STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315072	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heath Village	451 Schooley's Mountain Rd Hackettstown, NJ 07840

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 2 of the 21 residents (Resident #9 and Resident #14) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following:1. On 3/18/26 at 10:11 AM, the surveyor observed Resident #14 in bed. The resident's call device hung down to the floor, out of reach of the resident.On 3/18/26 at 10:13 AM, the surveyor interviewed Resident #14 and asked where their call bell was located. The resident replied that they did not see where it was. The resident stated further, What am I going to do if I need to call someone? On 3/18/26 at 1:22 PM, the surveyor made a second observation of Resident #14 lying in bed. The call device was in the same position as the previous observation, hanging down to the floor, out of reach of the resident.On 3/19/26 at 9:46 AM, the surveyor made a third observation of Resident #14 in bed. The call device was in the same position as the previous observations, hanging down to the floor, out of reach of the resident.On 3/19/26 at 9:51 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who acknowledged that the call bell should be accessible to the resident. Moreover, the CNA stated that the clip on Resident #14's call device was broken.A review of the admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated 1/5/26, revealed that Resident #14 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderately impaired cognition.A review of the care plan report initiated on 12/31/25 revealed that Resident #14 is risk for falls related to (r/t) impaired mobility after hospitalization for fall, use of psychoactive medications, and impaired cognition. Interventions included but were not limited to, Place call bell within reach and encourage to call for assistance.2. On 3/19/26 at 9:56 AM, the surveyor observed Resident #9 lying in bed. The resident's call device hung down to the floor, out of reach of the resident.On 3/19/26 at 12:27 AM, the surveyor made a second observation of Resident #9 lying in bed. The call device was in the same position as the previous observation, hanging down to the floor, out of reach of the resident.A review of the care plan report initiated on 1/16/26 revealed that Resident #9 is risk for falls r/t balance problems, confusion, poor safety awareness, and unsteady gait. Interventions included but were not limited to, Place call bell within reach and encourage to call for assistance.On 3/20/26 at 1:28 PM, the surveyor discussed the concern with the Licensed Nursing Home Administrator and the Director of Nursing (DON). The surveyor interviewed the DON who stated that the call bell must be placed within reach of the resident.The facility's Nurse Call System Policy and Procedures did not address the positioning of the call bell.NJAC 8:39-31.8(c)9

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, it was determined that the facility failed to revise the care plan (CP) report for 1 (one) of 21 residents (Resident #49) reviewed for a comprehensive CP.This deficient practice was evidenced by the following:On 3/18/26 at 10:13 AM, the surveyor observed Resident #49 in bed, awake, watching TV, and was able to answer the surveyor's inquiry. Resident #49 stated that they do not have any concerns with the facility.On 3/19/26 at 12:48 PM, the surveyor reviewed the electronic Health Record (eHR)/ hybrid medical record (paper and electronic) of Resident #49, which revealed the following:A review of the admission Record (AR, an admission summary) reflected that Resident #49 was admitted with diagnoses that included but were not limited to depression, anxiety, mood disorder, and dementia (loss of memory).A review of the quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care) of 2/27/26, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident had intact cognition. Further review of Q/MDS, reflected in Section N, revealed that the resident is taking antipsychotic medications.A review of the Order Summary Report (OSR) with the start date of 11/21/25, Seroquel 25 mg by mouth at bedtime for depression related to other specified mood disorders. A review of the Care Plan (CP) report with an initiated date on 11/22/25, with a focus on Resident #49, is on antidepressant Zoloft related to depression. On 3/20/26 at 11:13 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the Psychotropic medication, including Seroquel and Trazodone, should be included in the CP because it is part of the care for the resident and the LPN stated that the CP is also used to monitor the side effects of medications.On 3/20/26 at 11:20 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM), who stated that all the nurses are responsible for documenting the CP. The LPN/UM did not provide further information on why the Seroquel and the Trazodone were not in the CP. The LPN/UM updated the CP after the surveyor's inquiry.O 3/20/26 at 1:40 PM, the team of surveyors met with the Administrator, Director of Nursing, and Nursing Supervisor, but did not provide further information.A review of the facility policy titled Care Plan revealed under 8. Documentation Requirements - Care Plans must be accurate, current, and individualized.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the medical records, as well as review of other pertinent facility documentation, it was determined that the facility failed to a.) report and immediately investigate a fall which occurred for 1 of 4 sampled Residents, (Resident #15), who were investigated for falls and, b.)consistently implement identified safety interventions as per the residents physician's orders and care plan to prevent falls for 1 of 4 sampled Residents, (Resident #16), who were investigated for falls. This deficient practice was evidenced by the following: 1. On 3/18/26 at 11:45 AM, the surveyor interviewed Resident # 15, who was in their room, and the resident stated that the resident did fall in the facility two different times, with no injuries and that the staff educated the resident to call for assistance. A review of the resident medical records revealed the following: Resident # 15 was admitted with diagnoses which included, but were not limited to low back pian, age related osteoporosis, and chronic pain syndrome. The admission Minimum data Set (MDS) (an assessment tool), dated 1/3/26, revealed that Resident # 15 had a Brief Interview for Mental Status (BIMS) score of 15/15, that indicated that Resident # 15 was cognitively intact. A review of the facility fall investigation (FI) revealed that on 1/29/26 at 9:30 AM, during morning medication pass, Resident # 15 told the Licensed Practical Nurse (LPN #1), that the resident fell last night after using the bathroom and that the resident was assisted the resident back into the chair. The FI revealed that their investigation found that a staff member, a Certified Nursing Assistant (CNA #1), found Resident # 15, when doing rounds at 5:00 AM, and resident was in front of the recliner chair, stated that they slid down to the floor and stated was fine. The FI revealed that the CNA # 1 did not report the fall to anyone, educated the resident to call for help and then placed the resident back into the chair. The FI concluded that the resident had no injury. The facility provided the surveyor with an Employee Counseling Form (ECF) dated 2/6/26, which revealed that the CNA # 1did not report the incident to the nurse and nurse was unable to assess the resident as nurse was not aware of the incident, and the CNA should not move the resident that was found on the floor, and will report it to the nurse immediately so the nurse can assess the resident. The ECF was signed by the CNA and the Supervisor who provided counseling to the CNA # 1. Upon review of the resident's electronic health record (EHR), specifically the progress notes (PN), there was no PN which revealed that the resident had fallen on 1/29/26 at 5:00 AM. Upon further review, a PN written on 1/29/26 at 18:02 by LPN # 1, revealed During morning med pass, resident reported to this nurse that she fallen last night while transferring into her recliner after using toilet. Resident reported that she was assisted back into her chair by a staff member. At this time she has no c/o pain or signs of distress. MD and POA was made aware. no new orders. vs were taken . staff to educate resident that she is not to transfer herself into recliner, wheelchair or onto toilet. endorsed to next shift and resident. A review of the fall care plan (CP) revealed that the resident had a fall and it was updated with a date (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 1/29/26. At 1:20 PM, the surveyor interviewed with the Director of Nursing (DON), who stated that the CNA # 1 did not report the fall and did assist the resident back to the chair, and she was not supposed to. The DON stated that the facility did counsel the CNA # 1 about the correct steps to take with a fall. 2.) On 03/18/26 at 11:31 AM, the surveyor was conducting an initial tour of the facility and observed Resident#16 in bed in their room. The surveyor introduced themselves to the resident and the resident agreed to talk to the surveyor. The surveyor observed a floor mat in place to the resident's left side of bed, and a second mat standing against the wall not in place at right side of the bed. The resident verbalized she knew no details of the intention of the floor mats or how they were to be used A review of the EHR revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including but not limited to difficulty walking, muscle weakness and the need of care following surgery of the digestive system. A review of Resident# 16's MDS dated [DATE] reflected the resident needs assistance with transfers, ambulation and activities of daily living. The MDS reflected the resident had a BIMS score of 13 of 15 indicating the resident had little to no cognitive impairment A review of Resident #16's EHR revealed a Morse Fall Scale (an assessment tool used to determine a resident's risk level of falling), dated 12/23/25. The score documented on the assessment was 80 and a score of 45 or greater indicates a high risk of falls. The EHR further revealed a physician's order dated 9/17/25 that required floor mats on both sides of the resident's bed and placement to be checked every shift. A review of Resident #16's plan of care reflects a focus on the resident's risk for falls, initiated on 9/17/2025 with interventions including but not limited to mats on the floor when resident is in bed, initiated on 9/17/2025. On 03/18/26 at 1:25 PM, the surveyor made a second observation in the residents' room and observed the fall mat in place on resident left side of bed, no mat on right side of the bed, a was leaning against the bedroom wall. On 03/18/26 1:30 PM, the surveyor interviewed CNA #2, the CNA assigned to Resident# 16 care. The surveyor asked about Resident #16's mat placement. CNA#2 stated she was aware that mat from the resident's right side of the bed was against the wall, she stated the resident requested the tray table be next to the bed and the CNA did not put down the mat in order to accommodate the table position request. CNA #2 stated she did not report the issues with positioning the right mat to the nurse. On 03/18/26 at 1:40 PM, the surveyor interviewed LPN #2, the nurse overseeing care provided by CNA #2. The nurse confirmed the resident had an active physician's order for floor mats to be in place on both sides of the bed and stated the mats should have been in place. The LPN #2 further confirmed she did not receive a report of concern from CNA #2 about not placing the mat or difficulty using the mat and table on same side of the bed. LPN #2 confirmed that overbed tables can be positioned safely on top of the floor mats. LPN #2 accompanied the surveyor to the room and confirmed that mat from right side of bed was leaning up against the wall. She stated she would correct the situation immediately. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/26 at 1:29 PM, the Survey team met with Administrator, DON and Nursing supervisor to discuss findings to date. The DON agreed the mats should have been in place as ordered by the physician whenever the resident is in bed. A review of the undated Fall Prevention and Post-Fall Management policy, revealed that the purpose is to ensure that prompt and appropriate post-fall response occurs, and immediate post-fall procedure included safety first, initial assessment, neuro checks, notifications, and transfer decision. NJAC 8:39-33.1(d)

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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. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide ordered respiratory care consistent with professional standards of practice for 1 of 2 residents (Resident #9) reviewed for respiratory care.This deficient practice was evidenced by the following:On 3/18/26 at 10:27 AM, the surveyor observed Resident #9 lying in bed, receiving oxygen via a nasal cannula (NC, a plastic prong attached to a tube, inserted into the nostrils through which oxygen flows). The surveyor observed that the oxygen flow meter was set at 1.5 liters per minute (L/min). On 3/18/26 at 1:26 PM, the surveyor made a second observation of Resident #9 lying in bed, receiving oxygen via NC. The surveyor observed that the oxygen flow meter was set at 1.5 L/min. On 3/19/26 at 9:56 AM, the surveyor made a third observation of Resident #9 lying in bed, receiving oxygen via NC. The surveyor observed that the oxygen flow meter was set at 1.5 L/min. A review of the Order Summary Report for Resident #9 revealed an order with a start date of 1/23/26 for oxygen via nasal cannula at 2 L/min continuously every shift for shortness of breath (SOB).A review of the March 2026 Medication Administration Record for Resident #9 revealed that the nurses recorded oxygen use every shift on 3/18/26, as well as the day and evening shifts on 3/19/26.A review of the care plan report initiated on 1/16/26 revealed that Resident #9 has ineffective gas exchange and is on oxygen therapy due to SOB related to Myocardial Infarction (MI). An MI is the medical term for a heart attack. Interventions included but were not limited to, Administer oxygen as ordered.On 3/19/26 at 10:01 AM, the surveyor interviewed the Registered Nurse (RN) Supervisor in Resident #9's room. The surveyor asked the RN Supervisor what the oxygen flow rate was, in L/min, currently set on the oxygen flow meter. The RN Supervisor stated that the oxygen flow meter was set at 1.5 L/min. The RN Supervisor acknowledged that it was set incorrectly and adjusted the oxygen flow rate to 2 L/min per the physician's order. They stated that oxygen should be administered as ordered by the physician, and the nurses are expected to check the setting every shift.A review of the facility's Oxygen Use and Management Policy revealed, Oxygen shall be administered, monitored, and maintained in accordance with physician orders, manufacturer guidelines, CMS regulations, and applicable New Jersey Department of Health (NJDOH) standards.A review of the facility's Oxygen Use and Management Procedure, under Initiation of Oxygen Therapy, revealed, Set prescribed flow rate.A review of the facility's Oxygen Use and Management Procedure, under Nurse/CNA Responsibilities, revealed, Ensure that oxygen flow rate is at right setting as order by physician.On 3/19/26 at 1:47 PM, the surveyor discussed the concern with the Licensed Nursing Home Administrator and the Director of Nursing. They did not provide further information.NJ 8:39-25.2(c)3

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, record review, and review of facility policies, it was determined that the physician's progress notes (PPN) are not legible. This deficient practice was identified for 1 of 22 residents (Resident #35). This deficient practice was evidenced by the following:On 3/18/26 at 10:20 AM, the surveyor observed Resident#35 sitting in the activity room.On 3/18/26 at 1:23 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #35, which revealed the following:A review of the admission Record (AR, an admission summary) reflected that Resident #35 was admitted with diagnoses that included, but were not limited to, an unspecified dementia (loss of memory) and mood disturbance.A review of the quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care) dated 12/19/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident had severe cognitive impairment. On 3/20/26 at 10:49 AM, the surveyor observed that the physician had handwritten notes located in the chart. The surveyor noted that the handwritten notes were not legible.On 3/20/26 at 11:13 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), regarding the above concern, and the surveyor showed the LPN the handwritten progress notes written by the physician, dated 12/29/25, 1/27/26, and 2/27/26. The LPN stated that she was having difficulty reading the doctor's handwritten notes, and she will ask the LPN Unit Manager (UM) or another nurse to read them for her, but if they cannot, she would call the physician to clarify the notes.On 3/20/26 at 11:20 AM, the surveyor interviewed the LPN/UM, regarding the concern. The LPN/UM was trying to read the physician's notes and stated that she could read some of the notes, but not all of them. If it happens, she would call the physician to clarify the notes.On 3/20/26 at 1:30 PM, the team of surveyors met with the Administrator, the Director of Nursing (DON), and the Nursing Supervisor. The DON agreed that it was difficult to read the notes. No further information was provided.A review of the facility policy with the title Physician (MD/DO) Required Visits, updated in January 2025, did not address the legibility of doctors' notes.NJAC 8:39-35.2 (d)(5)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observation and interview on 3/24/26 in the presence of the Life Safety Director (LSD) Assistant Plant Operations Director (APOD) and Plant Operations Director (POD), it was determined that the facility failed to ensure that wooden handrails were installed, maintained, secured and splinter free in all required locations. This deficient practice was identified for 1 of 8 areas observed, had the potential to affect all residents, and was evidenced by the following by the following: An observation at 11:40 PM revealed that the Juniper Way wing handrails by the exit/egress doors to the public way were blocked from access due to a long 2-shelf furniture unit approximately 5' wide. In an interview during the above findings, the LSD, APOD and POD all confirmed the observation.The Plant Operations Staff was informed of the deficient practice at the Life Safety Code exit conference on 3/25/26 at 12:45 PM.NJAC 8:39-31.2(e) NFPA 10