 NJ ex order 26.4b1 and Resident #2's NJ ex order 26.4b1 [redacted] The [redacted] instructed Resident #3 NJ ex order 26.4b1 Resident #2. Resident #3 said NJ ex order 26.4b1 and [redacted]. CNA #1 NJ ex order 26.4b1 [redacted]. The [redacted] further revealed that approximately NJ ex order 26.4b1 [redacted]

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COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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incident (unable to recall exact date) she witnessed Resident #3 NJ ex order 26.4b1 Resident #1 NJ ex order 26.4b1 The US FOIA (B) further stated that Resident #1's NJ ex order 26.4b1 Resident #3 NJ ex order 26.4b1 NJ ex order 26.4b1 Resident #1 NJ ex order 26.4b1 The US FOIA (B) added that Resident #1's NJ ex order CNA #1 instructed Resident #3 NJ ex order 26.4b1 Resident #1. Resident #3 NJ ex order 26.4b1 The US FOIA (B) reported the NJ ex order 26.4b1 to an agency nurse on the same day. The US FOIA (B) was unable to recall who was nurse that she reported the incident on NJ ex order 26.4b1 .

During an interview with the surveyor on 3/14/23 at 1:40 pm, the US FOIA (B) (6) US FOIA (B) (6)) and US FOIA (B) (6) the US FOIA (B) (6) stated that on NJ ex order 26.4b1 (unknown time), the Licensed Practical Nurse (LPN #1) reported that Resident #3 NJ ex order 26.4b1 Resident #2's NJ ex order 26.4b1 , NJ ex order 26.4b1 . The US FOIA (B) (6) further stated that she did not interview Resident #2 because he/she NJ Exec Order 26.4b1 and has diagnosis of NJ Exec Order 26.4b1 The US FOIA (B) (6) also revealed that the US FOIA (B) witnessed a similar incident that occurred approximately NJ ex order 26.4b1 NJ ex order 26.4b1 involving Resident #3 and Resident #1. The US FOIA (B) (6) stated that on NJ ex order 26.4b1 she asked Resident #1 in writing saying, NJ ex order [Resident #3] NJ ex order 26.4b1 According to US FOIA (B) (6) "Resident #1 NJ ex order 26.4b1 The US FOIA (b)(6) wrote again "NJ ex order 26.4b1 and Resident #1 NJ ex order 26.4b1 " The US FOIA (B) (6) stated that she reported the incident to the US FOIA (B) on NJ ex order 26.4b1 . The US FOIA (B) confirmed that on NJ ex order 26.4b1 she was made aware of

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the first incidents that occurred prior to the [NJ ex order 26] incident involving Resident #3 and Resident #1 and the NJ ex order 26.4b1 involving Resident #2 and Resident #3. The [US FOIA (B)] instructed the US FOIA (B) (6) LPN #2 to monitor Resident #3 and the NJ ex order 26.4b1 on [NJ ex order 26] by the [US FOIA (B)]. The [US FOIA (B)] confirmed that she did not report the NJ ex order 26.4b1 to NJDOH.

During an interview with the surveyor on 3/14/23 at 2:16 pm, the UM/LPN #2 confirmed that she was made aware on [NJ ex order 26.] of the [NJ ex order 26.4b1] that happened NJ ex order 26.4b1 involving Resident #1 and Resident #2, and on [NJ ex order 26] involving Resident #2 and Resident #3. The UM/LPN #2 stated that she did not initiate the investigation because the [US FOIA (B)] said that [NJ ex order 26.4b1] The UM/LPN #2 further stated that she did not update the Resident #1 and Resident #3's CP NJ ex order 26.4b1

During an interview with the surveyor on 3/16/23 at 10:10 am, the [US FOIA] stated that on [NJ ex order 26] she was made aware of the [NJ ex order 26.4b1] by the [US FOIA (B)] and [US FOIA (B)] of the NJ ex order 26.4b1 Resident #2 and Resident #3 that occurred on [NJ ex order 26], and the incident with Resident #1 and Resident #3 that NJ ex order 26.4b1 According to the [US FOIA], during the interview with the [US FOIA] and [US FOIA (B)] on 3/8/23 (unable to recall exact time), Resident #3 could not remember NJ ex order 26.4b1 Resident #2 and Resident #3, the [US FOIA (B)] asked NJ ex order 26.4b1 [Resident #2]?, Resident #3 replied "NJ ex order 26.4b1 [Resident #2] [NJ ex]

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F 600	Continued From page 13 NJ ex order 26.4b1" Furthermore, the US FOIA revealed that Resident #3 NJ ex order 26.4b1 During an interview with the surveyor on 3/14/23 at 12:15 pm, the US FOIA (B) and the US FOIA revealed that the facility NJ ex order 26.4b1 on NJ ex order 26 when CNA #1 witnessed Resident #3 NJ ex ord Resident #2 NJ ex order 26.4b1 The US FOIA (B) further revealed that he educated Resident #3 NJ ex order 26.4b1 The US FOIA (B) stated the NJ ex order 26.4b1 to the US FOIA (B) (6) because the original statement from the staff and Resident #3 were NJ ex order 26.4b1 " During an interview with the surveyor on 3/14/23 at 1:37 pm, the US FOIA (B) (6) revealed that the NJ ex order 26.4b involving Resident #1 and Resident #3 NJ ex order 26.4b because CNA #1 NJ ex order 26.4b1 The LNHA added "NJ ex order 26.4b1 Review of the facility "SELF-STUDY ORIENTATION PACKET", indicated under "ABUSE/NEGLECT/ELDER JUSTICE/PEGGY'S LAW...to report any incidents or aggression or any indication of abusive behaviors. Protect residents immediately and report any cases of abuse to the Administrator immediately. This is everyone's responsibility. Notify Abuse Officer - - THE ADMINISTRATOR immediately!! Thoroughly investigate - - statements from everyone Reported immediately to state agency	F 600		

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F 600	Continued From page 14 and law enforcement officials when appropriate..." The facility policy titled; "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" dated 9/22/22, indicated "All reports of resident abuse...are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported...Reporting Allegations to the Administrator and Authorities 1. If resident abuse...is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law...2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying /likening the facility; b. The Local/state ombudsman; c. The resident's representative...Law enforcement officials; f. Attending physician; and...3. "Immediately" is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone...All allegations are thoroughly investigated...."	F 600		
F 609 SS=D	NJAC 8:39 - 4.1 (a) (5) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		5/21/23

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F 609	Continued From page 15 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00162301 Based on interview, medical records (MR) review, and review of pertinent facility documents on 3/14/23, 3/16/23, and 3/20/23, it was determined that the facility failed to immediately report 2 NJ ex order 26.4b1 Resident #3 to the New Jersey Department of Health (NJDOH) and follow their facility policy on "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" for 2 of 5 sampled	F 609	Complete Care at Monmouth F-609 Reporting of Alleged Violations Facility failed to report the incident of NJ ex order 26.4b1 to the New Jersey Department of Health on NJ ex order 26.4b1 Residents affected by deficient practice:	

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F 609	Continued From page 16 residents (Resident #1 and Resident #2) NJ ex order 26.4b1 . This deficient practice was evidenced by the following: 1. According to the "Admission Record (AR)", Resident #1 was admitted to the facility on NJ ex order 26.4b, with diagnoses which NJ ex order 26.4b1 The Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ ex which indicated NJ ex order 26.4b1 A Care Plan (CP), initiated on NJ ex order 26.4b, reflected that Resident #1 NJ ex order 26.4b1 The CP further included that Resident #1 NJ ex order 26.4b1 The surveyor attempted to interview Resident #1 on 3/14/23 and 3/16/23. The resident was given a NJ Exec Order 26.4b1 . The surveyor used the computer and paper and marker to NJ Exec Order 26.4b1 to the resident. The surveyor wrote on paper; Resident #1 NJ ex order 26.4b1 if Resident #3 NJ ex order 26.4b1 Resident #1 did not reply. The resident NJ ex order 26.4b1 When the surveyor began questioning about the incident which happened NJ ex order 26.4b1 Resident #1 NJ ex order 26.4b	F 609	Resident #1, #2 and #3 were affected. NJ ex order 26.4b was reported to N.J. Department of Health on NJ ex order 26.4b1 Identifying other Residents who could be affected by the deficient practice: All residents have the potential to be affected. The DON reviewed other incidents from the previous month to identify if there were other incidents that should have been reported to DOH and none was identified. Measures or systemic changes to ensure that the deficiencies will not recur: The facility□s policies and Procedures on Accident/ Incident Reporting and Abuse was reviewed with Administrator / DON/All staff. Emphasis on the reportable incidents according to the long-term regulations, NJ DOH Guidelines and the facility All staff should be educated on the facility□s incident/accident policy and procedure. Emphasis on reportable grid incidents/accidents and the prompt reporting to NJDOH to be done by the Administrator/DON or the designee as per regulation guidelines. Monitoring the continued effectiveness of the systemic change:	

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F 609	Continued From page 17 2. According to the AR, Resident #2 was admitted to the facility on [NJ ex order 26.4b1], with a diagnosis which NJ ex order 26.4b1 [redacted]. The MDS, dated [NJ ex order 26.4b], revealed Resident #2 had a BIMS score of [NJ e] which indicated a [NJ ex order 26.4b1] [redacted] [NJ ex order], initiated on [NJ ex order 26], included that Resident #2 NJ ex order 26.4b1 [redacted]. During the tour of the unit on 3/14/23 from 10:05 am to 11:00 am, the surveyor observed Resident #2 walking freely from his/her room to the unit's hallway. The surveyor further observed that Resident #2's room was at end of the hallway, not visible from the nurse's station. Resident #2 [NJ ex ord] [redacted] 3. According to the AR, Resident #3 was admitted to the facility on [NJ ex order 26.4b], with diagnoses which included but were not limited to: [NJ ex order 26.4b1] [redacted]. The MDS, dated [NJ ex order 26], revealed Resident #3 had a BIMS score of [NJ ex] which indicated [NJ ex order 26.4b1] [redacted]. Review of the investigation summary (IS) dated [NJ ex order 26] revealed on [NJ ex order 26] at 3:30 pm, Certified Nursing Assistant (CNA #1) witnessed Resident #3 NJ ex order 26.4b1 to Resident #2. The [US FOIA (B] also reported that (date unknown) she witnessed NJ ex order 26.4b1 Resident #1. The IS further revealed that the [US FOIA (B] revised her statement "all she saw was Resident #3 [NJ ex ord]	F 609	The DON/IP/Designee will conduct audits of all Reportable Events and the following of the policy and procedures. Audits will be completed weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action. Completion Date:5/29/23	

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Residents #1 and #2 NJ ex order 26.4b1 " Resident #3 was educated 'NJ ex order 26.4b1 "

Included in the IS was CNA #1's undated statement which indicated an NJ ex order 26.4b1 at 3:45 pm. The US FOIA (b was in the hallway and heard Resident #3 NJ ex order 26.4b1 The statement further indicated that the US FOIA (b witnessed Resident #3 NJ ex order 26.4 Resident #2 in his/her room. CNA #1 asked Resident #3 NJ ex order 2 Resident #2. Resident #3 NJ ex order 26.4b1

Included in the IS was Resident #3's statement dated NJ ex order 26.4, which indicated on: NJ ex order 26.4b1] 1. My next door Resident [Resident#2] NJ ex order 26.4b1 "[NJ ex order 26.4b1 2. With the [Resident #1], NJ ex order 26.4b1 "

NJ ex order, initiated on NJ ex order 26.4b indicated that the resident NJ ex order 26.4b1 Interventions included but was not limited to:

NJ ex order 26.4b1

The NJ ex o, initiated on NJ ex order 26 NJ ex order 26.4b1

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NJ ex order 26.4b1 further indicated that Resident #3 NJ ex order 26.4b1 Interventions which included but were not limited to; "assist me with developing more NJ Exec Order 26.4b1 of NJ Exec Order and NJ Exec Order 26.4b1 .Intervene as necessary to protect the NJ Exec Ord and NJ Exec Orde of others...Divert attention. Remove from situation and take to NJ Exec Order 26.4b as needed. Monitor NJ Exec Order 26.4 episode and attempt to determine underlying cause. Consider location, time of day, person involved, and situation. Document NJ Exec Order 26.4 and potential causes."

Review of Resident #3's NJ Exec Order 26.4b1 dated NJ ex order 26 at 11:15 am, the NJ ex order 26.4b indicated that "Client was referred by US FOIA (b)(6) ..after she discovered that Client made NJ Exec Order 26.4b1 with a [male/female] resident NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . Client reportedly NJ Exec Orde [male/female] resident on the NJ Exec Order 26.4b [male/female] resident has NJ Exec Order 26.4b ...According to staff, about a NJ Exec Ord prior Client put [his/her] NJ Exec Order 26.4b1 [male/female] residents who appeared to be NJ Exec Order 26.4b1 and NJ Exec Orde [him/her] on the NJ Exec Order 26.4b as well. Client reported that [he/she] NJ Exec Order 26.4b1 [male/female] resident to NJ Exec O [him/her]. Both [male/female] residents have NJ Exec Order 26.4b ..."

During an interview with the surveyor on NJ ex order 26.4b at 12:57 pm, CNA #1 revealed that on NJ ex order 26 around 3:45 pm, she heard a resident saying, NJ ex order 26.4b1 from Resident #2's room. CNA #1 entered Resident #2's room and witnessed Resident #3 NJ ex order 26 Resident #2 NJ ex order 26.4b1 and Resident #2's NJ ex order 26.4b1

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right. The CNA instructed Resident #3 NJ ex order 26.4b1 Resident #2. Resident #3 said NJ ex order 26.4b1 " and left the room. CNA #1 reported the incident to the nurse.

The CNA further revealed that approximately NJ NJ ex order 26.4b1 to the NJ ex order 26.4b1 (unable to recall exact date) she witnessed Resident #3 NJ ex ord NJ ex order 26.4b1 Resident #1 NJ ex order 26.4b1 The CNA further stated that Resident #1's NJ ex order 26.4b1 Resident #3 NJ ex order 26.4b1 Resident #1 NJ ex order 26.4b1 The CNA added that Resident #1's NJ ex order 26.4b1 . CNA #1 instructed Resident #3 NJ ex order 26.4b1 Resident #1. Resident #3 NJ ex order 26.4b1 The US FOIA (b reported the incident to an agency nurse on the same day. The US FOIA (b was unable to recall who the nurse was that she reported the incident on NJ ex order 26.4b1.

During an interview with the surveyor on 3/14/23 at 11:43 am, Resident #3 NJ ex order 26.4b1 [Resident #3] NJ ex order 26.4b1 Resident #3 NJ ex order 26.4b1 with Resident #2 [unable to recall time and date] NJ ex order 26.4b1 [Resident #1] NJ ex order 26.4b1 NJ ex order 26.4b1 , NJ ex order 26.4b1 Furthermore, the resident stated NJ ex order 26.4b1 Resident #2. Resident #2 NJ ex order 26.4b1 Resident #3 NJ ex order 26.4b1 Resident #2 NJ ex order 26.4b1 Resident #3's NJ ex order 26.4b1 Resident #2 NJ ex order 26.4b1 Resident #2 NJ ex order 26.4b1. Resident #3

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revealed that a few days after the incident on NJ ex order 26, the administrator had said NJ ex order 26.4b1 [redacted]

During an interview with the surveyor on 3/14/23 at 1:40 pm, the US FOIA (B) (6) [redacted] US FOIA (B) and US FOIA (B), the US FOIA (B) (6) stated that on NJ ex order 26 (unknown time), the Licensed Practical Nurse (LPN #1) reported that Resident #3 NJ ex order 26 Resident #2's NJ ex order 26.4b1 [redacted]. The US FOIA (B) (6) further stated that she did not interview Resident #2 NJ ex order 26.4b1 [redacted] The US FOIA (B) (6) also revealed that the US FOIA (B) witnessed a similar incident that occurred approximately NJ [redacted] incident involving Resident #3 and Resident #1. The US FOIA (B) (6) stated that on NJ ex order 26, she asked Resident #1 in writing saying, NJ ex order [redacted] [Resident #3] NJ ex order 26.4b1 [redacted] According to US FOIA (B) (6) "[Resident #1] NJ ex order 26.4b1 [redacted]." The ADON wrote; NJ ex order 26.4b1 [redacted] [Resident #1] NJ ex order 26.4b1 [redacted] The US FOIA (B) (6) stated that she reported the incident to the US FOIA (B) on NJ ex order 26. The US FOIA (B) confirmed that on NJ ex order 26 she was made aware of both incidents; NJ ex order 26 and the previous incident approximately NJ Exec Order 26.4b1. The US FOIA (B) instructed the US FOIA (B) (6) LPN #2 to monitor Resident #3 and the investigation started on NJ ex order 26 by the US FOIA (B). The US FOIA (B) confirmed that she did not report either incident to NJDOH.

During an interview with the surveyor on 3/14/23 at 2:16 pm, the UM/LPN #2 confirmed that she was made aware on NJ ex order 26 of the incidents that happened approximately NJ ex order 26.4b1 involving Resident #1 and Resident #2, and on NJ ex order 26

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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NJ ex order 26.4b1 Resident #2 and Resident #3. The UM/LPN #2 NJ ex order 26.4b1

During an interview with the surveyor on 3/16/23 at 10:10 am, the US FOIA stated that on NJ ex order 26 she was made aware of the incidents by the US FOIA (B) and US FOIA (B) of the NJ ex order 26.4b1 Resident #2 and Resident #3 on NJ ex order 26.4 and the NJ ex order 26.4b with Resident #1 and Resident #3 that NJ ex order 26.4b1 . According to the US FOIA, during the interview with the US FOIA and US FOIA (B) on NJ ex order 26 (unable to recall exact time), Resident #3 could not remember if there was NJ Exec Order 26.4b1 between Resident #2 and Resident #3, the US FOIA (B) asked "NJ ex order 26.4b1 [Resident #2]?, Resident #3 replied NJ ex o NJ ex order 26.4b1, NJ ex order 26.4b1 [Resident #2] NJ ex order 26.4b1 Furthermore, the SW revealed that Resident #3 NJ ex order 26.4b1 Resident #1.

During an interview with the surveyor on 3/14/23 at 12:15 pm, the US FOIA (B) (6) and the US FOIA (B) (6) revealed that the facility had investigated an incident when CNA #1 reported that she witnessed Resident #3 NJ ex order 26.4 Resident #2's NJ ex order 26.4b1 Resident #2 NJ ex order 26.4b1. The US FOIA (B) further revealed that he educated Resident #3 NJ ex order 26.4b1 . The US FOIA (B) (6) and US FOIA (B stated the incident was not reported to the US FOIA (B) (6) because the original statement from the staff and Resident #3 were "NJ ex order 26.4b1 ."

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F 609	Continued From page 23 Review of the facility "SELF-STUDY ORIENTATION PACKET", indicated under "ABUSE/NEGLECT/ELDER JUSTICE/PEGGY'S LAW...to report any incidents or aggression or any indication of abusive behaviors. Protect residents immediately and report any cases of abuse to the Administrator immediately. This is everyone's responsibility. Notify Abuse Officer - - THE ADMINISTRATOR immediately!! Thoroughly investigate - - statements from everyone Reported immediately to state agency and law enforcement officials when appropriate..." The facility policy titled; "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" dated 9/22/22, indicated "All reports of resident abuse...are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported...Reporting Allegations to the Administrator and Authorities 1. If resident abuse...is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law...2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying /likening the facility; b. The Local/state ombudsman; c. The resident's representative...Law enforcement officials; f. Attending physician; and...3. "Immediately" is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted	F 609		

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F 609	Continued From page 24 via special carrier, fax, e-mail, or by telephone...All allegations are thoroughly investigated...." NJAC 8:39-9.4(f)	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint #NJ 00162301	F 657	Complete Care at Monmouth	5/29/23

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F 657	Continued From page 25 Based on interviews and review of the medical records (MRs) and other facility documentation on 3/14/23, 3/16/23, and 3/21/23, it was determined that the facility failed to update and/or initiate care plan interventions timely for a resident who was at risk for NJ Exec Order 26.4b1 and NJ Exec O use while NJ Exec Order 26.4b1). This deficient practice was identified for 1 of 5 sampled resident (Resident #4) reviewed for care plans. This deficiency is evidenced by the following: 1. According to the Admission Record, Resident #4 was admitted to the facility on NJ ex order 26. A Physician's progress notes (PN) dated NJ ex order 26.4b indicated diagnoses which included but were not limited to: NJ ex order 26.4b1 . A Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b1, revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ ex which indicated NJ ex order 26.4b1 An Order Summary Report (OSR) included a Physician's Order (PO), dated NJ ex order 26 for: May go NJ ex order and NJ ex order 26.4b1 A Care Plan (CP), initiated on NJ ex order 26.4b1 and revised on NJ ex order 26.4b, included but were not limited to: while NJ ex order 2 ,NJ ex order 26.4b1 . Interventions, initiated on NJ ex order 26 reflected Resident #4 NJ ex order 26.4b1	F 657	F657 Care Planning Residents affected by deficient practice: Residents #4 was affected by this deficient practice. The deficient practice was identified that the facility failed to update and /or initiate care plan intervention timely for resident #4 NJ ex order 26 Resident #4 NJ ex order 26.4b1 Identifying other Residents who could be affected by the deficient practice: All residents who sign out on pass with a history of current or past substance/ drug use. Care plan was reviewed for other residents who go out on pass with a history of substance abuse and updated. Measures or systemic changes to ensure that the deficiencies will not recur: All Licensed staff are educated by DON/IP/Designee on the facility policy and procedure on Comprehensive Care Planning. Care plans of residents with history of substance abuse were reviewed. All residents newly admitted to the facility with an identified history with substance abuse will be care planned within 48 hours of admission. Monitoring the continued effectiveness of	

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F 657	Continued From page 26 NJ ex order 26.4b1 A nursing PN signed by the US FOIA (B) (6) dated NJ ex order 26.4 at 7:44 AM, revealed a late entry for NJ ex order 26.4 5pm. It indicated the "resident signed self out for out on pass. Resident NJ Exec Order 26.4 to facility with the NJ Exec Order 26.4b1 NJ Exec reported resident was found NJ Exec Order 26.4b1 of a NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 As per NJ Exec when he/she arrived to the scene NJ Exec Orde reported to him/her that resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 was administered. Resident was with no signs of NJ Exec Order 26.4 This writer spoke with the physician and made aware. Per physician continue to monitor resident for NJ Exec Order 26.4b1 ." Review of the of the CP did not reveal that interventions were developed or implemented after the incident on NJ ex order 26.4b . NJ ex order 26.4b1) form revealed Resident #4 NJ ex order 26.4b1 and NJ ex order 26.4 . NJ ex order 26.4b1 which was not according to the resident's CP. A nursing PN signed by the US FOIA (B , dated NJ ex order 26 at 8:00 AM, revealed the resident NJ ex order 26.4b1 on NJ ex order 26 which the facility learned on NJ ex order 26 when the correctional facility informed them the resident NJ ex order 26.4b1 . During an interview with the surveyor on 3/21/23 at 2:00 PM, Licensed Practical Nurse (LPN) #1 assigned to Resident #4 on NJ ex order 26 stated the resident NJ ex order 26.4b1 and	F 657	the systemic change: The DON/IP/Designee will conduct audits of all residents who sign out on pass with a history or current substance use/ abuse to ensure care plan focus, goals and interventions are initiated timely. Audits will be completed. Weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Completion Date:	

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return before 8:00 PM. LPN #1 confirmed that a family member indicated Resident #4 NJ ex order 26.4b1 and on NJ ex order 26 and was the reason Resident #4 NJ ex order 26.4b1. LPN #1 was unsure of the resident's care plan or if it was updated on NJ ex order 26.4b or prior to the NJ ex order 26.4b1 NJ ex order 26.4b1

During an interview with the surveyor on 3/21/23 at 1:21 PM, the US FOIA (B) (6) LPN #2 stated the US FOIA (b)(6) initiates the baseline care plan, the US FOIA (B) (6) completes the comprehensive CP, and the UMs complete the updates. She added, the CP is important because it served as a communication tool among interdisciplinary staff on how to care for residents. The UM/LPN #2 agreed the aforementioned incident on NJ ex order 26.4b was a NJ ex order 26.4b is Resident #4's status which NJ ex order 26.4b1 . However, the care pan was not revised until NJ ex order 26, after the NJ ex order 26.4b1. The UM/LPN #2 stated she was unsure if she had to update the care plan but acknowledged the CP should have been updated to reflect the resident's NJ ex order 26.4b1

During a telephone interview with the surveyor post survey on 4/4/23 at 10:26 AM, the US FOIA (B) (6) /Registered Nurse (RN) #2, assigned supervisor on NJ ex order 26.4b day (7AM-3PM) and evening (3-11PM) shifts stated he was unaware of the incident on NJ ex order 26.4b. He was unsure who initiates or updates residents' care plan and was unaware on how to initiate or update resident's CP.

During an interview with the surveyor on 3/21/23 at 4:50 PM, the US FOIA (B stated there was incident report completed for the aforementioned incident

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F 657	Continued From page 28 on [NJ ex order 26.4] because the incident did not occur at the facility. However, the resident's [NJ ex order 26.4b1] [redacted] The [US FOIA (B)] further stated she updated Resident #4's CP; however, it was not revised until [NJ ex order 26]. She could not explain why the CP was not updated timely. During an interview with the surveyor on 3/21/23 at 4:50 PM and a telephone interview post survey on [NJ ex order 26] at 2:00 PM, the [US FOIA (B) (6)] stated the [US FOIA (B) (6)], and [US FOIA (b)(6)] [US FOIA (B)] are expected to initiate and update CPs for each resident. CPs are initiated on admission and updated or revised for changes in condition and or when incident or accident occur. Review of the facility's policy titled "Care Planning", updated 10/2021 revealed "our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident." Review of the facility's policy titled "Change in a Resident's Condition or Status" updated 10/2019 revealed "1. The nurse will notify the Physician or physician on call when there has been a(an); a. accident or incident involving the resident ...e. significant change in the resident's physical/emotional/mental condition ...2. A significant change is a major decline or improvement in the resident's status that; a. Will not normally resolve by itself without intervention by staff ...c. Requires interdisciplinary review and/or revision to the care plan ..." NJAC 8:39-11.1	F 657		

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F 657	Continued From page 29 NJAC 8:39-11.2 (i)	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information	F 660		5/21/23

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regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:

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F 660	Continued From page 31 Complaint #NJ 00162301 Based on interviews and review of the medical records (MRs) and other facility documentation on 3/14/23, 3/16/23, and 3/21/23, it was determined the facility failed to develop a discharge care plan, update the discharge goals based on the resident's needs, and notify the physician of a NJ ex order 26.4b1 [redacted]. This deficient practice was identified for 1 of 3 sampled residents (Resident #4) NJ ex order 26.4b1 [redacted]. The deficient practice is evidenced by the following. 1. According to the Admission Record, Resident #4 NJ ex order 26.4b1 [redacted] A Physician's progress notes (PN) dated NJ ex order 26.4b indicated diagnoses NJ ex order 26.4b1 [redacted] A Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b1 [redacted] revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ ex o [redacted] which indicated NJ ex order 26.4b1 and the resident NJ ex order 26.4b1 [redacted] The goal-setting portion (Section Q) of the MDS indicated the resident NJ Exec Order 26.4b1 [redacted] in the assessment. The questions about expectations for NJ ex order 26.4b1 [redacted] and if a referral was made to a local contact agency were marked NJ ex order [redacted]. The MDS further revealed that Resident #4 NJ ex order 26.4b1 [redacted] Review of the Order Summary Report (OSR)	F 660	Complete Care at Monmouth F-660 Discharge Planning Residents affected by deficient practice: Residents #4 was affected by this deficient practice. The deficient practice was identified that the facility failed to develop a discharge care plan, update the discharge goals based on the resident's needs and notify the physician of a discharge for a resident to the community. Resident #4 NJ ex order 26.4b1 [redacted]. Identifying other Residents who could be affected by the deficient practice: All residents who have the potential of being discharged. All residents who have the potential of being discharged were reviewed, to ensure that they have discharge care plan in place. Measures or systemic changes to ensure that the deficiencies will not recur: All Licensed staff are educated by DON/IP/Designee on the facility policy and procedure on Discharge procedure and discharge summary plan. Monitoring the continued effectiveness of the systemic change: The DON/IP/Designee will conduct audits	

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F 660	Continued From page 32 revealed no physician order (PO) for discharge to the [redacted] Review of the MR revealed that a care plan (CP) for discharge (DC) planning or DC to [redacted] was not developed since admission. Review of nursing progress notes [redacted] revealed a documentation by the [redacted] on [redacted] at 8:00 AM that Resident #4 [redacted]) on [redacted], no time. [redacted] [redacted] On [redacted], the facility was informed by a [redacted] that Resident #4 [redacted] and [redacted]. There was [redacted] of Resident #4's [redacted] when the [redacted] notified them. On [redacted] at 3:29 PM, a [redacted] documented [redacted] The PN did not reveal detailed documentation the condition of Resident #4 upon DC, or details of the DC. Review of the MR revealed no indication the physician was notified. Further review of the MR revealed, typed and written, document titled '[redacted]," signed by Resident #4 but undated, indicated that Resident #4 [redacted] The document indicated Resident #4's DC date was [redacted]. The RP's home was the DC location, the resident was [redacted] During exit on [redacted] at 4:50 PM, the	F 660	of all residents with a discharge plan to ensure proper procedure is followed and, Care plan completed, Discharge goals updated, and Physician notified. Audits will be completed weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

(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
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Administrator and the [redacted] could not explain why the timeline of the incident or the physician's DC orders were not documented in the MR.

On 3/24/23, post survey, the surveyor received a typewritten timeline document from the facility titled "[redacted] [Resident #4]." The timeline document revealed on [redacted], Resident #4 [redacted] at 11 AM and [redacted] the CF called the facility to [redacted] and [redacted] provided an update. On that same date, afternoon hours, the [redacted] informed the [redacted] that the resident [redacted]. Afterwards, the Administrator contacted Resident #4 [redacted] but they [redacted]. On [redacted], Resident #4 [redacted], and they discussed the potential [redacted] of the resident returning to the facility. Resident #4 [redacted] and mentioned he/she [redacted]. Shortly after, Resident #4 [redacted], gathered his/her belongings, and said he/she would try to check into a [redacted] Approximately half an hour later, Resident #4 called the [redacted] to inform him [redacted]

The timeline document revealed no indication the physician was notified about the [redacted] to the [redacted]. Furthermore, there was no indication that Resident #4 was provided with DC education/instruction or [redacted].

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During a telephone interview with the surveyor on 4/3/23 at 1:51 PM, the resident's attending US FOIA (B) (6) confirmed they were not notified of Resident #4's [redacted] on [redacted].

During a telephone interview with the surveyor on 3/21/23 at 2:45 PM, the [redacted] stated that Resident #4 NJ ex order 26.4b1 [redacted] The RP explained the resident NJ ex order 26.4b1 [redacted] which he was not aware of until Resident #4 called him/her. The [redacted] continued to explain the facility offered Resident #4 a NJ ex order 26.4b1 [redacted].

During a telephone interview with the surveyor on 4/4/23 at 2:00 PM, the US FOIA (b)(6) confirmed that the timeline document was accurate, and Resident #4 NJ ex order 26.4b1 [redacted]

Review of the NJ ex order 26.4b1 [redacted] dated [redacted] revealed that Resident #4's DC NJ ex order 26.4b1 [redacted]."

Review of the MR revealed a [redacted] note indicating that an interdisciplinary care plan (IDCP) meeting was held on [redacted], NJ ex order 26.4b1. The SS notes further indicated that a separate [redacted] was uploaded in the electronic MR. Further review of the SS notes revealed no indication that an NJ ex order 26.4b1 meeting was held.

Review of the document titled NJ ex order 26.4b1 [redacted]) dated [redacted] signed by the

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resident, the NJ Exec the US FOIA (B) (6) the US FOIA (B) (6) and US FOIA as attendees included but were not limited to the following: the care plan was reviewed and updated. Resident #4 NJ ex order 26.4b1 An NJ ex order 26.4b1 which Resident #4 would consider if the NJ Exec contacts the US FOIA (B) (6) . Although it was indicated that the US FO was updated during the IDCP meeting, a US FO for DC planning/DC to the community was not developed or initiated on or after NJ ex order 26.4b1 IDCP meeting.

Review of the NJ ex order dated NJ ex order 26.4b1 signed by the resident, the US FOIA (B) (6)), US FO , and US FOIA as attendees included but were not limited to the following: the care plan was reviewed and updated. Although Resident #4 NJ ex order 26.4b1 during an IDCP meeting on NJ ex order 26.4b1, there was no indication in the MR that it was followed through or a CP for DC planning/DC to the community was developed on or after NJ ex order 26.4b1 IDCP meeting.

Review of the NJ ex order dated NJ ex order 26.4b1 signed by the resident, the US FO , US FOIA (B) , US FOIA (B) (6) , US FOIA , and US FOIA (B) (6) as attendees included but were but not limited to the following: Resident #4 was notified of the DC notice NJ ex order . Although the IDCP team NJ ex order 26.4b1 with Resident #4 on 1 NJ ex order 26 IDCP meeting, the team had not established a care plan for DC planning/DC to the community on or after the meeting.

The surveyor was unable to interview the former US FOIA for Resident #4.

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F 660	Continued From page 36 During an interview with the surveyor on 3/21/23 at 4:50 PM, the [redacted] and [redacted] stated that CPs are initiated on admission and must be updated or revised when there are changes in residents' needs and goals. They both confirmed the physician was not notified of the [redacted] and there was [redacted] for the resident. They also confirmed Resident #4 was not provided [redacted] or prescriptions for his/her medications. They stated the DC was complicated by Resident #4's situation, and the [redacted]. However, they acknowledged the facility should have followed the appropriate DC procedure. During a follow-up telephone interview with the [redacted] on 4/4/23 at 2:00 PM, he stated that there had been conversations with Resident #4 about DC[redacted]; however, he was unable to explain why there was no care plan for DC planning or DC to the community established at that time. Review of the policy titled "Nursing Discharge Procedure" dated 9/30/22 revealed under "Planned Discharge" that 1. Review of the discharge plan at initial care conference to include needed level of care at discharge, plan of residence, arrangements for follow up care ...3. Subsequent discharge plan to be discussed with the primary physician for needs of scripts for both medication and equipment needs, a. order for discharge to be placed in orders tab of PCC (point click care, an electronic MR)...5. Discharged instructions to be opened and completed by SS, therapy, and nursing...7. Transfer/Discharge report must be completed, a.	F 660		

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F 660	Continued From page 37 Ensure to complete all areas...b. complete area of date of DC plan...c. confirm active medications...write any end dates needed...8. All forms to be reviewed, signed, and then copied for upload ..." NJAC 8:39-5.4(b)(c)	F 660		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #NJ 00162301 Based on interviews and review of the medical records (MRs) and other facility documentation on 3/14/23, 3/16/23, and 3/21/23, it was determined the facility failed to implement interventions and establish a procedure for a resident who left the facility for a [redacted] and did not return on time or as expected. This deficient practice was identified for 1 of 3 sample residents (Resident #4) reviewed for incidents and accidents. The deficient practice is evidenced by the following. 1. According to the Admission Record, Resident #4 was admitted to the facility on [redacted]. A Physician's progress note (PN) dated [redacted]	F 689	Complete Care at Monmouth F-689 Free of Accidents Hazards/Supervision/Devices Residents affected by deficient practice: Residents #4 was affected by this deficient practice. The deficient practice was identified that the facility failed to ensure residents who signed [redacted] was monitored and new intervention developed after an incident. All Licensed staff were educated by DON/ADON on the facility policy and procedure on proper care plan interventions. Resident #4 [redacted]	5/29/23

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F 689	Continued From page 38 indicated diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] A Minimum Data Set (MDS), an assessment tool, dated NJ ex order 26.4b1, revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ ex which indicated NJ ex order 26.4b1 and the resident NJ ex order 26.4b1 [redacted]). A Care Plan (CP), initiated on NJ ex order 26.4b1 and revised on NJ ex order 26.4b1 included but were not limited to: while NJ ex order 26 the NJ ex order 26.4b1 [redacted]. Interventions, initiated on NJ ex order 26 reflected Resident #4 NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1 [redacted] An Order Summary Report (OSR) included a Physician's Order (PO), dated NJ ex order 26 for: NJ ex order 26.4b [redacted] A nursing PN signed by the US FOIA (B) (6) [redacted], dated NJ ex order 26.4b at 7:44 AM, revealed a late entry for NJ ex order 26.4b at 5 PM. The PN indicated "Resident #4 NJ ex order 26.4b1 [redacted]. The resident returned to facility with the NJ Exec Order 26.4b1 [redacted] (NJ Exec O NJ Exec reported NJ ex order 26.4b1 [redacted] As per NJ Exe when he/she arrived at the scene NJ Exec Order 26.4b1 reported to him/her that resident NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 Resident was with no signs of NJ Exec Order 26.4b [redacted] This writer spoke with the physician and made aware. Per physician continue to monitor	F 689	Identifying other Residents who could be affected by the deficient practice: All residents who sign out on pass have the potential to be affected by the deficient practice. Care plans of residents who may be affected were reviewed. Measures or systemic changes to ensure that the deficiencies will not recur: All Licensed staff are educated by DON/ADON/Designee on the facility policy and procedure on Incidents and Accidents and updating interventions in the care plan post incident while out on pass. Monitoring the continued effectiveness of the systemic change: The DON/IP/Designee will conduct audits of all residents on who go out on pass and the following of the policy and procedure to ensure care plan interventions are updated post incident. Audits will be completed weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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resident for NJ Exec Order 26.4b1

There was no indication in the MR that Resident #4 NJ ex order 26.4b1

Further review of the nursing PN revealed a second incident and another late entry by the US FOIA (b) on NJ ex order 26 at 8:00 AM. The nursing PN indicated that Resident #4 NJ ex order 26.4b1 no time of the day was indicated. The MR did not reveal the NJ ex order 26.4b1 Furthermore, on NJ ex order 26 the facility was informed by a correctional facility (CF) that Resident #4 NJ ex order 26.4b1 and NJ ex order 26.4b1 . In addition, the MR NJ ex order 26.4b1 of Resident #4's whereabouts until NJ ex order 26 when the CF called them. On NJ ex order 26 at 3:29 PM, the PN further revealed a nursing documentation NJ ex order 26.4b1

During exit conference on NJ ex order 26.4b at 4:50 PM, the US FOIA (b)(6) confirmed the facility was not aware of the resident's NJ Exec Order 26.4b1 until the correctional facility called on NJ ex order 26 and informed them the resident NJ ex order 26.4b1 .

A sign out register form titled NJ ex order 26.4b1 included a "NJ ex order 26.4b1" area where the resident or NJ Exe would complete and sign the date, time, name of resident, signature of person accepting responsibility. On the form, also included the date, time, and the signature of the facility representative for "Signing In". The form revealed

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Resident #4 NJ ex order 26.4b1 in each out on pass date from NJ ex order 26.4b1, no year. On that same form, the resident used the blank side to NJ ex order 26.4b and in on NJ ex order 26 and NJ ex order 26 and NJ ex order 26 NJ ex o on NJ ex order 26 at 11:00 AM.

During an interview with the surveyor on 3/21/23 at 2:00 PM, Licensed Practical Nurse (LPN) #1 assigned to Resident #4 on NJ ex order 26 day shift (7AM-3PM) and evening shift (3PM-11PM) stated the resident would NJ ex order 26.4b1 on a regular basis and NJ ex order 26 before 8:00 PM. LPN #1 confirmed any resident who goes NJ Exec Ord is expected to NJ Exec Ord unless it is scheduled NJ Exec Order 26.4b1, in that case, medications are provided to the resident. LPN #1 explained Resident #4 NJ ex order 26 unsure of the time, and NJ ex order 26.4 . LPN #1 confirmed Resident #4 NJ ex order 26.4b1 , after 11PM. She added, she mentioned to LPN #3 about Resident #4 NJ ex order 26.4b1 before she left the facility. LPN #1 continued to explain, the next morning on NJ ex order 26 during day shift, unsure of the time, NJ ex order 26.4b1 asking about the resident's medication regimen and was told Resident #4 NJ ex order 26.4b1 due to NJ ex order 26.4b1. She then informed the DON about the call. LPN #1 confirmed she did not notify the US FOIA (B) (6)) or US FOIA (B) (6) , the physician, the US FO , the US FOIA (B or US FOIA (B) (6) r during her shift on NJ ex order 26 when Resident #4 NJ ex order 26.4b1 and was unable to explain why. However, she acknowledged she should have notified them to ensure the resident was safe.

During a telephone interview post survey with the

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F 689	Continued From page 41	F 689		

surveyor on 4/3/23 at 1:56 PM, LPN #3 who was assigned to Resident #4 on [redacted] night shift (11PM-7AM) confirmed Resident #4 [redacted] She stated she did not receive a report from LPN #1 that the resident went [redacted]. She continued to state during her shift, the [redacted]) assigned to the resident informed her the resident was not in the room. She was unable to answer if she did her rounds that night but stated she would usually do it or delegate to CNAs. She added, she called LPN #1 at home to discuss the situation and at that time LPN #1 informed her Resident #4 [redacted]. LPN #3 was unable recall what time the CNA informed her or when she called LPN #1. The surveyor asked if she notified the [redacted], the physician, and the [redacted] or [redacted], she stated no because it was not her responsibility but LPN #1's since it happened during her shift. She added, she was unsure if there was a NS that night and she had no contact information of the [redacted] or the [redacted].

During an interview with the surveyor on 3/21/23 at 1:21 PM, the UM/LPN #2 who was on duty on [redacted] day and evening shifts confirmed if a resident requested to go [redacted] or [redacted], there would be a written or verbal report passed on to the next shift nurse. She explained residents requesting to go [redacted] are provided medications and if the resident was scheduled for [redacted] he/she would have been provided medications. She continued to explain she was unable to recall if she was on duty that evening and unaware of the resident's [redacted]. However, she confirmed if a resident did not return as expected from an [redacted] the nurse should have reached out to the [redacted] and physician, notified the [redacted], the [redacted], or the [redacted].

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F 689	Continued From page 42 During a telephone interview post survey with the surveyor on 4/4/23 at 8:50 AM, the NS/Registered Nurse (RN) #3 on US ex oder 26 night shift stated nurses are responsible to do room to room rounds to ensure residents are all accounted for. She explained the UM/LPN #2 and LPN #1 did not inform her during shift handoff that Resident #4 US ex oder 26.4b1 and US ex oder 26.4b1. She added, LPN #2 did not inform her upon discovering Resident #4 US ex oder 26.4b1 She continued to state she had no knowledge of the incident until LPN #1 arrived on US ex oder 26 and informed her during shift hand off. She confirmed nurses are expected to report to the NS any incident or accidents immediately so interventions could be initiated. She added, the nurses should have notified her immediately. During a telephone interview with the surveyor on 3/21/23 at 10:01 AM and 2:24 PM, the NJ Ex stated he/she was not notified that Resident #4 US ex oder 26.4b1 The RP continued to state that Resident #4 US ex oder 26.4b1 or US ex oder 26 after Resident #4 US ex oder 26.4b1 During an interview with the surveyor on 3/21/23 at 4:50 PM, the US FOIA (B stated nurses are expected to report incidents/accidents to the US FOIA (B) (6) or US FOIA (b)(6) and document in the MR. She confirmed she was unaware of the incident until US ex oder 26 when it was reported to her the resident was arrested. She stated, since the resident US ex od on US ex oder 26.4b1, the nurses should have notified the NS, herself, or the Administrator upon learning the resident US ex od .	F 689		

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F 689	Continued From page 43 Review of the facility's policy titled "Out on Pass" updated 1/2023 revealed "1. Patients/Residents must have a physician's order ...2. Each resident leaving the premises (excluding transfer/discharges) must sign themselves out or be signed out by responsible party. 3 ...Registers must indicate the resident's expected time of return. 4. Patients/Residents going out on pass for prolonged periods of time may request/require medications to be administered while patient/resident is out ...medications that must be administered while the resident is out will be given to the resident/person signing the resident out ...10. Residents must sign in upon return to the facility." Review of the facility's policy titled "Change in a Resident's Condition or Status" updated 10/2019 revealed "1. The nurse will notify the Physician or physician on call when there has been a(an); a. accident or incident involving the resident ...e. significant change in the resident's physical/emotional/mental condition ...2. A significant change is a major decline or improvement in the resident's status that, a. Will not normally resolve by itself without intervention by staff ...c. Requires interdisciplinary review and/or revision to the care plan ..." NJAC 8:39-27.1 (a)	F 689		

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S 000	Initial Comments COMPLAINT #: NJ00162301 CENSUS: 74 SAMPLE SIZE: 5 The facility is 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: NJ00162301 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was evidence by the following. shifts reviewed. Reference: New Jersey Department of Health	S 560	Complete Care at Monmouth -S560 Mandatory Access to Care Plan of Correction. Residents affected by deficient practice: Staffing ratio requirements were reviewed by the staffing coordinator. Education on ratio requirements provided by administrator on importance of meeting these requirements.	5/21/23

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

Electronically Signed | 05/07/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

(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 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 2/19/23 to 2/25/23, 2/26/23 to 3/4/23, 3/5/23 to 3/11/23, and 3/12/23 to 3/18/23, revealed the staffing to resident ratios did not meet the minimum requirement. The facility was deficient in CNA staffing for residents on 26 of 28 day shifts, deficient in CNAs to total staff on 1 of 28 evening shifts, and deficient in total staff for residents on 1 of 28 overnight shifts as follows: -02/19/23 had 5 CNAs for 76 residents on the day shift, required 9 CNAs.	S 560	Identifying other Residents who could be affected by the deficient practice: All residents have the possibility to be affected. Measures or systemic changes to ensure that the deficiencies will not recur: The facility has put in place the following: a. Audit of staffing conducted by staffing coordinator to ascertain staff willing to work overtime shifts. b. Six agency contracts maintained. c. Recruitment sign on bonuses for new staff d. Admin/DON has started an employee morale/recruitment and retention committee. e. Employee of the month program f. Staffing coordinator to send all needs to agencies 4 weeks in advance. g. Indeed, job openings advertisement h. Staffing coordinator to communicate interview scheduling. i. Staffing coordinator to review other facility CNA wages in the vicinity to ensure wages are not lower then average. j. Admin will monitor the staffing ratios in QAPI reporting for 3 months. Monitoring the continued effectiveness of the systemic change: 4. Administrator to review and monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061318	A. BUILDING: _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

(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 -02/21/23 had 6 CNAs for 76 residents on the day shift, required 9 CNAs. -02/22/23 had 6 CNAs for 76 residents on the day shift, required 9 CNAs. -02/23/23 had 7 CNAs for 76 residents on the day shift, required 9 CNAs. -02/24/23 had 8 CNAs for 77 residents on the day shift, required 10 CNAs. -02/25/23 had 7 CNAs for 77 residents on the day shift, required 10 CNAs. -02/26/23 had 7 CNAs for 77 residents on the day shift, required 10 CNAs. -02/26/23 had 3 CNAs to 9 total staff on the evening shift, required 4 CNAs. -02/27/23 had 7 CNAs for 78 residents on the day shift, required 10 CNAs. -02/28/23 had 6 CNAs for 78 residents on the day shift, required 10 CNAs. -03/01/23 had 5 CNAs for 76 residents on the day shift, required 9 CNAs. -03/02/23 had 8 CNAs for 76 residents on the day shift, required 9 CNAs. -03/03/23 had 7 CNAs for 76 residents on the day shift, required 9 CNAs. -03/04/23 had 7 CNAs for 76 residents on the day shift, required 9 CNAs. -03/05/23 had 6 CNAs for 79 residents on the day shift, required 10 CNAs. -03/06/23 had 8 CNAs for 79 residents on the day shift, required 10 CNAs. -03/06/23 had 5 total staff for 79 residents on the overnight shift, required 6 total staff. -03/07/23 had 8 CNAs for 77 residents on the day shift, required 10 CNAs. -03/08/23 had 6 CNAs for 74 residents on the day shift, required 9 CNAs. -03/09/23 had 7 CNAs for 74 residents on the day shift, required 9 CNAs. -03/10/23 had 7 CNAs for 73 residents on the day shift, required 9 CNAs.	S 560	on monthly QAPI meeting for 3 months effectiveness of plan. Completion Date: 5/21/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061318	A. BUILDING: _____ B. WING _____	C 03/21/2023

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S 560	Continued From page 3 -03/11/23 had 7 CNAs for 73 residents on the day shift, required 9 CNAs. -03/12/23 had 7 CNAs for 73 residents on the day shift, required 9 CNAs. -03/13/23 had 8 CNAs for 73 residents on the day shift, required 9 CNAs. -03/15/23 had 8 CNAs for 74 residents on the day shift, required 9 CNAs. -03/16/23 had 6 CNAs for 74 residents on the day shift, required 9 CNAs. -03/17/23 had 8 CNAs for 74 residents on the day shift, required 9 CNAs. -03/18/23 had 8 CNAs for 74 residents on the day shift, required 9 CNAs. The surveyor conducted an interview with the Staffing Coordinator (SC) on 3/21/23 at 9:22 am. The SC stated that the facility uses agency staff to fill the staffing needs of the CNAs. She added that they offered incentive for those who work extra hours. The SC also stated that she was aware of the new minimum staffing ratio requirements for nursing homes. The SC reports to the Facility Administrator (FA) and the Director of Nursing when having difficulty with staffing. The SC added that the facility is currently hiring for CNAs. NJAC 8:39-5.1(a)	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315284	A. BUILDING _____ B. WING _____	R-C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	**229 BATH AVENUE LONG BRANCH, NJ 07740**

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{F 000}	INITIAL COMMENTS	{F 000}		
{F 600} SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	{F 600}		

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

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.

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
315284 Y1	A. Building B. Wing Y2	6/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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 F0609	Correction	ID Prefix F0657	Correction	ID Prefix F0660	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(c)(1)(i)-(ix)	Completed
LSC	05/21/2023	LSC	05/29/2023	LSC	05/21/2023
ID Prefix F0689	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/29/2023	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	
3/21/2023	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061318	A. Building B. Wing	6/5/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MONMOUTH, LLC	229 BATH AVENUE LONG BRANCH, NJ 07740

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 05/21/2023	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	
3/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO