STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mohawk Meadows	1 O'Brien Lane Lafayette, NJ 07848

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 Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C39051/IQBased on interviews, medical record reviews, and review of other pertinent facility documentation on 08/14/25, 08/15/25, and 08/18/25, it was determined that the facility failed to report within two hours to the New Jersey Department of Health (NJDOH) allegations involving resident abuse for : a.) on 8/15/24 when facility was notified of an allegation of misappropriation of resident's funds by the Social Worker (SW) b.) an allegation of resident-to-resident verbal abuse involving Resident #11 and Resident #13; and C.) an allegation of resident-to-resident verbal abuse involving Resident #11 and Resident #14. This deficient practice was identified for 1 of 14 residents reviewed for abuse (Resident #11), and was evidenced by the following:A.) On 8/15/25 at 12:31 P.M., the surveyor notified the Licensed Nursing Home Administrator (LNHA) that the SW reported to them that the SW had taken Resident #11's debit card and used it to remove cash out of Resident #11's bank account.According to the admission Record (AR) face sheet, Resident #11 was admitted to the facility with diagnoses which included but were not limited to acute and chronic respiratory failure with hypoxia (medical condition where a part of the body, or the entire body, is deprived of an adequate oxygen supply at the tissue level), benign neoplasm (an abnormal growth of tissue in some part of the body) of brain, acute and chronic respiratory failure with hypercapnia (excessively high levels of carbon dioxide (CO2) in the blood), and chronic obstructive pulmonary disease with (acute) exacerbation (a condition involving constriction of the airways and difficulty or discomfort in breathing).A review of the Minimum Data Set (MDS), an assessment tool dated 08/07/25, Resident #11 had a Brief Interview of Mental Status (BIMS) score of 11/15, which indicated Resident #11's cognition was moderately impaired.On 08/18/25 at 11:57 A.M., the surveyor interviewed the Director of Nursing (DON) and LNHA together. They stated that they did not report the allegation of misappropriation of Resident #11's money to the NJDOH because their investigation concluded that no misappropriation of money had occurred.B.) On 08/15/25 at 11:37 A.M., the surveyor interviewed Resident #11 who reported an allegation of verbal abuse between Resident #13 and themself. On 08/15/25 at 02:09 P.M., the surveyor notified the DON and LNHA of an allegation that Resident #13 verbally abused Resident #11.According to the closed AR face sheet, Resident #13 was admitted to the facility with diagnoses which included were not limited to fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing, hemiplegia (paralysis of one side of the body), unspecified affecting right dominant side, and unspecified fracture of right acetabulum, subsequent encounter for fracture with routine healing.A review of the MDS dated [DATE], revealed that Resident #13 had a BIMS score of 11/15, which indicated that Resident #13's cognition was moderately impaired.On 08/18/25 at 11:57 A.M., the surveyor interviewed the DON and LNHA together. The DON stated that based on the context of the investigation and interview regarding verbal abuse between Resident #11 and Resident #13, the DON did not believe this allegation had to be reported to the NJDOH. The DON further stated that she did not believe it need to be reported because Resident #13 was no longer at the facility.C.) On 08/15/25 at 11:37 A.M., the surveyor interviewed Resident #11 who reported an allegation of verbal abuse between Resident #14 and themself. On 8/15/25 at 02:09 P.M., the surveyor notified the DON and LNHA of an allegation that Resident #14 verbally abused Resident #11.According to the AR face sheet, Resident #14 was admitted to the facility with diagnoses which included were not limited to; Type 2 diabetes mellitus with hyperglycemia (chronic metabolic disorder where the body doesn't properly use insulin, leading to elevated blood sugar levels), essential hypertension (elevated blood pressure), and alcohol abuse.A review of the MDS dated [DATE], revealed Resident #14 BIMS score of 15/15 which indicated that Resident #14's cognition was intact.On 08/18/25 at 11:57 A.M., the surveyor interviewed the DON and LNHA together. The DON stated that based on the context of the investigation and interview regarding verbal abuse between Resident #11 and Resident #14, the DON did not believe this allegation had to be reported to the NJDOH.A review of the facility's policy titled Abuse, Prevention and Prohibition Program dated revised 06/27/23, included the following information under Reporting/Response:D. The facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime.i. Immediately, but no later than 2 hours after forming the suspicion or belief if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, law enforcement, and the Ombudsman (if applicable per state regulation).ii. No later than 24 hours after forming the suspicion or belief if the alleged violation (e.g., misappropriation of property, neglect) does not involve

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #: 390051Based on interviews, medical record review, and review of other pertinent facility documentation on 8/18/2025, it was determined that the facility failed to consistently document on the Treatment Administration Record (TAR) according to the acceptable standards of nursing practice for 1 of 3 residents (Resident #11) reviewed for documentation. 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 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.Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or 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 prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem.According to the admission Record (AR), Resident #11 was admitted to the facility with diagnoses which included but were not limited to: morbid obesity, chronic obstructive pulmonary disease (a lung condition caused by damage to the airways that limit airflow), and respiratory failure. According to the Minimum Data Set (MDS), an assessment tool dated 08/07/25, Resident #11 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident's cognition was moderately impaired. A review of the resident's Order Summary Report (OSR) reflected the following Physician's Orders (PO):-Bipap (bilevel positive airway pressure and is a non-invasive ventilation therapy that uses a machine to deliver pressurized air to a patient through a mask) at bedtime for respiratory failure, dated 05/16/25.-Apply moisturizing lotion to dry skin of both feet and heels, dated 05/16/25.-Cleanse abdominal folds with soap and water, pat dry and apply zinc oxide paste after pericare every shift, dated 05/16/25.- Cleanse bilateral groins and inner buttocks with soap and water, pat dry and apply zinc oxide paste every shift, dated 05/16/25.-Incentive spirometer every shift for respiratory failure. Encourage 10 breaths per waking hour, dated 05/16/25.A review of the corresponding June 2025 TAR revealed blank spaces for the following Pos on 06/1/25 (evening), 06/17/25 (day), and 06/24/25 (evening) shifts:-Apply moisturizing lotion to dry skin of both feet and heels, dated 05/16/25.-Cleanse abdominal folds with soap and water, pat dry and apply zinc oxide paste after pericare every shift, dated 05/16/25.- Cleanse bilateral groins and inner buttocks with soap and water, pat dry and apply zinc oxide paste every shift, dated 05/16/25.-Incentive spirometer (a handheld, clear plastic device with a mouthpiece, tubing, and a main chamber with a piston or ball, designed to encourage slow, deep breaths) every shift for respiratory failure. Encourage 10 breaths per waking hour, dated 5/16/25.A review of the corresponding June 2025 TAR revealed blank spaces for the following PO on 06/01/25, 06/06/25, 06/22/25, 06/24/25 at 09:00 P.M.-Bipap at bedtime for respiratory failure, dated 05/16/25.A review of the June 2025 Progress Notes (PNs) did not include documentation regarding the treatment orders administration.On 08/18/25 at 11:49 A.M., the surveyor interviewed the Registered Nurse (RN), who stated that the treatments were always signed out on the TAR after administering the treatments to the residents. The RN further stated it was important to sign out the TAR to document whether the resident had received the treatment. The RN also stated that there was not supposed to be any blank spaces on the TAR according to the facility's policy. On 08/18/25 at 11:57 A.M., the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA). The DON stated that the nurses should sign on the TAR whether a treatment was administered or not. The DON stated if a resident refused a treatment, the nurse was to code it appropriately on the TAR and write a progress note. The DON further indicated that there should not be any blank spaces on the TAR.A review of the facility policy titled Nursing Documentation dated

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. C39051/IQBased on interviews, medical record review, and other pertinent facility documentation on 08/14/25, 08/15/25, and 08/18/25 it was determined that the facility failed to obtain a physician's order (PO) for the resident's (Resident #11) bilevel positive airway pressure (BiPAP) machine (a non-invasive ventilation therapy that uses a machine to deliver pressurized air to a patient through a mask). This deficient practice was identified for 1 of 14 residents reviewed (Resident #11).The deficient practice was evidenced by the following:A review of the Electronic Medical Record (EMR) was as follows:According to the admission Record (AR) face sheet, Resident #11 was admitted to the facility with diagnoses which included but were not limited to; acute and chronic respiratory failure with hypoxia (medical condition where a part of the body, or the entire body, is deprived of an adequate oxygen supply at the tissue level), benign neoplasm (an abnormal growth of tissue in some part of the body) of brain, acute and chronic respiratory failure with hypercapnia (excessively high levels of carbon dioxide (CO2) in the blood), and chronic obstructive pulmonary disease with (acute) exacerbation (a condition involving constriction of the airways and difficulty or discomfort in breathing).A review of the Minimum Data Set (MDS), an assessment tool dated 08/07/25, Resident #11 had a Brief Interview of Mental Status (BIMS) score of 11/15, which indicated Resident #11's cognition was moderately impaired.A review of Resident #11's care plan (CP) included a focus area initiated 11/08/24, that the resident was at risk for signs and symptoms of respiratory distress due to COPD and a history of smoking. Intervention includes to administer BiPAP as ordered.A review of Resident #11's progress notes (PN) revealed that Resident #11 has been using a BiPAP machine since 11/12/24.A review of Resident #11's Order Summary Report (OSR), revealed no order for BiPAP until 05/16/25.On 08/18/25 at 11:54 A.M., the surveyor interviewed a Registered Nurse (RN) who worked on Resident #11's unit. The RN stated that she would ensure that a resident who had a BiPAP had an order for a BiPAP. The RN further stated that if she saw a resident with respiratory equipment but not an order for it, she would call the doctor for an order as it would be regarding a resident's breathing.On 08/18/25 at 11:57 A.M., the surveyor interviewed the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) together. The surveyor asked the DON what her expectations were for staff regarding a resident and their respiratory equipment such as oxygen or a BiPAP. The DON stated that expected her staff to have obtained an order for a resident's respiratory interventions.At that time, the surveyor presented the DON and LNHA with the receipt for Resident #11's BiPAP dated 10/2024, and then Resident #11's order for BiPAP dated 05/16/25. The LNHA stated that Resident #11 came to the facility with the BiPAP machine and that there should have been an order for it.A review of the facility's policy titled Physician Orders last revised 08/01/17, revealed under Policy: Nursing Department will verify that physician orders are complete, accurate and clarified as necessary, and that resident receives their medication timely. N.J.A.C. S 8:39-27.1