STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315096	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Doctors Subacute Healthcare, LLC	59 Birch Street Paterson, NJ 07522

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 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 1 (one) of the 13 residents (Resident #1) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: On 9/21/2025 10:55 AM, the surveyor observed Resident #1 in bed, awake, and able to answer the surveyor's inquiry. The surveyor observed that the call device was tied to the resident's arm rail and was dangling towards the floor. The surveyor asked the resident if the resident was able to use the call bell, and the resident stated, I am not sure where it is; I just yell out to the staff for help. On 9/23/2025 at 11:37 AM, the surveyor reviewed the electronic Health Record (eHR)/ hybrid medical record (paper and electronic) of Resident #1, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #1 was admitted with diagnoses that included but were not limited to a fracture to the upper end of the right humerus (broken bone), repeated falls, muscle weakness, and cerebral infarction (a blood vessel in the brain is blocked). A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) dated 8/22/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated that the resident had moderate impairment in cognition. Further review of the A/MDS, as reflected in section GG, revealed that the resident requires assistance from staff for daily living activities. A review of the Care Plan (CP) report initiated on 8/15/25 focused on the resident's ADL (activity of daily living) self-care performance deficit related to a fall and right humerus fracture. Interventions included, but were not limited to, encouraging the resident to use the call device for assistance. On 9/24/2025 at 9:16 AM, the surveyor interviewed the Certified Nurse Assistant (CNA), who stated that the call device should be near the residents within reach, so that if they need any assistance, they can call the staff. On 9/24/2025 at 9:18 AM, the surveyor interviewed the Registered Nurse (RN), who stated that the staff makes sure that the call device is within the resident's reach so that they can easily call for help. On 9/24/2025 at 11:04 AM, the team of surveyors met with the Director of Nursing (DON) and the regional administration to discuss the above concern, but did not provide further information. A review of the facility policy titled Subject: Call light Answering stated under Steps and Procedures: 7. Make the resident as comfortable as possible. Position the call bell within easy reach of the resident. 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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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS, an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 3 of 13 residents (Resident #3, 5, and #51) during the review of resident assessment. This deficient practice was evidenced by the following: The MDS is a comprehensive tool, a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 9/22/25 at 1:01 PM, the surveyor provided the MDS Coordinator/Registered Nurse (MDSC/RN) with the list of 3 residents who had not completed an MDS in over 14 days. The surveyor also requested a copy of the resident's final validation report (generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On 9/23/25 at 10:38 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who stated that she started in June this year, and when she started, the former MDSC was also behind, and she was catching up. On the same day, the surveyor reviewed with the MDSC/RN, who provided the surveyor with a final validation report from CMS, the 3 residents' MDS assessments that were not submitted within fourteen days of completion, as follows: 1. Resident #3 annual MDS (An/MDS) assessment has an assessment reference date (ARD, the last day of the observation period) of 8/15/25. It was signed as completed on 9/3/25 and not transmitted until 9/6/25. 2. Resident #5 quarterly MDS (Q/MDS) assessment has an ARD of 7/21/25. It was signed as completed and not transmitted until 8/11/25. 3. Resident #51 the admission MDS (A/MDS) assessment has an ARD of 7/26/25. It was signed as completed and not transmitted until 8/11/25. On 9/23/25 12:40 PM, the surveyor met with the Director of Nursing (DON) regarding the above concern; there was no information provided. NJAC 8:39-11.1

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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. Based on interviews and record review, it was determined that the facility failed to accurately code the Minimum Data Set (MDS, an assessment tool used to facilitate the management of care), in accordance with federal guidelines, for 1 (one) of 13 residents (Resident #3), who were reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: On 9/21/2025 at 10:11 AM, the surveyor observed Resident #3 in bed watching television, alert and oriented x3, able to answer questions appropriately. On 9/22/2025 at 9:37 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #3, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #3 was admitted with diagnoses that included, but were not limited to, schizophrenia (a mental health condition that affects how people think, feel, and behave). A review of the annual Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care), dated 8/15/24, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated that the resident had moderately impaired cognition. Further review of the A/MDS in Section A1500 - Preadmission Screening and Resident Review (PASRR). Is the resident currently considered by the state-level II PASSR process to have serious mental illness and/or intellectual disability or a related condition? 0. No. A review of the form PASSR Level II Determination Notification of Resident #3 revealed that the PASSR Level II was completed, and the resident has mental health treatment needs that can be met in a nursing facility, and was signed and dated on 8/24/12. A review of the Care Plan (CP) report initiated on 11/15/23, focused on Resident #3, who has a positive PASSR level I & II completed. Interventions included, but were not limited to, the resident having a stable mood and behavior and not harming themselves or others. On 9/22/2025 at 10:02 AM, the surveyor interviewed the Social Service Director (SSD), who stated that she has been working in the facility for one and a half years now. Resident #3 is PASSR Level II, which was completed on 8/24/12. She was not in the facility by that time, but the SSD during that time assessed that the resident met the criteria and triggered PASSR Level II. The form was submitted to the human services department, which is why it was determined that Res. #3 is level 11. On 9/22/2025 at 10:07 AM, the surveyor interviewed the MDS Coordinator (MDSC), who stated that it should be coded as Level II, as it says in the form. The former MDSC who did the assessment coded it wrong. On 9/23/25 12:40 PM, the surveyor met with the Director of Nursing (DON) regarding the above concern; there is no information provided. NJAC 8:39-33.2 (d)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on the interview and record review, it was determined that the facility failed to ensure that the residents' Primary Physician (PP) or an alternating advanced practice nurse (APN) signed the monthly Physician Orders (PO). The deficient practice was observed for 3 of 13 residents (Resident #3, 5, and #47) reviewed and occurred over the previous 6 months. This deficient practice was evidenced by the following: 1. A review of the electronic Medical Record (eMR) for Resident #3 revealed that PP #1 or an alternating APN has not electronically signed the monthly POs of April, May, July, and September 2025. 2. A review of the eMR for Resident #5 revealed that the PP #2 has not electronically signed the monthly PO from April to September 2025. 3. A review of the eMR for Resident #47 revealed that PP #1 or an alternating APN has not electronically signed the monthly POs of April, May, July, and September 2025. On 9/22/2025 at 10:29 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who stated that the PP comes to the facility on a regular basis at least once a month and documents and signs the monthly PO in the eMR. On 9/23/25 12:40 PM, the surveyor met with the Director of Nursing (DON) regarding the above concern; there was no information provided. A review of the facility policy titled Subject: Physician Orders with a reviewed date of 12/2024 revealed under Procedures: 5. All verbal or written orders must be signed by the prescriber monthly. NJAC 8:39-23.2(b)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to ensure the consistent hospice services were provided, in accordance with professional standards and principles to meet the resident's needs (Resident #6). This deficient practice was identified for one (1) of one (1) resident reviewed for hospice and end of life care. This deficient practice was evidenced by the following:On 9/21/25 at 10:19 AM, during the initial tour, the surveyor observed Resident #6 seated at the edge of the bed, eating from a plastic container and had a bruise on their upper lip. The surveyor reviewed the medical record for Resident #6. According to the admission Record (AR; or face sheet, an admission summary), the resident was admitted to the facility with diagnoses that included, unspecified dementia (loss of cognitive functioning), type 2 diabetes mellitus (high blood sugar), acquired absence of the right toe and peripheral vascular disease (narrowing of the blood vessels of the legs and arms causing reduction of blood flow). A review of the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 7/31/25, reflected a Brief Interview for Mental Status (BIMS) score of 4 out 15 which indicated the resident's cognition was severely impaired. Section O. reflected Resident #6 received hospice services while a resident at the facility. Additionally, the qMDS revealed the resident required supervision or touching assistance for activities that included: toileting hygiene, shower, bathing, upper/lower body dressing, putting on/taking off footwear, sit to lying, lying to sitting, sit to stand, transfer from chair to bed, to get on and off the toilet and to walk 10 feet; the resident was occasionally incontinent of bowel and bladder. A review of the individualized comprehensive care plan included an intervention to communicate the resident's needs to hospice, to work together, to obtain comfort and care for the resident, initiated on 3/31/25. A review of the active Order Summary Report (OSR) revealed a physician order (PO) for Palliative/Hospice evaluation and treatment with a start date of 4/27/25. A review of the hospice progress note dated 4/28/25 revealed that Resident # 6 would receive routine home care, the hospice nurse would determine the level of care, coordinate any change in level of care with the facility nurse. A review of the Aide Weekly Visit Record revealed the last time a Hospice Aide visited the resident was on 7/11/25, A review if the Hospice Care log sheet reflected the Registered Nurse visited on 7/1/25, 8/29/25, 9/5/25 and 9/18/25 A Licensed Practical Nurse visited on 7/23/25. On 9/23/25 at 11:15 AM, during an interview with the surveyor, the Registered Nurse/ Unit Manager (RN/UM) was not sure how often the hospice aide, and the hospice registered nurse visited the resident. The RN/UM thought the hospice registered nurse visited weekly but could not be sure and could not explain why the hospice log reflected the last visit was on 7/11/25. The RN/UM was aware of any changes to the resident's hospice plan of care. On 9/24/25 at 9:08 AM, during an interview with the surveyor, the Certified Home Health Agency (CHHA) stated that after each visit with the resident she was assigned to, she filled out the Aide Weekly Visit Record to record the services she had provided to the resident. At that time, the CHHA confirmed the last visit was on 7/11/25. On 9/23/25 at 12:37 PM, during a meeting with the survey team, and the Director of Nursing (DON), the surveyor discussed the concern with the record that did not reflect the resident received continuous timely hospice care. At that time, the DON stated that the expectation was that the facility was in constant communication with the hospice nurse and that the visits should have occurred weekly. A review of the provided facility policy, Hospice Program, dated/revised 6/2025, included that the hospice providers are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility. Social Services was designated to coordinate care provided to the resident by the facility staff and hospice staff and was assigned to obtain the most recent plan of care specific to each resident. No further information was provided. NJAC 8:39-27.1(a)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure Resident #28 was offered pneumococcal vaccination according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations. This deficient practice was identified for one (1) of five (5) residents reviewed for immunization status. The deficient practice was evidenced by the following:Reference: A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 2/13/23, included the following. The CDC recommended routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults 65 years or older who have only received pneumococcal polysaccharide vaccine (PPSV23) and should be administered at least 1 year after the most recent PPSV23 vaccination. Reference: A review of the CDC's Advisory Committee on Immunization (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 10/26/24, included the following: For those who were [AGE] years of age or older and have only received pneumococcal polysaccharide vaccine (PPSV23) the CDC recommended administration of PCV 20 or PCV21or PCV15 a year or more after receiving the PPSV23. On 9/22/25 at 10:48 AM, the surveyor reviewed the immunization record for Resident #28. According to the electronic Medication Record (eMR) Resident #28 received the pneumococcal polysaccharide vaccine on 12/11/23 (PPSV23). The consent form was signed by the resident on 12/6/23. Resident #28's admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included chronic obstructive pulmonary disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs), heart failure and chronic kidney disease stage 3 (decrease ability of the kidney to filter waste product from the blood leading to build up of toxins and other health problems). Resident #28's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 8/8/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out 15 which indicated the resident's cognition was intact. Further review of the qMDS dated [DATE], under section O0300 A. Is the resident's Pneumococcal vaccine to date? The response was marked 1, which reflected, yes. A review of the individualized comprehensive care plan included a focus to meet the resident's emotional, intellectual, physical and social needs, initiated on 9/13/23. A review of the eMAR did not reflect documentation that PCV20 or PCV21 or PCV15 was offered a year or more, thereafter the facility administered the PPSV23. On 9/23/25 at 11:43 AM, during an interview with the surveyor, the Registered Nurse/ Infection Preventionist (RN/IP) stated that when a resident was admitted to the facility, the resident was provided information and offered immunization that included the pneumococcal vaccine. At that time, the RN/IP was not aware if Resident #28 was offered a subsequent pneumococcal vaccine immunization. The RN/IP stated that the immunizations were reviewed during the quarterly reviews but could not show documentation that the facility had a surveillance of which resident required further pneumococcal vaccination. On 9/23/25 at 12:27 PM, during a meeting with the survey team and the Director of Nursing, the surveyor discussed the concern that the resident's assessment reflected the resident's pneumococcal vaccination was current, the last immunization administration was on 12/11/23 in the facility which was not in accordance with the CDC's recommendations. A review of the facility provided policy, Pneumonia Vaccine dated/reviewed 1/2025 reflected under the policy statement that the facility offered pneumococcal vaccination to eligible residents, following CDC's updated immunization schedule and ensuring documentation, informed consent, and appropriate follow-up were in place. No further information was provided. N.J.A.C. 8:39-19.4 (i)