STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315453	A. BUILDING _____ B. WING _____	12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 12/12/19 CENSUS: 146 SAMPLE SIZE: 29 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent facility document, it was determined that the facility failed to ensure that medication was administered in accordance with the physician's order. This deficient practice was identified for 1 of 29 residents reviewed for medication (Resident #119), and was evidenced by the following: During the initial tour of the [redacted] on 12/03/19 from 10:00 AM to 11:30 AM, the surveyor observed Resident #119 awake and seated in a chair in his/her room. When interviewed, the resident stated that he/she was	F 684	This Plan of Correction is submitted by Complete Care at Shorrock Gardens as requested under Federal and State regulation and statutes as applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan of Correction does not constitute an agreement by the Facility that the surveyors findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.	1/10/20

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

Electronically Signed | 01/02/2020

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F 684	Continued From page 1 watching television. On 12/05/19 at 10:30 AM, the surveyor observed Resident #119 again seated in the chair. When interviewed by the surveyor, the resident stated that a few weeks ago, he/she did not receive his/her [redacted]) for a few days because the medication was unavailable. Review of the Admission Record revealed that Resident #119 was admitted to the facility on [redacted] Review of an Order Summary Report, with active orders as of 12/09/19, revealed a physician's order, dated [redacted], for [redacted] milligram (mg) to be given twice daily. According to the order, the medication was to be administered for the treatment of [redacted]. Review of a Progress Note (PN), dated 11/21/19 at 11:37 AM, revealed that the [redacted] was not available for administration to the resident and that staff were waiting for the medication to be delivered from the pharmacy. Review of subsequent PNs, from 11/22/19 through 11/25/19, revealed that the pharmacy was not notified again and that the [redacted] was not administered to the resident from 11/21/19 to 11/25/19. Further review of the PNs revealed that there was no documentation to show that Resident #119's physician was notified that the medication was not available to the resident. Review of the corresponding Medication Administration Record (MAR), dated November	F 684	1. Resident #119 was affected by this deficient practice. It was determine that nurse failed to follow proper procedure of notifying Physician that medicine was not available from pharmacy. 2. All resident have the potential to be affected by this practice. 3. Facility wide education was given on the step by step procedure of notification to Physician when medication is not available or administered. 4. Nurse unit manager or designee will conduct 5 resident MAR audits weekly for one month, than 5 residents MARS per month for 3 months. Results of these audits will be monitored by DON or designee. And deficient finding will be addressed immediately. All results will be reviewed at Quarterly QAPI meetings.	

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F 684	Continued From page 2 2019, revealed that the [redacted] was scheduled for admisinistration at 09:00 AM and 05:00 PM daily. The documentation found on the MAR reflected that Resident #119 did not receive the medication on the following dates: 11/20/19; 11/21/19; 11/23/19; 11/24/19; and 11/25/19, which reflected a total of 10 missed doses. On 12/05/19 at 10:45 AM, the surveyor interviewed the Licensed Practical Nursing (LPN #1). LPN #1 stated that she called the pharmacy on 11/22/19 regarding Resident #119's missing medication. LPN #1 stated that she did not realize the medication was missing until she went to administer the medication to the resident and that she was not informed of the missing medication during shift report. LPN #1 confirmed that she did not notify the resident's physician, the Unit Manager nor the Supervisor on duty about the missing medication. On 12/05/19 at 11:00 AM, the surveyor interviewed LPN #2 who stated that she called the pharmacy to inquire about when the medication was to be delivered to the facility. LPN #2 also stated that she did not inform the Unit Manager nor the Supervisor about the missing medication and that she could not remember if she notified the doctor. On 12/05/19 at 11:15 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated that she was not made aware of Resident #119's missing medication until surveyor inquiry. LPN/UM #1 stated that the nurses should have informed her about the missing medication. LPN/UM #1 also stated that it was the facility's policy that nurses notify the doctor after a resident missed two doses of a medication. LPN/UM #1 stated that	F 684		

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F 684	Continued From page 3 nurses should have notified Resident #119's physician or Nurse Practitioner (NP). On 12/05/19 at 11:25 AM, the surveyor interviewed the resident's Nurse Practioner (NP). The NP stated that he was responsible for Resident #119 and that the nurses had not notified him about the missing [redacted] medication. The NP stated that he was in the building every day and that nurses could have notified him at any time. The NP stated that if he had been made aware, he would have assessed the resident and maybe switched the medication or ordered the same medication from a local pharmacy. During an interview with the Director of Nursing (DON) on 12/10/19 at 10:00 AM, the DON stated that the nurses should have notified the NP and that it was unacceptable to not notify the doctor or the NP. The surveyor reviewed the facility's medication administration policy in the presence of the DON. The policy did not contain information regarding what nurses should do when medications were not available for a resident. NJAC: 8:39-27.1 (a)	F 684		
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.	F 689		1/10/20

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F 689	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the resident's environment was as free from hazards as possible by failing to ensure that medical equipment was plugged directly into an electrical receptacle without the use of power strips or adapters. This deficient practice was identified for Resident # 79, 1 of 29 residents reviewed and was evidenced by the following: During a tour of the [redacted] Unit on 12/03/19 at 10:31 AM, the surveyor observed the Resident #76's room which revealed the bed and air mattress were plugged into a power strip. On 12/03/19 at 12:27 PM, the surveyor observed Resident #76 in the unit's dining room eating lunch. The resident was seated in a high back wheelchair, wearing [redacted] that was connected to an [redacted] On 12/03/19 at 2:13 PM, the surveyor showed the Licensed Practical Nurse Unit Manager (LPN/UM) the power strip and she stated she did not know the policy of the use of power strips and she would have to get the Maintenance Director. On 12/03/19 at 2:30 PM, the surveyor showed the Maintenance Director the power strip and he stated that the bed and air mattress were not supposed to be plugged into the power strip. He then unplugged the bed and the mattress from the power strip. He stated that the facility does not supply power strips and that no medical equipment should be plugged into a power strip.	F 689	This Plan of Correction is submitted by Complete Care at Shorrock Gardens as requested under Federal and State regulation and statutes as applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan of Correction does not constitute an agreement by the Facility that the surveyors findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. 1.Resident #79 was at risk but not affected by this practice. 2. All residents had the potential to be affected by this practice. 3. All staff to be educated, including outsourced contracted services, i.e. Housekeeping that no medical equipment is to be plugged into power strips/surge protectors for any reason. A sign will be posted near power strips/surge protectors stating," no medical equipment to be plugged into any power strips/surge protectors for any reason". 5 room audits to be completed and logged daily for 2 weeks then 5 audits per a week for 1 month. Audits will be conducted by maintenance director or designee. 4. Maintenance director or designee will review and monitor results of audits at	

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F 689	Continued From page 5 He also stated that the facility had an in-service about a month ago on the topic of power strips. The Maintenance Director stated he performed random room checks to ensure that the power strips are being used correctly. On 12/10/19 at 9:00 AM, the surveyor informed the Administrator of the finding. The Administrator stated that the facility did not have a policy for the use of power strips. The surveyor reviewed a document titled, "In-service Education for General Housekeeping," dated [redacted] which indicated medical equipment such as the bed, [redacted] could not be plugged into power strips and must be plugged directly into the wall. Further review revealed the LPN/UM signed the she had attended the in-service.	F 689	quarterly QAPI meetings.	
F 761 SS=D	NJAC 8:39-31.2(e) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/10/20

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F 761	Continued From page 6 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to identify and remove expired medication and medical supplies from the emergency cart (Crash cart). This deficient practice was identified in 1 of 2 emergency carts inspected and was evidenced by the following: On 12/03/19 at 11:21 AM, the surveyor inspected the [redacted] Unit emergency cart, and observed two [redacted] with an expiration date of 09/2016. There was also one pack of [redacted] items that expired on 10/2017. On 12/03/19 at 11:30 AM, the surveyor showed the expired items to the unit Licensed Practical Nurse (LPN #3) who inspected the items and confirmed that they were expired. LPN #3 collected the expired items and stated that she would give them to the Unit Manager to discard. Upon further interview, LPN #3 stated that the 11 PM-7 AM shift nurses were responsible for checking the crash cart and removing expired item.	F 761	This Plan of Correction is submitted by Complete Care at Shorrock Gardens as requested under Federal and State regulation and statutes as applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan of Correction does not constitute an agreement by the Facility that the surveyors findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. 1. No residents were affected by this practice. 2. All residents had potential to be affected by this practice. 3. All crash carts will be checked 2 times daily by night Nurse/Nursing supervisor to ensure nothing has expired. 4. Audits will be reviewed weekly by DON or designee for 4 weeks then monthly for	

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F 761	Continued From page 7 On 12/12/19 at 12:20 PM, the surveyor interviewed the DON regarding the maintenance of medications and medical supplies in the emergency cart. The DON stated that the night shift was responsible for checking the crash cart and removing expired items and that they did not have a policy regarding the maintenance of items in the emergency crash cart. NJAC 8:39-29.4	F 761	3 months. QAPI will be initiated and monitored and reviewed by the QAPI quarterly meetings.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other pertinent facility documents, it was determined that the facility failed to ensure that residents' call lights sound was audible and was answered in a timely manner. This deficient practice was identified for 8 of 10 residents (Residents #9, #12, #38, #55, #62, #66, #105, and #130), who attended the group meeting and for 1 of 1 resident representative (Resident #19) interviewed and was evidenced by the following: On 12/05/19, the surveyor reviewed the Resident Council Meeting minutes for September 2019, October 2019 and November 2019.	F 919	This Plan of Correction is submitted by Complete Care at Shorrock Gardens as requested under Federal and State regulation and statutes as applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan of Correction does not constitute an agreement by the Facility that the surveyors findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.	1/10/20

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F 919	Continued From page 8 The 09/27/19 meeting minutes reflected that the facility was recruiting Certified Nursing Assistance to help in answering call lights and tending to the resident needs. On 12/05/19 at 10:30 AM, the surveyor conducted a group meeting with 10 alert and oriented residents who resided on the [redacted] Unit of the facility. When the residents were asked about staff response to their call bell, 7 of 10 residents (Residents #9, #12, #38, #55, #62, #66, and #130) stated that when they turned their call bells on, they usually waited greater than 30 minutes before they get staff assistance. Both Resident #9 and Resident #105 stated they have been left sitting on the toilet for up to 45 minutes waiting for assistance from staff. All 8 residents stated that they complained about the long call bell wait to the Licensed Practical Nurse/Unit Manager (LPN/UM #1) and that they also had complained during their monthly Resident Council Meetings and that nothing had been done about it. On 12/06/19 at 12:05 PM, while the surveyor was seated at the nurse desk on the [redacted] Unit, the surveyor observed Resident #19 as he/she was being wheeled by a family member from the dining room to the resident's room. On 12/06/19 from 12:10 PM to 12:40 PM, the surveyor observed Resident #19's room call light illuminated outside the door, which indicated the call light was on. As the surveyor was seated at the nurses' desk, the surveyor noticed that the call light sound was barely audible. The surveyor observed that the call light sound was coming from a call system speaker located behind the	F 919	1. 8 of the mentioned residents were affected by this practice. 2. All residents had the potential to be affected by this practice. 3. Tape was removed and covers were placed over call bell boxes immediately after issue was identified. Facility in service will be conducted to all staff regarding tampering with call bell systems. Nursing supervisor or designee to check call bell systems daily to ensure no tampering and document any findings. Call bell audits to be conducted each shift for 2 week then daily for 1 month and weekly for 3 months. 4. Results of these audits will be monitored and reviewed at our quarterly QAPI meetings.	

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F 919	Continued From page 9	F 919		

nurses' desk. Upon further investigation, the surveyor noted that the speaker was covered with a clear tape and that the volume button on the call bell speaker was positioned to low.

On 12/06/19 at 12: 55 PM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) while Resident #19's call bell was on. When CNA #1 was asked if she could hear the call bell, CNA #1 answered that she was unable to hear the resident's call bells. CNA #1 stated that she was assigned to [redacted] Unit and had worked at the facility for about six month. CNA #1 added that the call bell system has always been low. CNA #1 also stated that she usually had to look up towards the ceiling for her to see that a resident's light was on.

On 12/06/19 at 1:00 PM, the surveyor interviewed CNA #2 who stated that she had been working at the facility for about a year. CNA #2 stated that the call light system on the [redacted] Unit was not like the other units. CNA #2 stated that on the other units, the call light system was loud. When CNA #2 was asked if she could hear Resident #19's call light at the nurses' desk, CNA #2 answered, "no." CNA #2 stated that she usually had to look at the panel on the wall or look down the hallways in order to see that a call light was on.

On 12/06/19 at 1:15 PM, the surveyor asked for the Assistant Administrator (AA) to turn on the shower room's nurse call light. After turning on the shower room call light, both the AA and the surveyor went to the nurses' desk. When asked if she could hear the call bell from the desk, the AA stated she could barely hear the nurse call light. The surveyor then showed the AA the call bell speaker box which was covered with tape. The

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F 919	Continued From page 10	F 919		

AA removed the tape from the speaker box and the sound became louder. The AA switched the volume from low to high which also increased the sound. The AA stated that the tape on the speaker decreased the sound and might have prevented staff from hearing the resident's call bell. The AA stated that she did not know who applied tape to the call bell speaker.

On 12/06/19 at 1:20 PM, the surveyor interviewed Resident #19's family member. She stated that she usually turned the call bell on when the resident returned from lunch because it took very long for staff to answer the call lights. The family member stated that she usually turned the call light on ahead of time, so that by the time staff answered the light, Resident #19 was ready to use the bathroom.

On 12/06/19 at 1:30 PM, during an interview with the LPN/UM #1, she stated that she had worked at the facility for five years and that the call bell sound had been the same. LPN/UM #1 stated she did not know who placed the tape over the speaker.

On 12/10/19 at 9:30 AM, the Director of Nursing (DON) acknowledged that some residents had complained during their group meeting regarding long waits for call lights response. The DON stated that she did random nurse call light audits and that there had not been any problems.

NJAC 8:39-31.8(C)9