

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMPLETE CARE AT HOLIDAY CITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4 PLAZA DRIVE</b> <b>TOMS RIVER, NJ 08757</b>		
(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  COMPLAINT #123103  CENSUS: 131  SAMPLE SIZE: 5	F 000			
F 609 SS=B	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility 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	F 609		8/5/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/19/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMPLETE CARE AT HOLIDAY CITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4 PLAZA DRIVE</b> <b>TOMS RIVER, NJ 08757</b>		
(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 609	<p>Continued From page 1</p> <p>by: COMPLAINT # NJ 123103</p> <p>Based on interviews, Medical Record (MR) review and review of pertinent facility documents on 7/30/19, it was determined that the facility failed to notify proper law enforcement agencies as well as failure to follow the facility's policy titled "Abuse Prevention-Mandatory Reporting" for 2 of 2 sampled for abuse (Resident #2 and #3). This deficient practice was evidenced by the following:</p> <p>1. According to the "Admission Record (AR)," Resident #2 was admitted to the facility on [REDACTED] with diagnoses which included but were not limited to: [REDACTED]</p> <p>According to the Minimum Data Set (MDS), an assessment tool dated [REDACTED] Resident #2 had a Brief Interview for Mental Status (BIMS) score of [REDACTED] indicating Resident #2 had [REDACTED] cognitive impairment. The MDS also indicated that Resident #2 needed assistance with Activities of Daily Living (ADLs).</p> <p>2. According to the "Admission Record (AR)," Resident #3 was admitted to the facility on [REDACTED] with diagnoses which included but were not limited to: [REDACTED]</p> <p>According to the Minimum Data Set (MDS), an assessment tool dated [REDACTED] Resident #3 had a Brief Interview for Mental Status (BIMS) score of [REDACTED], indicating Resident #3 had [REDACTED] cognitive impairment. The MDS also indicated that Resident #3 needed assistance with Activities</p>	F 609	<p>F-609-Reporting of Alleged Violation Level "B"</p> <p>1. Resident #2 and #3 were involved, but not adversely affected, by the deficient practice of failing to ensure the local police were called for a reportable event involving an alleged violation. The residents were immediately separated from one another, and Resident #2 was relocated to reside in another room, to prevent recurrence of the incident. Both residents have Care Plan interventions in place to ensure staff monitor visits between the two residents. The NJ Dept of Health and Ombudsman were notified of this incident on the date the event occurred.</p> <p>2. All residents involved in a reportable event of an alleged violation have the potential to be affected.</p> <p>3. Inservice Education for facility RN Supervisors, and other staff who hold supervisory responsibilities, was conducted on 7/30/19, by the facility Administrator regarding the requirement to notify the local police when a reportable event with an alleged violation is called into the Department of Health.</p> <p>4. Facility will monitor compliance by having the Administrator or administrative designee include the case number or officer's name, date and time when reported to the police department, to the reportable event AAS-45 form that is</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMPLETE CARE AT HOLIDAY CITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4 PLAZA DRIVE</b> <b>TOMS RIVER, NJ 08757</b>		
(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 609	<p>Continued From page 2 of Daily Living (ADLs).</p> <p>Review of the facility's "Reportable Event Record/Report (RERR)" dated [REDACTED] revealed the following: On 2/25/19, Resident #2 was sitting in common area next to Resident #3 yelling and agitated. Resident #2 then proceeded to make contact with Resident #3 to the [REDACTED] with closed fist. Residents were immediately separated. Resident #2 was moved to a different room. Both Resident were assessed. Resident #2 will be supervised by staff in the common area while visiting Resident #3.... The RERR further indicated that the facility notified the New Jersey Department of Health (NJDOH) on [REDACTED] at 4:00 p.m.</p> <p>During an interview on 7/30/19 at 11:30a.m., the Administrator stated " I cannot find if the police were notified or not. In the future I will make sure the police are notified."</p> <p>Review of the facility's policy titled "Abuse Prevention- Mandatory Reporting" dated 6/14/07, revealed the following: Under "Policy"; It is the policy of this facility to report any suspected abuse to the Administrator/Director of Nursing (DON)/Nursing Supervisor immediately, as well as to notify the Department of Health (DOH) immediately, but no later than 2 hours after forming suspicion result in serious bodily injury, or not later than 24 hours if the events that caused the suspicion do not result in serious bodily injury. The facility will also notify the responsible party in a timely manner, and promptly and thoroughly investigate the incident. Under "Procedure" #5: The police should be contacted immediately in cases involving suspected abuse/assault of any kind.</p>	F 609	<p>submitted to the Department of Health. All reportable event incidents shall be reviewed at the facility's quarterly quality assurance committee meeting.</p> <p>5. Date of Compliance - 8/5/19.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMPLETE CARE AT HOLIDAY CITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4 PLAZA DRIVE</b> <b>TOMS RIVER, NJ 08757</b>		
(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 609	Continued From page 3  Review of the facility's "Interoffice Memo" dated 9/22/2017, revealed the following: Local Law enforcement agency, in addition to the Office of Ombudsman for the Institutionalized Elderly (OOIE), and the Department of Health and Senior Services (DOHSS), must be notified if there is "reasonable cause to suspect or believe that the institutionalized elderly person is or has been a victim of a crime."  N.J.A.C 8:39-9.4(f)	F 609		