STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315038	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Summit Ridge	20 Summit Street West Orange, NJ 07052

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Complaint #: 2661084Based on interviews, medical record review, and review of other pertinent facility documentation on 11/17/2025 and 11/20/2025, it was determined that the facility failed to report a verbal abuse allegation that a resident's representative (RR) reported to the facility's staff and to the Department of Health (DOH) for 1 of 3 residents reviewed for abuse. The deficient practice was identified for 1 of 3 residents reviewed (Resident #3) and was evidenced by the following:According to the admission Record (AR), Resident #3 was admitted to the facility with diagnoses which included but were not limited to: paraplegia (type of paralysis that affects the lower half of the body), spinal stenosis (when the space inside the backbone is too small and puts pressure on the spinal cord), and diabetes. According to the Comprehensive Minimum Data Set (MDS), an assessment tool dated 10/24/2025, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact.A review of the facility's document titled Summary of Investigation dated 11/10/2025 revealed that the RR reported to the facility that a nurse told Resident #3 to shut up. On 11/17/2025 at 12:40 PM, the surveyor conducted a phone interview with RR who stated that Resident #3 had told her that a staff member had told the resident to shut up. The RR further stated that the resident was unsure of the staff member's name. The RR stated she reported what was told to her to the facility's Social Worker (SW) but could not remember the date she reported the incident to the SW.On 11/20/2025 at 10:29 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the allegation was not reported to the DOH because the resident said there was no verbal abuse that had occurred. The LNHA stated that the resident denied the abuse allegation and was cognitively intact. LNHA further stated that staff were interviewed and nothing was able to be proven. The LNHA further stated that she would call the DOH about the alleged abuse. There was not evidence that facility fully investigated the allegation of verbal abuse or called the abuse to the DOH.A review of the facility's policy titled Abuse, Neglect, and Exploitation with a revised date of 5/1/2025 revealed under VII. Reporting/Response, 1. Reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.NJAC 8:39-9.4

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Complaint: 2661084Based on interviews, medical record review, and review of other pertinent facility documents on 11/17/2025 and 11/20/2025, it was determined that the facility failed to provide documented evidence that care was provided to a resident who required maximal assistance for toileting hygiene. This deficient practice occurred for 1 of 3 residents (Resident #3) reviewed.The deficient practice was evidenced by the following:According to the admission Record (AR), Resident #3 was admitted to the facility with diagnoses which included but were not limited to: paraplegia (type of paralysis that affects the lower half of the body), spinal stenosis (when the space inside the backbone is too small and puts pressure on the spinal cord), and diabetes. According to the Comprehensive Minimum Data Set (MDS), an assessment tool dated 10/24/2025, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. The MDS further revealed that the resident needed substantial and maximal assistance with toileting hygiene and was frequently incontinent of bowel and bladder.A review of the facility's grievance forms dated 11/10/2025 revealed the following: Resident #3 reported they had concerns in the timeliness of having incontinence care completed on 11/2/2025 and 11/9/2025.A review of Resident #3's Documentation Survey Report, a form utilized for documentation of Activity of Daily Living (ADL) care by the Certified Nursing Assistants (CNAs) for November 2025, revealed NA on the following dates for toileting hygiene: 11/2/2025 on day shift (7-3) and evening shift (3-11)11/9/2025 on day shift (7-3) and evening shift (3-11)A review of Resident #3's Progress Notes (PNs) for November 2025, did not reveal that incontinence care was provided on the aforementioned dates. On 11/17/2025 at 9:45 AM, the surveyor conducted an interview with Resident #3. Resident #3 stated that there was one time when they sat in their feces. The resident was unable to tell the surveyor the date or time and no additional information. On 11/18/2025 at 9:54 AM, the surveyor conducted a telephone interview with Social Worker #2 (SW#2) who stated that Resident #3 and their representative complained within the last two weeks about the resident not being provided with incontinent care prior to eating.On 11/20/2025 at 9:45 AM, the surveyor conducted an interview with the Infection Preventionist (IP) and asked about NA. IP stated that she believed NA meant it was non-applicable. She further stated she did not know why it was documented unless the resident was out of the building which would be documented in the chart as part of the facility. The IP further stated she would not be able to speak on whether Resident #3's care was provided on 11/2/2025. The IP stated the unit managers and supervisors were responsible for checking the ADL documentation for completeness not the codes documented. The IP further stated it was important to document ADLs every shift to ensure care was given. On 11/20/2025 at 9:48 AM, the surveyor conducted an interview with Certified Nursing Assistant #1 (CNA #1) who confirmed that Resident #3 was incontinent. She stated that she provided total assistance for Resident #3 in addition to ADL care. CNA #1 stated she documents NA in the ADL documentation sheet if the resident did not have a bowel movement under the toileting and hygiene section. A review of the facility's policy titled Charting and Documentation with an updated date of 1/2022 revealed under Policy Interpretation and Implementation, 2. The following information is to be documented in the resident medical record: c: Treatments or services provided. The documentation of NA in the facility's Documentation Survey Report indicates not attempted . NJAC 8:39-27.1 (a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #: 2661084Based on interviews, medical record review, and review of other pertinent facility documents on 11/17/2025 and 11/20/2025, it was determined that the facility failed provide evidence that a physician's order for wound care was carried out and documented for two days to treat a facility acquired pressure injury in accordance with professional standards. This deficient practice occurred for 1 of 3 residents reviewed for wound. The deficient practice was evidenced by the following:According to the admission Record (AR), Resident #3 was admitted to the facility with diagnoses which included but were not limited to: paraplegia (type of paralysis that affects the lower half of the body), spinal stenosis (when the space inside the backbone is too small and puts pressure on the spinal cord), and diabetes. According to the Comprehensive Minimum Data Set (MDS), an assessment tool dated 10/24/2025, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact.A review of the facility's document titled Skin Injury dated 11/4/2025, revealed that Resident #3 was noted with an opening on their sacrum during care. A review of Resident #3's Progress Notes (PNs) dated 11/4/2025 revealed the following written by Licensed Practical Nurse (LPN #1): Cleanse with NS [normal saline], medi honey apply and cover. MD [Medical doctor] and family member made aware.A review of Resident #3's wound assessment report with date of service of 11/5/2025 revealed the following:Measurements: Length: 2. 7 centimeters (cm)Width: 1.00 cmDepth: 0.10 cm. Observations: Location: coccyxEtiology: pressure ulcer/injuryStage/severity: stage 2acquired in house: yes Treatment: Dressing change frequency: BID (twice per day), and PRN (as needed)Clean wound with: cleanse with normal salinePrimary treatment: medical grade honey Other dressings: bordered foamA review of Resident #3's Order Summary Report (OSR) and Treatment Administration Record (TAR) revealed no evidence of physician's orders and no evidence the wound care to the resident's sacrum was provided on 11/4/2025 and 11/5/2025. A further review of Resident #3's OSR with an order date of 11/6/2025, revealed the following physician's order: Medi honey Wound/Burn Dressing External Gel. Apply to coccyx topically every day and evening shift for wound care. Clean with NS [normal saline], apply honey, cover with bordered form gauze. A review of Resident #3's TAR dated 11/6/2025 revealed the aforementioned order for wound care. On 11/17//2025 at 1:52PM, the surveyor conducted an interview with the Assistant Director of Nursing (ADON) who stated that if a wound was discovered, the nurse should call the doctor for treatment orders and put the orders in the computer. The ADON stated he did not see a wound care order for Resident #3's sacrum on 11/4/2025 and 11/5/2025. The ADON further stated that a wound care order should have been initiated on 11/4/2025. The ADON confirmed that Resident #3's wound care orders were initiated on 11/6/2025. The DON stated it was important to get treatment orders as soon as possible and put them into the computer so the wound would not get worse. On 11/20/2025 at 11:23 AM, the surveyor conducted an interview with LPN #1 who stated the Certified Nursing Assistant (CNA) made her aware of Resident #3's sacrum wound but was unable to recall the exact date. She stated that she and the supervisor wrote an incident report and that she notified the doctor. LPN #1 stated she was unsure of which doctor she notified. LPN #1 further stated if she wrote the note for 11/4/2025, it meant she got the order for the wound treatment on the same day. LPN #1 stated that when she got an order from the doctor, she would be responsible for putting it in the computer. LPN #1 stated she did not know why Resident #3's wound order was not put in the computer until 11/6/2025. A review of the facility's policy titled Wound Treatment Management with an implemented date of 6/1/2025 revealed under Policy Explanation and Compliance Guidelines, 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record.A review of the facility's policy titled Charting and Documentation with an updated date of 1/2022 revealed under Policy Interpretation and Implementation, 2. The following information is to be documented in the resident medical record: c. Treatments or services performed. 7. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided.NJAC 8:39-27.1 (a)