STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Madison, LLC	625 State Highway 34 Matawan, NJ 07747

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure medications (meds) were administered in the allotted timeframe for 1 of 1 resident (Resident #122) reviewed for medication administration times.This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.1.On 2/25/26 at 11:01 AM, during an initial tour, the surveyor observed Resident #122 awake, alert and walking in their room. Resident #122 stated that the nurses took long time to administer their morning meds. Resident #122 stated I have diabetes and I am on insulin (a hormone that lowers the level of glucose (a type of sugar) in the blood). The surveyor reviewed the hybrid Medical Record (MR; paper and electronic MR) for Resident #122.A review of Resident #122's admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; alcoholic cirrhosis (a condition where the liver is severely damaged) of liver with ascites (abnormal buildup of fluid within the abdomen usually causing swelling, abdominal pain and sometimes breathing difficulties), type 2 diabetes mellitus (DM2) with diabetic polyneuropathy (a type of nerve damage caused by long-term high blood sugar), major depressive disorder (a common but serious mental health condition characterized by a persistent, intense and long lasting low mood, sadness, or loss of interest in daily activities), and hepatic encephalopathy (loss of brain function occurs when the liver is unable to remove toxins from the blood). A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 1/2/26, reflected that the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated that Resident #122 had intact cognition. Further review of the MDS indicated that the resident received insulin, antidepressant (medications used to treat depression) and diuretics (also known as water pills; medicines that help you move extra fluid and salt out of your body). A review of the individualized comprehensive care plan created on 12/26/25 included a focus care area that the resident had diabetes mellitus. Intervention included but were not limited to: diabetes medication as ordered by doctor. Other focus area reflected: Resident used antidepressant medication related to (r/t) depression; Resident was on diuretic therapy related to edema (swelling); Resident was at risk for ascites r/t cirrhosis. A review of Resident #122's Order Summary Sheet (OSR) included the following physician orders (PO): A PO dated 12/26/25 for Duloxetine HCL Capsule Delayed Release Particles 30 milligram (mg) - give 1 capsule by mouth at (continued on next page)

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.

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedtime for depression.A PO dated 12/26/25 for Famotidine Oral Tablet 20 mg - give 1 tablet by mouth at bedtime for gerd (a chronic condition where stomach acid frequently flows back into the esophagus, the tube connecting the mouth and stomach).A PO dated 12/26/25 for Furosemide oral tablet 40 mg- give 1 tablet by mouth two times a day for ascites/edema.A PO dated 12/26/25 for Gabapentin capsule 300 mg- give 1 capsule by mouth every 8 hours for nerve pain.A PO dated 1/8/26, for Insulin Glargine-yfgn (type of long acting insulin to control blood sugar) subcutaneous solution pen-injector 100 units/milliliter (ml)- Inject 42 units subcutaneously (sq; injecting directly into the fatty tissue layer just underneath the skin) at bedtime for DM2. A PO dated 12/27/26 for Insulin Lispro (type of rapid acting insulin to control blood sugar) 100 units/ml solution. Inject as per sliding scale: if . , sq before meals and at bedtime for DM. A PO dated 12/26/25 for Lactulose oral solution 10 gram (gm)/15 ml- give 20 ml by mouth two times a day for Liver disease.A PO dated 12/26/25 for Sofosbuvir-Velpatasvir oral tablet 400-100 mg- give one tablet by mouth one time a day for Hepatitis (Hep; a viral infection that causes liver swelling) C. A PO dated 1/29/26 for Spironolactone oral tablet 100 mg- give two tablets (tab) by mouth one time a day for ascites/edema. Give two tabs = 200 mg.A review of the February 2026 Progress Notes (PNs) revealed no documentation regarding Resident #122's meds not being administered as scheduled per POs.A review of the Medication Administration Audit Report, dated 2/1/26 through 2/24/26, revealed the following:On 2/1/26: 1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 10:56 AM.2.Furosemide 40 mg tablet, scheduled for 9:00 AM was administered at 10:55 AM.3.Lactulose 20 ml, scheduled for 9:00 AM was administered at 10:55 AM.4.Sofosbuvir-Velpatasvir tablet, scheduled for 9:00 AM was administered at 11:04 AM.5.Insulin Lispro 6 units before meals, scheduled for 11:30 AM was administered at 12:54 PM.On 2/4/26:1.Insulin Lispro 2 units before meals, scheduled for 7:30 AM was administered at 8:58 AM.2.Insulin Lispro 8 units before meals, scheduled for 11:30 AM was administered at 12:38 PM.On 2/5/26:1. Insulin Lispro 4 units before meals, scheduled for 11:30 AM was administered at 13:27 PM.2. Insulin Lispro 4 units before meals, scheduled for 4:30 PM was administered at 7:16 PM.3.Furosemide 40 mg tablet, scheduled for 5:00 PM was administered at 7:15 PM. 4.Insulin Gilargine-yfgn 42 units scheduled at bedtime for 9:00 PM was administered at 6:51 PM.5.Insulin Lispro 6 units before meals, scheduled for 9:30 PM was administered at 10:56 PM.On 2/6/26:1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 11:33 AM.On 2/7/26:1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 10:14 AM.2.Furosemide 40 mg tablet, scheduled for 9:00 AM was administered at 10:14 AM.3.Lactulose 20 ml, scheduled for 9:00 AM was administered at 10:14 AM.4.Sofosbuvir-Velpatasvir tablet, scheduled for 9:00 AM was administered at 10:14 AM.5. Furosemide 40 mg tablet, scheduled for 5:00 PM was administered at 9:43 PM.On 2/8/26: 1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 10:35 AM.2.Furosemide 40 mg tablet, scheduled for 9:00 AM was administered at 10:35 AM.3.Lactulose 20 ml, scheduled for 9:00 AM was administered at 10:35 AM.4.Sofosbuvir-Velpatasvir tablet, scheduled for 9:00 AM was administered at 10:35 AM.5. Gabapentin 300 mg capsule, scheduled for 2:00 PM was administered at 3:40 PM. 6. Furosemide 40 mg tablet, scheduled for 5:00 PM was administered at 7:08 PM.7.Famotidine 20 mg tablet, scheduled for 9:00 PM was administered at 10:15 PM.8.Duloxetine 30 mg capsule, scheduled for 9:00 PM was administered at 10:15 PM. 9.Lactulose 20 ml, scheduled for 9:00 PM was administered at 10:15 PM.10.Insulin Gilargine-yfgn 42 units scheduled at bedtime for 9:00 PM was administered at 10:15 PM.On 2/9/26:1.Insulin Lispro 4 units before meals, scheduled for 7:30 AM was administered at 9:24 AM.On 2/13/26:1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 11:13 AM.2.Furosemide 40 mg tablet, scheduled for 9:00 AM was administered at 11:13 AM.3.Lactulose 20 ml, scheduled for 9:00 AM was administered at 11:13 AM.4.Sofosbuvir-Velpatasvir tablet, scheduled for 9:00 AM was administered at 11:13 AM.5.Furosemide 40 mg tablet, scheduled for 5:00 PM was administered at 6:34 PM.On 2/14/26:1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 2:52 PM.2.Furosemide 40 mg tablet, scheduled for 9:00 AM was (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered at 2:52 PM.3.Lactulose 20 ml, scheduled for 9:00 AM was administered at 2:52 PM.4.Sofosbuvir-Velpatasvir tablet, scheduled for 9:00 AM was administered at 2:52 PM.5. Insulin Lispro 4 units before meals, scheduled for 11:30 AM was administered at 12:52 PM.On 2/15/26:1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 10:32 AM.2.Furosemide 40 mg tablet, scheduled for 9:00 AM was administered at 10:32 AM.3.Sofosbuvir-Velpatasvir tablet, scheduled for 9:00 AM was administered at 10:32 AM.4. Gabapentin 300 mg capsule, scheduled for 2:00 PM was administered at 3:15 PM. 5. Insulin Lispro 8 units before meals, scheduled for 4:30 PM was administered at 5:50 PM. On 2/16/26:1. Furosemide 40 mg tablet, scheduled for 5:00 PM was administered at 6:22 PM.2.Famotidine 20 mg tablet, scheduled for 9:00 PM was administered at 10:24 PM.3.Duloxetine 30 mg capsule, scheduled for 9:00 PM was administered at 10:24 PM. 4.Lactulose 20 ml, scheduled for 9:00 PM was administered at 10:24 PM.On 2/17/26:1.Famotidine 20 mg tablet, scheduled for 9:00 PM was administered at 10:52 PM.2.Duloxetine 30 mg capsule, scheduled for 9:00 PM was administered at 10:52 PM. 3.Lactulose 20 ml, scheduled for 9:00 PM was administered at 10:56 PM.4.Insulin Gilargine-yfgn 42 units scheduled at bedtime for 9:00 PM was administered at 10:53 PM.5.Insulin Lispro 6 units before meals, scheduled for 9:30 PM was administered at 10:54 PM.On 2/18/26:1.Insulin Lispro 6 units before meals, scheduled for 7:30 AM was administered at 8:45 AM.2.Insulin Lispro 4 units before meals, scheduled for 11:30 AM was administered at 12:47 PM.3.Insulin Lispro 10 units before meals, scheduled for 4:30 PM was administered at 5:49 PM.On 2/19/26:1.Insulin Lispro 8 units before meals, scheduled for 7:30 AM was administered at 8:43 AM.2.Insulin Lispro 8 units before meals, scheduled for 11:30 AM was administered at 12:40 PM.On 2/20/26: 1.Insulin Lispro 6 units before meals, scheduled for 11:30 AM was administered at 1:40 PM.2.Insulin Lispro 4 units before meals, scheduled for 4:30 PM was administered at 6:12 PM.3.Furosemide 40 mg tablet, scheduled for 5:00 PM was administered at 6:13 PM.4.Famotidine 20 mg tablet, scheduled for 9:00 PM was administered at 10:26 PM.5.Duloxetine 30 mg capsule, scheduled for 9:00 PM was administered at 10:26 PM. 6.Lactulose 20 ml, scheduled for 2100 (9:00 PM) was administered at 2226 (10:26 PM).7.Insulin Gilargine-yfgn 42 units scheduled at bedtime for 9:00 PM was administered at 10:26 PM.On 2/21/26: 1.Gabapentin 300 mg capsule, scheduled for 2:00 PM was administered at 3:12 PM.On 2/22/26:1.Furosemide 40 mg tablet, scheduled for 5:00 PM was administered at 6:33 PM.On 2/23/26: 1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 11:04 AM.2.Furosemide 40 mg tablet, scheduled for 9:00 AM was administered at 11:04 AM.3.Lactulose 20 ml, scheduled for 9:00 AM was administered at 11:04 AM. 4.Sofosbuvir-Velpatasvir tablet, scheduled for 9:00 AM was administered at 11:04 AM.5. Furosemide 40 mg tablet, scheduled for 5:00 PM was administered at 8:43 PM.On 2/24/26:1.Spironolactone 100 mg two tablets, scheduled for 9:00 AM was administered at 11:02 AM.2.Furosemide 40 mg tablet, scheduled for 9:00 AM was administered at 11:02 AM.3.Lactulose 20 ml, scheduled for 9:00 AM was administered at 11:02 AM. 4.Sofosbuvir-Velpatasvir tablet, scheduled for 9:00 AM was administered at 11:02 AM.5.Insulin Lispro 2 units before meals, scheduled for 4:30 PM was administered at 5:44 PM.7.Famotidine 20 mg tablet, scheduled for 9:00 PM was administered at 11:00 PM.8.Duloxetine 30 mg capsule, scheduled for 9:00 PM was administered at 11:00 PM.9.Lactulose 20 ml, scheduled for 9:00 PM was administered at 11:07 PM.10.Insulin Gilargine-yfgn 42 units scheduled at bedtime for 9:00 PM was administered at 11:00 PM.11.Insulin Lispro 4 units before meals, scheduled for 9:30 PM was administered at 11:00 PM.On 2/27/26 at 12:48 PM, during the interview with the surveyor, the Licensed Practical Nurse (LPN) stated that medications were to be administered one hour before or one hour after the scheduled administration time. The LPN explained if a medication like insulin was due at 7:30 AM, it could be given between 6:30 AM - 8:30 AM and further stated it should not be administered an hour and a half later, it would be a med error. The LPN stated insulin would be administered before meals as per the physician order. The LPN stated she was familiar with Resident #122. The LPN could not explain why Resident #122's medications were administered late.On 3/2/26 at 12:00 PM, during an interview with the surveyor, the Director of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON) stated the meds should be administered one hour before or one hour after the due time. The DON stated there were five rights for med administration: Right Patient (resident), Right Drug, Right Dose, Right Route and Right Time. The DON further stated if the nurses were missing any meds or if the meds were delayed, the nurses should inform the physician. The surveyor made the DON aware of the above-mentioned concerns for Resident #122 and the DON acknowledged late med administration was not acceptable. The DON further stated the nurses should report it to the physician and document that in Progress Notes (PN) in EMR. The DON stated if the insulin was due at 9:00 PM, the earliest it could be given was at 8:00 PM and it was unacceptable to administer at 6:51 PM. The surveyor reviewed the Med Audit report with the DON for late med administration and the DON stated he was not aware of it and had to investigate that. On 3/2/26 at 1:43 PM, the survey team met with the DON, Licensed Nursing Home Administrator (LNHA), Regional Nurse Consultant (RNC), Regional Director of Operations (RDO). The surveyor made the facility administration aware of the above-mentioned concerns for Resident #122. A review of the facility's Medication Administration policy dated revised on 10/25 revealed Policy: Medications are administered .as ordered by the physician and in accordance with professional standards of practice. Under section Policy Explanation and Compliance Guidelines: 10. Ensure that the six rights of medication administration are followed: e. Right timeA review of the facility's Administering Medications policy date updated 10/22 revealed Policy statement: Medications shall be administered in a safe and timely manner, and as prescribed. Under section Policy Interpretation and Implementation: 2. Mediations must be administered in accordance with the orders, including any required time frame. 3. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 5. The individual administering the medication must check the label against the physician's order to verify the right resident,.right time before giving the mediation. 11.If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication will document in medication administration record.A review of the facility provided, Licensed Practical Nurse Job Description included but was not limited to; Major Duties and Responsibilities: Prepares and administers medications as per physicians' orders . Additional Assigned Taks: Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with ., and state/federal regulations and guidelines. N.J.A.C. 8: 39-27.1

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to a.) provide a resident's activities of daily living (ADL) care in a dignified manner (Resident #135) and b.) ensure residents were transported from one area of the unit to another in a dignified manner (Resident #100 and #96). This deficient practice was identified on 1 of 3 units and was evidenced by the following:1.On 2/25/2026 at 10:44 AM, the surveyor observed the door open to Resident #135s room. From the hallway, the surveyor observed the resident in bed, lying on their left side, with the blankets pulled down. The resident was not covered, and the curtains were not drawn. The resident was wearing an adult brief. The resident's bed was in a high position. At that time, the resident's roommate left the room. A male aide was observed in the hallway, who then entered the room and shut the door. On 2/25/2026 at 10:55 AM, the surveyor remained in the hallway and the roommate returned to room. The roommate opened the door, and the surveyor observed Resident #135 was still receiving care. The curtain was not drawn. The roommate shut the door behind them. The surveyor reviewed the electronic medical record (EMR) for Resident #135. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; spastic diplegic cerebral palsy (a neuromuscular disorder characterized by high muscle tone primarily affecting the legs, leading to stiffness, a scissoring gait, and potential walking difficulties), schizoaffective disorder, unspecified (a chronic mental health condition combining hallucinations, delusions, disorganized speech with major mood disorder episodes (mania or depression)) and legal blindness, as defined in USA. A review of the Minimum Data Set (MDS) an assessment tool dated 1/17/2026, revealed the resident's Brief Interview for Mental Status (BIMS) was unable to be accessed, indicating the resident was severely cognitively impaired. Further reviewed revealed the resident was dependent on staff for care. A review of the individual comprehensive care plan (ICCP) revealed a focus of an ADL self-care performance deficit r/t (related to) Disease Process, Date Initiated: 08/13/2024. On 2/26/2026 at 11:13 AM, the surveyor interviewed the hospice aid (HA) #1, who confirmed he was the one who provided ADL care to Resident #135 the day before. He stated while providing care for residents the curtains should be pulled for privacy. He stated the resident's bed should always be in the lowest position before he left the room. The surveyor reviewed the above observation with HA #1. HA #1 stated he forgot an adult brief, so he ran out of the room to get one. He acknowledged he should have drawn the curtain, covered the resident, and put the bed down to low position before he left the room. 2. On 2/25/2026 at 11:27 AM, during the initial tour of the A wing unit, the surveyor observed resident #100 sitting in the main activity area in a recliner chair. On 2/26/2026 at 9:22 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 transport Resident#100 in a recliner chair facing backwards from the main activity area to their room. Resident #100 waived to the surveyor as they were transported down the hallway. On 2/26/2026 at 9:27 AM, the surveyor observed LPN #1 return Resident #100 in the recliner chair to the activity area by transporting the resident rear facing. On 2/26/2026 at 9:28 AM, the surveyor interviewed LPN #1 who stated residents should be transported facing forward for safety. He stated staff should be able to see residents during transport because residents may try to get out of the chair. The surveyor reviewed the above observation with LPN #1, who acknowledged he should have turned the resident around. The surveyor reviewed the EMR for Resident # 100. A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified dementia, unspecified severity, with agitation (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions) and anxiety disorder, unspecified, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life). A review of the MDS dated [DATE] revealed the resident had a (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BIMS of 00 out of 15, indicating the resident was severely cognitively impaired. Further review revealed the resident required supervision or touching assistance with transfers. A review of the ICCP revealed a focus of has an ADL self-care performance deficit r/t Disease Process Date Initiated: 09/22/2025 and has limited physical mobility. [identifier redacted] utilizes a [name redacted] (reclining chair) when OOB, Date Initiated: 07/25/2023 3. On 2/25/2026 at 11:27 AM, during the initial tour of A wing unit, the surveyor observed resident #96 sitting in the main activity area in a recliner chair.On 2/26/2026 at 9:35 AM, the surveyor observed HA #1 transport Resident #96 in reclining chair, facing backwards, from their room to the main activity area. On 2/26/2026 at 11:13 AM, the surveyor interviewed HA #1, who stated residents should be transported forward facing for safety. The surveyor reviewed the above observation for Resident # 96 with HA #1, who acknowledge he should have transported the resident forward facing.The surveyor reviewed the EMR for Resident #96. A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified dementia, unspecified severity, without behavioral disturbance and anxiety disorder, unspecified. A review of the MDS dated [DATE], revealed the resident had a BIMS) of 00 out of 15, indicating the resident was severely cognitively impaired. Further review revealed the resident was dependent for transfers. A review of the ICCP revealed a focus of an ADL self-care performance deficit r/t Disease Process, Date Initiated: 10/01/2025 with an intervention of transfer: The resident requires maximum assistance by 1 staff to move between surfaces. Date Initiated: 10/01/2025. On 2/26/2026 at 11:20 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) #1, who stated ADL care should be provided with privacy by pulling the curtain and closing the door, especially if there was a roommate. The surveyor made her aware of the above observation for Resident #135. LPN/UM #1 stated that should not have happened, resident's privacy should always be maintained. During the same interview, LPN/UM #1 stated residents should always be transported forward facing in their chair for safety and so the residents would not get disoriented. The surveyor made LPN/UM #1 aware of the above observations for Resident #100 and #96. On 2/26/2026 at 11:38 AM, the surveyor interviewed the Director of Nursing (DON), who stated while performing care the most important thing was purely privacy. He stated the curtain should be pulled completely closed and the resident should be covered for dignity. The DON stated a resident's bed should never be left in a high position for safety. The surveyor made the DON aware of the above observations for Resident #135. During the same interview, the DON stated residents should always be transported forward facing in their chair so you (the staff) could make sure they (the resident) did not fall. The surveyor made the DON aware of the above observations for Resident #100 and #96. On 3/2/2026 at 1:43 PM, in the presence of the survey team, the DON, the Licensed Nursing Home Administrator, the Regional Clinical Director and the Regional Director of Operations were made aware of the above concerns for Residents #135, #100, and #96. A review of the facility policy Promoting/Maintaining Resident Dignity date implemented 9/1/23 revealed Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment .Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. NJAC 8:39-4.1(a)12,16

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of pertinent facility documentation, it was determined that the facility failed to accurately code a resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 2 of 30 residents (Resident #90 and #132) reviewed for accurately coding the MDS according to the Resident Assessment Instrument (RAI - used to assess and care plan residents). The deficient practice was evidenced by the following: 1.On 2/25/26 at 10:37 AM, during initial tour, Resident #90 was observed in their room in their bed. Resident #90 then stated that they were a smoker, and they could smoke up to four times a day. They further stated that the facility holds onto their cigarettes until it was time to smoke. On 2/25/26 at 11:16 AM, the surveyor reviewed a list of smokers provided by the facility. Resident #90 was identified as a smoker. A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; nicotine dependence (compulsive addiction to tobacco products). A review of the most recent comprehensive MDS dated [DATE], indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating cognitively intact cognition. A further review in Section J, Health Conditions, the question for tobacco use was marked as no, which meant Resident #90 was assessed as a non-smoker. A review of CJCARE Smoking Assessment & SPN's dated 7/22/25, 10/3/25, 10/23/25, and 1/23/26, included in the section titled history, that the resident was currently a smoker. A review of the resident's smoking contract revealed the resident signed a smoking contract in September 2023. On 2/26/26 at 1:18 PM, the surveyor interviewed the Recreational Aide who stated that the resident would usually come out to smoke in the evenings as they liked to sleep in during the day. On 2/27/26 at 11:28 AM, the surveyor interviewed the MDS Coordinator (MDSC) who stated that when completing an annual MDS resident assessment she received information on the resident from progress notes and assessments completed by the nursing and activities department. She further stated that she reviewed all the MDS resident assessments for accuracy prior to submission. The MDSC verified that section J1300 for resident #90 was checked off as no for tobacco use. She confirmed that the resident did use tobacco and stated, I apologize for the mistake. On 2/27/26 at 12:07 PM, the surveyor interviewed the MDSC who stated that she reviewed the MDS resident assessment documentation and that it was a data entry error on her part. She further apologized and stated that she will initiate an MDS assessment modification to indicate that the resident did use tobacco. On 3/3/26 at 9:46 AM, the Regional Nurse Consultant, in the presence of the Licensed Nursing Home Administer (LNHA), DON, Regional Director of Operations, [NAME] President of Clinical Operations (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the survey team acknowledged that MDSC should be using resident assessments such as the smoking assessments when completing annual MDS resident assessments to accurately reflect the resident. 2.On 2/25/2026 at 10:13 AM, during initial tour, Resident #132 was observed alert in their room lying in their bed. The resident stated that they had been at the facility for approximately three weeks. A review of Resident #132 admission Record reflected that the resident was admitted with diagnoses that included but not limited to; Schizophrenia and Bipolar disorder. A review of Resident #132's admission MDS dated [DATE] in section B Comatose, was coded as one (1), indicating that Resident #132 was in a persistent vegetative state or had no discernible consciousness. A review of Resident 132's progress notes reflected on 1/14/2026 a Brief Interview for Mental Status (BIMS) assessment, a brief verbal test used to check a resident's mental status or cognitive function, was completed. The progress note reflected that the BIMS assessment revealed, Resident #132 had a BIMS of 15 out of 15, indicating that Resident #132 was cognitively intact. Further review of progress notes further revealed a progress note dated 1/13/26 that the resident was received at the facility Alert and verbal. On 2/27/2026 at 11:28 AM, the surveyor interviewed the MDSC, who indicated the submission of the MDS assessments were completed by nursing staff, social work as well as the MDSC and ultimately the information was entered into the MDS by the MDSC. When questioned why Resident #132 was coded as comatose the MDSC indicated they would need to further investigate. On 2/27/2026 at 12:07 PM, the MDSC stated she had reviewed documentation for Resident #132 and stated that it was, a data entry error on my part. The MDSC further stated that they have already initiated a modification to correct the error. A review of the facility's MDS 3.0 Completion policy, date revised 10/30/2025, included.residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.according to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. NJAC 8:39-33.2 (d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary services to maintain adequate grooming for a resident who was dependent on the staff for Activities of Daily Living (ADL). This deficient practice was observed for 1 of 1 resident (Resident #81) reviewed for ADL care. The deficient practice was evidenced by the following:On 2/25/26 at 10:28 AM, during an initial tour, the surveyor observed Resident #81 sitting in their wheelchair (w/c). The resident stated I am in bad shape while showing the surveyor both of their hands with long, jagged fingernails with sharp edges and then pointed towards their chin that had grey colored, curled up facial hair. Resident #81 stated I have asked them (the staff) to shave many times. The surveyor reviewed the Electronic Medical Record (EMR) for Resident #81:A review of the admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included, but were not limited to; Anemia (a shortage of healthy red blood cells or hemoglobin, which prevents the body from getting enough oxygen), malaise (a feeling of lack of energy or general weakness) and muscle weakness.A review of the quarterly Minimum Data Set (MDS) an assessment tool dated 12/9/25, revealed the Resident #81 had a Brief Interview for Mental Status (BIMS) of 6 out of 15, indicating the resident's cognition was severely impaired. Further review revealed Resident #81 was dependent on staff for all their ADLs including personal hygiene.A review of the individualized comprehensive care plan (ICC) created on 8/14/24 included a focus area that the resident had an ADL self-care performance deficit related to impaired balance. Interventions initiated 10/9/25 included but were not limited to .Bathing/showering: Check nail length and trim and clean on bath day and as necessary. On 2/26/26 at 1:24 PM, the surveyor observed Resident #81 in their w/c. The surveyor observed Resident #81's both hands with long, jagged fingernails with sharp edges and facial hair. Resident #81 stated, I have told one of the girls (Certified Nurse Aid/CNA) regarding my nails and facial hair and she (the CNA) said she would trim them sometime today.On 2/27/26 at 11:54 AM, the surveyor observed resident sitting in their w/c. The surveyor observed Resident #81's long jagged fingernails on both hands and facial hair. Resident #81 stated, I have tried to do my left-hand nails myself, but they (the staff) do not want me to do it.On 2/27/26 at 12:15 PM, during an interview with the surveyor, the CNA stated during bed bath and/or shower, she would provide the resident hair care, nail care, foot care like applying lotion to their feet after washing them and shave them if it was needed. The CNA stated if the resident asked her to shave their facial hair, then she would do it for appearance. The CNA then stated, I do not think a [identifier redacted] wants to keep a beard. The CNA further stated the nail care was important for hygiene, residents could scratch themselves and they dig into places and touch everywhere. The surveyor accompanied by the CNA went to Resident #81's room and after looking at the resident's fingernails on both hands, the CNA stated, resident's nails were fine and the resident stated their nails were too long and wanted their fingernails to be trimmed and their facial hair to be shaved. On 2/27/26 at 12:28 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who was responsible for providing education to all the staff. The ADON stated the CNAs should be checking resident's nails daily during care. The ADON further stated the nail care was important for infection control and residents could hurt themselves by scratching. The ADON stated facial hair should be shaved for dignity and further stated, I do not want a [identifier redacted] to be sitting there with their facial hair. In the presence of the surveyor, the ADON reviewed the Electronic Medical Records (EMR) for Resident #81 and confirmed there was no documentation for nail care. In the presence of the surveyor, the ADON observed and acknowledged that Resident #81's fingernails and facial hair needed to be trimmed.On 3/2/26 at 11:59 AM, the surveyor interviewed the DON who stated hygiene was very important for infection control and presentation. The DON stated the expectation from the staff was to provide nail care and shaving assistance at the resident's request and as needed. The surveyor made the DON aware of the above-mentioned concerns for Resident #81. On 3/2/26 at 1:43 PM, the survey team met with the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON, Licensed Nursing Home Administrator (LNHA), Regional Nurse Consultant (RNC), Regional Director of Operations (RDO). The surveyor made the facility administration aware of the above-mentioned concerns for Resident #81. A review of the facility's Activities of Daily Living (ADLs) policy dated implemented on 9/24 revealed: Care and services will be provided for the following activities of daily living: 1. Bathing, dressing grooming and oral care; Under section Policy Explanation and Compliance Guidelines:2. A resident who is unable to carry out activities of daily living will received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.A review of the facility's Grooming a Resident's facial hair undated policy revealed under Policy: It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standard of practice.A review of the facility's Nail Care policy dated implemented on 9/24, provided on 3/2/26, revealed under Policy: The purpose .to provide guidelines for the provision of care to a resident's nails for good grooming and health. Under section Policy Explanation and Compliance Guidelines: 2. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 3. Routine nail care, to include trimming and filling, will be provided on a regular basis and as needed. 4. Procedure: h. Document completion of task, any complications, or if resident refuses. A review of the facility's Nail Care policy dated implemented on 9/24, provided on 3/3/26, revealed under Policy: The purpose .to provide guidelines for the provision of care to a resident's nails for good grooming and health. Under section Policy Explanation and Compliance Guidelines: 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filling, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises. 5. The resident's plan of care will identify: a. The frequency of nail care to be provided. 6. Principles of nail care: a. Nails should be kept smooth to avoid skin injury. A review of the facility provided, Licensed Practical Nurse Job Description included but was not limited to; Performs rounds to ensure resident needs are being met and personnel are performing their assigned duties.A review of the facility provided, Certified Nursing Assistant Job Description included but was not limited to; Under Major Duties and Responsibilities: Assists residents with or performs activities of daily living for resident in accordance with care plans and established policies and procedures. Under section Additional Assigned Tasks: Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with .state/federal regulations and guidelines. NJAC 8:39-27.1(a), 27.2(g)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, it was determined that the facility failed to clarify conflicting physician's orders for lactulose (a medication used to treat chronic constipation and hepatic encephalopathy: a brain condition caused by liver disease).The deficient practice was identified for 1 of 1 resident (Resident #5) reviewed for Dialysis and was evidenced by the following:On 2/26/2026 at 11:29 AM, the surveyor interviewed Resident #5, who stated they received dialysis in the morning on Monday, Wednesday, and Friday. The surveyor reviewed the Electronic Medical Record (EMR) for Resident #5.A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to; gastrointestinal hemorrhage (bleeding that occurs in the intestinal tract), type 2 diabetes mellitus (a chronic condition characterized by insulin resistance and high blood sugar levels), and end stage renal disease (the final stage of chronic kidney disease where kidneys can no longer function to sustain life without treatment).A review of the resident's quarterly Minimum Data Set, an assessment tool used to facilitate the management of care dated 01/08/2026, included the resident had a Brief Mental Status score of 15 out of 15, which indicated no cognitive impairment. Further review revealed the resident received dialysis.A review of the resident's Individual Comprehensive Care Plan included a focus area for potential for constipation dated 10/03/2025. Interventions included to follow facility bowel protocol for bowel management. Another focus area for nutrition dated 10/07/2025 revealed a goal of regular bowel movements; A focus area for history of constipation dated 10/07/2025, revised 02/26/2026 revealed an intervention to follow bowel habits; and a focus area for hemodialysis related to renal failure dated 10/03/2025.A review of the Order Summary Report revealed the following physician's order (PO):-A PO dated 10/02/2025 for No lactulose for dialysis residents;-A PO dated 02/02/2026 for Resident Dialysis M-W-F 6 AM;-A PO dated 11/18/2025 for lactulose encephalopathy oral solution, give 10 grams by mouth every 24 hours as needed (PRN) for constipation. A review of the Medication Administration Record (MAR) revealed the administration of the PRN lactulose encephalopathy oral solution on 12/07/2025 at 9:48 AM coded with E (effective).A review of the progress notes in the EMR revealed a physician note dated 10/31/2025 that included .lactulose as needed. There was no record of a progress note related to the administration of the PRN lactulose on 12/07/2025.On 02/27/2026 at 9:16 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1) who was caring for Resident #5. LPN #1 reviewed the POs for both No lactulose and PRN lactulose. LPN#1 stated, the No lactulose order does not show on the MAR, it was in the ancillary section, and the nurses do not see it or sign for it. LPN#1 further stated For clarification, when someone goes to dialysis, if they cannot have a bowel movement, most of the time they get lactulose because they can't have Milk of Magnesia. Lactulose is an order you get, it's recommended for dialysis residents. LPN#1 reviewed the MAR and confirmed the PRN lactulose was administered on 12/07/2025. LPN#1 then stated, that order for No lactulose shouldn't be there.On 02/27/2026 at 9:26 AM, in the presence of the surveyor, the Director of Nursing (DON) reviewed the POs for Resident #5. The DON stated the No lactulose order came in a batch order upon admission for all residents and orders should be specified after that. The DON confirmed that the resident also had a PO for PRN lactulose. The DON then stated, I can say that is a contraindication to have an order for No lactulose and an order for lactulose.On 02/27/2026 at 11:31 AM, during a telephone interview with the surveyor, the physician stated I don't typically order lactulose based on loose bowel movements causing dehydration. That batch order is not something I normally order myself.On 03/02/2026 at 9:32 AM, the surveyor interviewed the physician over the telephone who confirmed he did order the PRN lactulose.On 03/03/2026 at 9:45 AM, in the presence of the survey team, the Regional Nurse Consultant (RNC) stated The facility has a standing order for all dialysis residents for No lactulose, initiated on admission, and reviewed by the physician. The physician acknowledged this order. The RNC further stated The resident was receiving lactulose nightly at the hospital. Upon transfer, the order was changed to PRN and approved by the physician (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during reconciliation. The RNC confirmed the batch No lactulose order should have been discontinued upon admission by the nurse who received the resident and reconciled the orders with the physician.A review of the facility provided, Licensed Practical Nurse Job Description included but was not limited to; Major Duties and Responsibilities: Prepares and administers medications as per physicians' orders . Additional Assigned Taks: Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with . state/federal regulations and guidelines. NJAC 8:39-23.2(b)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure a controlled medication (Methadone)(used for opioid dependence treatment) was stored with the appropriate labeling and the coordinating controlled drug sheet (CDS)(a record of inventory) was altered appropriately for one (1) of three (3) medication carts inspected. The deficient practice was evidenced by the following: On 2/26/26 at 11:10 AM, the surveyor inspected the B wing front hall medication cart, in the presence of the Licensed Practical Nurse (LPN #1). The surveyor observed four (4) Methadone liquid bottles labeled for Resident #68 in a cellophane bag. The bag had a label with unsampled Resident #1's name crossed out with pen. LPN #1 acknowledged that the label was not for Resident #68 and was crossed out. LPN #1 was unable to speak to why the bag was not properly labeled for Resident #68. At that time, the surveyor requested the corresponding controlled drug sheet (CDS) for the Methadone for Resident #68. LPN #1 removed the Chain of Custody Record/External Facility (a form generated by a clinic indicating the total number of doses for a specific resident given to the facility to keep inventory of a controlled medication) from a binder and signed the form. Then, the surveyor observed LPN #1 go to the nursing station and returned with white correction fluid and proceeded to use the correction fluid to cover her signature on the form. LPN #1 explained that she had mistakenly signed for the date 2/27/26 indicating she had administered Methadone on 1/27/26. LPN #1 was unable to speak to why she signed the form and thought she was able to use the correction fluid on controlled drug records. On 2/26/2026 at 11:17 AM, the surveyor interviewed the Unit Manager/LPN (UM/LPN), who stated she was responsible for going to the clinic every week and obtaining the Methadone bottles for Resident #68. The UM/LPN reviewed the Chain of Custody Record/External Facility for Resident #68. UM/LPN stated she had signed the form when she picked up the Methadone and the form was used to keep inventory and document when the Methadone was administered and by whom. The UM/LPN acknowledged that there was white correction fluid on the form for a signature for 1/27/26 and under the section Name of Staff Administering Dose. The UM/LPN stated white correction fluid was not allowed to be used on the form. The UM/LPN added she thought the clinic used the white correction fluid on the form under the section Name of Staff Administering Dose. The UM/LPN explained the proper procedure was if the nurse made a mistake signing the form, they would draw a line with a pen through the signature name, initial and add a description of the error. At that time, the UM/LPN went to the medication cart and reviewed the bag labeled for unsampled resident #1 containing Resident #68's Methadone bottles. The UM/LPN acknowledged the bag was labeled for unsampled Resident #1 and the name was crossed out with a pen. The UM/LPN stated the nurses had put Resident #68's Methadone bottles in a used bag meaning that the bag originally contained medication for unsampled Resident #1 and was reused to store the Methadone bottles for Resident #68. The UM/LPN added unsampled resident #1 was also on Methadone. The UM/LPN stated each bag should be labeled for the appropriate resident. The UM/LPN also stated that she had plenty of cellophane bags in the facility to make sure the label was appropriate and could not speak to why a bag for another resident was used and label crossed out. The surveyor reviewed the Order Summary Report for Resident #68 which reflected an active physician's order (PO) for Methadone HCl (hydrochloride) Oral Concentrate 10 MG (milligrams)/5 ML (milliliters) Give 132 MG by mouth one time a day for Opioid dependence. The surveyor reviewed the Order Summary Report for unsampled Resident #1 which reflected an active PO for Methadone HCl Oral Concentrate 10 MG/ML via G-Tube (gastrostomy tube-tube inserted into the stomach) one time a day every Mon, Tue, Thu, Fri, Sat for Opioid dependence. On 2/27/2026 at 10:05 AM, the surveyor interviewed the Director of Nursing (DON) regarding controlled drug procedures. The DON explained that each UM was responsible for picking up Methadone on a weekly (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	basis and ensuring the inventory forms were accurate. The DON added that he had cellophane bags at the facility for the purpose of keeping the Methadone bottles together for each resident. The DON added that the bag should be properly labelled for each resident. On 2/27/26 at 11:42 AM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone. The CP stated unit inspections were conducted monthly which included spot checking the medication carts and controlled drugs. The CP stated the label on the medication bag should match the name of the resident's medication in the bag. On 3/3/26 at 9:44 AM, the survey team met with the administrative team. The Regional Clinical Nurse stated education was provided to the nurses to properly store medications and not to cross out names on a label and correction fluid was not to be used. The DON added correction fluid was removed from all units. A review of the facility policy Medication Administration dated reviewed/revised 10/20/25, provided by the DON, revealed Compare medication source (bubble pack, vial, etc.) with MAR (medication administration record) to verify resident name, medication name, form, dose route, and time. A review of the facility policy Medication Administration dated as reviewed/revised 3/17/25, provided by the DON, revealed the policy of the facility was to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. In addition, The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient specific-narcotic dispensed from the pharmacy. NJAC 8:39-29.4(g)(h)(k), 29.6(b)(1), 29.7(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of pertinent facility records, it was determined that the facility failed to ensure infection control practices were implemented by staff not appropriately donning(put on) and doffing(remove) Personal Protective Equipment (PPE), in accordance with accepted national standards, Centers for Disease Control and Prevention (CDC) guidelines, before and after exiting a resident's room, (Resident #109), who was on Transmission Based Precautions (TBP) due to Methicillin-resistant Staphylococcus aureus (MRSA) (a type of bacteria resistant to common antibiotics that can be transmitted through direct contact) and perform hand hygiene to prevent the spread of infection, on one (1) of three (3) units . The deficient practice was evidenced by the following: According to the U.S. CDC guidelines for Transmission-Based Precautions dated 4/3/2024, indicated to Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. On 2/25/26 at 10:08 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse(UM/LPN), who stated that Resident #109 was on TBP but would have to check if it was MRSA or MSSA (methicillin-susceptible Staphylococcus aureus in the bloodstream).On 2/25/26 at 10:18 AM, the surveyor observed, from the hallway, Resident #109's closed bedroom door with a reddish color sign from the New Jersey Department of Health Communicable Disease Services on the door which indicated CONTACT AND DROPLET PRECAUTIONS ARE IN PLACE. STOP EVERYONE MUST: CLEAN THEIR HANDS, INCLUDING BEFORE ENTERING AND WHEN LEAVING THE ROOM. STOP PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another patient. Make sure eyes, nose, and mouth are fully covered before room entry. Remove face protection before room exit.On 2/25/26 at 10:57 AM, the surveyor observed the Physical Therapist (PT) in Resident #109s room. The PT was not wearing PPE, a gown or glove. The surveyor heard from the hallway outside the resident's room, the PT talking with the resident. The PT came out of the resident's room and closed the door. At that time, the surveyor interviewed the PT. The surveyor, with the PT, reviewed the signage on the resident's door. The PT stated that contact precautions meant that anyone entering the room would have to wear a gown and gloves before entering and discard before leaving the room. The PT acknowledged that she had not donned or doffed a gown and/or gloves prior to going into the room. The PT added she was unsure if the signage was for Resident #109 and thought it was for a different resident. The PT also stated that Resident #109 had an infection in their hand and was on an IV (intravenous) antibiotic, so the resident was on Enhanced Barrier Precautions (EBP) meaning a gown and gloves were necessary only if high contact resident care was being provided.The surveyor reviewed the electronic medical record for Resident #109.A review of the admission Record reflected diagnoses which included, but were not limited to; sepsis due to MSSA and acute osteomyelitis, right hand.A review of the resident's interdisciplinary comprehensive Care Plan Report dated as initiated 2/2/26 and revision 2/12/26 revealed a focus area, Resident #68 requires EBP R/T (related) to IV line. Another focus area with a date initiated 1/30/26 and revision date 2/12/26 indicated Resident #109 is on antibiotic therapy r/t Vancomycin (an antibiotic) for MRSA infection from 2/17/26-2/17/26.A review of the Order Summary Report indicated a Physician's Order (PO) with a start date 2/17/26 for Vancomycin HCL(hydrochloride) solution reconstituted 1000 milligrams/200 milliliter (ML),Use 1 gram intravenously one time a day for MRSA until 2/27/26. An additional PO with a start date 2/18/26 indicated Infection Precautions-contact for MRSA every shift for CONTACT PRECAUTIONS FOR MRSA.A review of the February 2026 Medication Administration Record (MAR) revealed nurses were signing a PO dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Madison, LLC	625 State Highway 34 Matawan, NJ 07747

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/2/26 with a discontinuation date of 2/18/26 for Resident requires EBP for a diagnosis of a IV line every shift for IV line.On 2/26/26 at 10:43 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that they were familiar with Resident #109. CNA #1 stated the resident was independent and was able to do their own care, but she would bring the resident linens, meal tray and anything they needed. CNA #1 added she would wear a gown and gloves if she needed to provide care or assist with care.On 2/26/26 at 11:40 AM, the surveyor attempted to interview Resident #109. The surveyor knocked on the resident's room door that had the same signage observed prior. The resident opened the door and declined to be interviewed and shut the door.On 2/26/26 at 12:13 PM, the surveyor observed CNA #2 enter Resident #109's room and then come out of the room with a meal tray and closed the door. The surveyor had not observed CNA #2 put on a gown and gloves when entering Resident #70's room or perform hand hygiene after exiting the room. At that time, the surveyor interviewed CNA #2, who stated she was not assigned to Resident #109 and was just picking up a lunch tray that was finished. The surveyor, with the CNA #2, reviewed the signage on the resident's door. CNA #2 stated she was unsure if the resident was on contact precautions but knew that the signage meant they must have some kind of infection and that a gown and gloves were required before going into the room and removed before coming out. CNA #2 acknowledged she had not put on PPE or performed hand hygiene.On 2/26/26 at 12:14 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated Resident #109 was on EBP and she was required to wear a gown and gloves if providing care. LPN #1 also stated contact precautions meant anyone had to put on a gown and gloves before entering the room and before leaving the room, had to remove the gown and gloves and perform hand hygiene.At that time, the surveyor, with LPN #1, reviewed the signage on the closed door of Resident #109's room. LPN #1 stated that she was confused and had to check with the Unit Manager/LPN.On 2/26/26 at 12:18 PM, the surveyor, with the UM/LPN and LPN #1, reviewed the signage on the closed door of Resident #109's room. The UM/LPN stated the signage meant before entering the room, a gown and gloves were required even if dropping off or picking up a meal tray. The UM/LPN added she was unsure if the resident was on contact precautions because the resident had a wound that was covered, and the IV antibiotic will be completed tomorrow. The UM/LPN stated she would have to check with the Director of Nursing (DON).On 2/26/26 at 1:02 PM, the surveyor interviewed the Rehab Director/Speech Therapist (RD/ST) who stated every morning there was a meeting with department heads and any resident on TBP was discussed. The RD/ST added signage was on the resident's door to alert staff what PPE was required, and the staff should check the signage. The RD/ST stated she did not have a list of the residents who were on TBP but off the top of her head knew of two residents whose names she stated, which neither was Resident #109. The surveyor then asked if Resident #109 was on TBP and the RD/ST explained she could check the electronic record. After reviewing the electronic record for Resident #109, the RD/ST stated the resident was on contact precautions. The RD/ST explained a resident on contact precautions usually had therapy in their room and a gown, gloves and a mask were required. The RD/ST added there were circumstances a resident would be allowed in the gym as the only resident in the gym and equipment cleaned immediately after. On 2/26/26 at 1:12 PM, the surveyor interviewed the UM/LPN who stated she was contacting the infection disease physician for Resident #109. The UM/LPN confirmed Contact precautions signage was on the resident's door and should be followed. The UM/LPN added the resident was not on droplet precautions and acknowledged both were listed on the signage. On 2/27/26 at 11:42 AM, the surveyor interviewed the Infection Preventionist (IP/LPN) who stated any resident on contact precautions was usually known upon admission including what type of infection they had. The IP/LPN added she has educated the staff on what to do for contact precautions which included do not step a pinky toe in that room without full PPE meaning a gown and gloves were required to be worn before entering the resident's room and removed before exiting the room and perform hand hygiene. The IP/LPN also stated Resident #109 had been on contact precautions for MRSA in the bloodstream and was being (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharged today. The IP/LPN acknowledged that she was following CDC guidelines. The IP/LPN stated there may have been confusion because the resident was on another wing then transferred to their current room and had MSSA in a wound and the wound had closed so the staff may have thought the resident was on EBP. The IP/LPN added the resident still had MRSA in the blood and was on an antibiotic which was completed today. The IP/LPN also stated the Rehab department was mistaken and should have been following contact precautions in the resident's room. The IP/LPN had a list of residents on TBP which indicated Resident #109 was on Contact Precautions and the reason was IV line Contact MRSA.On 3/3/26 at 9:44 AM, the survey team met with the facility administrative team. The Regional Clinical Nurse (RCN) stated the staff were re-educated on proper infection control practices. The RCN and DON acknowledged Resident #109 was on contact precautions during their stay as designated by the signage.A review of the facility policy titled Isolation-Categories of Transmission-Based Precautions revised/reviewed 1/2022, provided by DON, revealed for Contact Precautions gloves and a gown were to be worn before entering the room and removed before leaving the room and perform hand hygiene.A review of the facility policy titled Transmission-Based (Isolation) Precautions dated as reviewed/revised 10/14/25, provided by the DON, revealed It is the policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. The policy had the following definitions:Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Transmission-based precautions (a.k.a.Isolation Precautions) refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact and droplet) in order to prevent or control infections.The policy had an explanation and compliance guidelines which included but not limited to;1. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission.4. Residents on transmission-based precautions should remain in their rooms except for medically necessary care.e. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room, wing, or facility-wide. Additionally, either the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage.10. Contact Precautions-a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment.c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment.Further review of the policy included a table for Recommendations for Personal Protective Equipment (PPE) which indicated for Contact Precaution, gloves was the type of PPE required with recommendations Whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails). [NAME] gloves upon entry into the room or cubicle. In addition, for Contact Precaution, gown was the type of PPE required with recommendations Whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. [NAME] gown upon entry into the room or cubicle.Also, the policy included a table for Type and Duration of Transmission-Based Precautions Recommended for Selected Infections and Conditions indicated for the infection/condition of Multidrug-resistant organisms (MDROs), infection or colonization (i.e. MRSA.) the precaution was standard/contact based on local, state, regional, or national recommendations. Contact Precautions recommended in settings with evidence of ongoing transmission or in settings with increased risk for transmission or wounds that cannot be contained by dressings.NJAC 8:39-19.4 (a) (1, 2)(b)