| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315134 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Green Knoll | 875 Route 202-206 North<br>Bridgewater, NJ 08807 |

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 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>Based on observation, interviews, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the dumpster and surrounding area free of garbage and debris.On 02/04/2026 9:21 AM, in the presence of the Food Service Director (FSD), the surveyor toured the kitchen and the designated garbage area and observed the following: There were multiple carboard boxes outside of the dumpster on the ground and surrounding area. The FSD stated that the area should have been cleaned by the maintenance and dietary departments. On 2/5/26 at 9:00 AM, the FSD provided the surveyor with a facility policy titled, Garbage and dumpster area policy with a revised date of 5/8/21. The policy revealed, 3. If any trash blows out of the trash can or you drop any trash on the ground or around the dumpster, you are responsible to pick it up. If you make a mess by the dumpster when throwing out garbage, you must clean it up. 4. Everyone is responsible to breakdown and throw out their own boxes. They are to be put in the small recycling bin only, not in the long dumpster. Do not throw boxes in bins unless they are broken down. On 2/9/26 at 12:56 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Clinical Director (RCD), Regional Director of Operations (DOO), and [NAME] President of Quality and Performance Improvement (VPQPI) to review concerns found during the survey. The LNHA stated all boxes need to be broken down and put into the dumpster and not left on the ground.On 2/11/26 at 12:06 PM, the surveyor met with the LHNA, DON, RCD, and DOO for exit conference. No further pertinent information was provided. NJAC 8:39-19.7 |

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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to keep the call bell within residents' reach. This deficient practice was identified for 8 of 30 residents (Resident #6,15, 37, 44, 55, 139, 152 and 155) reviewed for accommodations of needs and was evidenced by the following:1.On [DATE] at 11:56 AM, the surveyor observed Resident #139 in bed wearing glasses with floor mats on both sides of the bed and the call bell on the floor not within the resident's reach.<br><br>On [DATE] at 7:40 AM, the surveyor observed Resident #139 in bed with floor mats on both sides of the bed and the call bell on the floor not within the resident's reach.<br><br>The surveyor reviewed the medical record for Resident #139.<br><br>A review of the admission record reflected that Resident #139 was admitted to the facility with diagnoses that included but were not limited to; dementia (an umbrella term for a progressive decline in cognitive function) and diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar).<br><br>A review of Resident #139's Quarterly Minimum Data Set (MDS) an assessment tool, dated [DATE] revealed the resident had a brief Interview for mental status (BIMS) score of 7 out of 15 which indicated a severe cognitive impairment. Section GG assessed Resident as being dependent on staff for Activities of Daily Living (ADL) care.<br><br>A review of Resident #139's Care Plan Report (CPR) reflected a Focus area that the resident was at risk for falls dated as initiated on [DATE] with interventions that included but were not limited to; Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident must have prompt response to all requests for assistance.<br><br>2.On [DATE] at 12:00 PM, the surveyor observed Resident #37 in bed with their eyes closed and the call bell on the floor behind the dresser not within the resident's reach.<br><br>On [DATE] at 12:52 PM, the surveyor observed Resident #37 in bed with the call bell on the floor behind the dresser not within the resident's reach.<br><br>On [DATE] at 7:42 AM, the surveyor observed Resident #37 in bed with call bell on the floor behind the dresser.<br><br>The surveyor reviewed the medical record for Resident #37.<br><br>A review of the admission Record revealed the resident was admitted to the facility with diagnoses that included but were not limited to; Alzheimer's Disease and Chronic Kidney Disease, stage 3 (long-term progressive loss of kidney function).<br><br>A review of the Quarterly MDS dated [DATE] reflected the resident had a BIMS score of 3 out of 15 which indicated a severe cognitive impairment.<br><br>Section GG assessed that Resident #37 required substantial maximum assistance from staff for ADL<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | care.<br><br>A review of the CPR reflected a focus area that the resident was at risk for falls with interventions that included but were not limited to; the resident needs a safe environment with .a working and reachable call light .<br><br>On [DATE] at 12:56 PM, the surveyor showed the Certified Nursing Assistant (CNA) assigned to Resident #37's care (CNA #3) the call bell on the floor. CNA #3 confirmed that she should have placed the call bell within the resident's reach.<br><br>On [DATE] at 7:44 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) observed the call light on the floor behind the dresser and confirmed that all call bells should be placed within the resident's reach.<br><br>3. On [DATE] at 12:15 PM, the surveyor observed Resident #55 in bed with their eyes closed and the call bell on the roommate's end table behind the privacy curtain not within the resident's reach.<br><br>The surveyor reviewed the medical record for Resident #55.<br><br>A review of the admission Record reflected Resident #55 was admitted to the facility with diagnoses that included but were not limited to; dependence on renal dialysis (a life-sustaining medical procedure that replaces kidney function in individuals with severe kidney failure) and hypertension (high blood pressure).<br><br>A review of Resident #55's Quarterly MDS dated [DATE] reflected the resident had a BIMS score of 5 out of 15, which indicated a severe cognitive impairment.<br><br>Section GG assessed that the resident required substantial/maximum assistance from staff for ADL care.<br><br>A review of Resident #55's CPR had a Focus area that indicated the resident was at risk for falls with interventions that included but were not limited to; the resident needs a working and reachable call light .<br><br>4. On [DATE] at 12:38 PM, the surveyor observed Resident #152 in bed with the call bell on the floor not within the Resident's reach.<br><br>The surveyor reviewed the medical record for Resident #152.<br><br>A review of the admission Record reflected Resident #152 was admitted to the facility on [DATE] with diagnoses that included but were not limited to; dementia and hypertension.<br><br>A review of the Quarterly MDS dated [DATE] reflected Resident #152 had a BIMS score of 1 out of 15 which indicated severe cognitive impairment. Section GG further assessed Resident #152 was dependent on staff for ADL care.<br><br>A review of Resident #152's CPR reflected a focus area resident is at risk for falls initiated on [DATE] with interventions that included but were not limited to; Ensure the resident's call light and personal items are within reach encourage the resident to use the call bell for assistance. The (continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident needs prompt response to all requests for assistance.<br><br>On [DATE] at 12:42 PM, the surveyor showed CNA #2 152's call bell on the floor. CNA #2 confirmed that the call bell should be within the resident's reach and stated that the resident was able to use it.<br><br>5. On [DATE] at 12:55 PM, the surveyor observed Resident #44 in bed. The surveyor observed that the resident did not have a call bell.<br><br>The surveyor reviewed the medical record for Resident #44.<br><br>A review of the admission Record reflected that Resident #44 was admitted to the facility on [DATE] with diagnoses that included but were not limited to; diabetes mellitus and cerebral infarction (stroke that results in an area of necrotic tissue in the brain.)<br><br>A review of the Annual MDS dated [DATE] reflected Resident #44 had a BIMS score of 2 out of 15 which indicated severe cognitive impairment. Section GG assessed Resident #44 required supervision or touching assistance for transfers and ambulation.<br><br>A review of the CPR had a focus area resident is at risk for falls initiated [DATE] with interventions that included but were not limited to; Ensure the resident's call light is within reach and encourage the resident to use it.The resident needs prompt response to all requests for assistance.<br><br>On [DATE] at 12:56 PM, the surveyor showed the CNA assigned to Resident #44's care (CNA #3) the missing call bell. CNA #3 confirmed that the call bell was missing and that all residents should have a call bell so that they are able to call for staff assistance when needed.<br><br>6. On [DATE] at 1:00 PM, the surveyor observed Resident #15 in bed with their eyes closed on a specialty mattress and the call bell under the bed not within the resident's reach.<br><br>The surveyor reviewed the medical record for Resident #15.<br><br>A review of the admission Record reflected Resident #15 was admitted to the facility with diagnosis that included but were not limited to; Alzheimer's Disease and hypertension.<br><br>A review of Resident #15's Quarterly MDS dated [DATE] reflected the resident's cognitive skills for daily decision making were severely impaired and that Resident #15 was dependent on staff for ADL care.<br><br>A review of Resident #15's Care Plan Report reflected a Focus area that indicated the resident had an ADL self-care deficit dated as initiated on [DATE] with interventions that included but were not limited to; encourage the resident to use the bell to call for assistance.<br><br>On [DATE] at 1:02 PM, the surveyor showed the CNA assigned to Resident #15's care (CNA #1) the call light on the floor under the bed. CNA #1 confirmed that all call lights should be within the resident's reach.<br><br>On [DATE] at 1:56 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing (DON), Regional Clinical Director, Regional Director of Operations and VP of Quality and Performance Improvement to discuss the above observations and concerns.<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 10:55 AM, during an interview with the surveyor, the DON confirmed that all residents should have call bells and that nurses and CNAs should ensure that they are placed within the residents' reach so that they were able to summon the staff for assistance.<br><br>On 2/1126 at 12:06 PM, no further information was provided.<br><br>NJAC 8:39-27.1 (a); 31.8 (c) (9)<br><br>7. On [DATE] at 10:55 AM, the surveyor observed Resident #155 in their room. The resident was sitting up in bed and was watching television. The resident was alert and oriented and the surveyor asked the resident how they would contact the facility staff since the call bell system for the room is not working. The resident told the surveyor that they would ask their roommate to contact the facility staff using the roommate's call bell. The surveyor observed a tap bell on the resident's bedside table, not within reach of Resident #155.<br><br>The surveyor reviewed the medical record for Resident #155.<br><br>A review of the admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; gastrostomy status(refers to the presence of an artificial opening (stoma) in the stomach, usually with a tube (PEG) inserted directly through the abdominal wall for long-term nutritional support) and multiple sclerosis (chronic and often disabling, autoimmune disease of the central nervous system).<br><br>A review of the Quarterly MDS, dated [DATE], indicated that Resident #155 had a BIMS score of 6, which indicated that the resident's cognition was severely impaired. The MDS further indicated that Resident #155 was dependent on staff for ADL care.<br><br>A review of the Resident's CPR included a focus area, Falls, with interventions that included, but were not limited to: keeping the resident's call light within reach and encouraging the resident to use it for assistance as needed. Resident #155 also needed a prompt response to all requests for assistance.<br><br>8.) On [DATE] at 11:00 AM, the surveyor observed Resident #6 in their room; the resident was seated in their bed reading. The surveyor interviewed the resident about the facility's call bell system. Resident #6 stated they would request staff assistance by using the call bell. The call bell was next to the resident, but they were unaware that the call bell system in their room was not working. The surveyor asked the resident whether the facility had given them a tap bell. The resident was unsure whether they had received a tap bell, but the surveyor and the resident couldn't locate one.<br><br>A review of the admission Record reflected that the resident was admitted to the facility with a diagnosis that included but not limited to; restless leg syndrome (a common neurological disorder characterized by irresistible urge to move the legs, typically accompanied by uncomfortable crawling, tingling, or aching sensation), chronic pain syndrome (a condition where pain last 3 to 6 months beyond normal healing), and venous insufficiency peripheral (occurs when damaged or blocked veins struggle to return blood to the heart, causing venous pooling.)<br><br>A review of the Quarterly MDS dated [DATE] indicated that Resident #6 had a BIMS score of 14, which indicated that the resident's cognition was intact.<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the Resident's CPR identified a focus area, Falls, with interventions that included but were not limited to; place the call bell within reach.<br><br>On [DATE] at 11:15 AM, the surveyor in the presence of the Licensed Practical Nurse/ Unit Manager (LPN/UM) searched for Resident #6's tap bell. The LPN/UM acknowledged that the call bell system for Resident #155 and Resident #6's rooms were not working. The LPN/UM found Resident #6's tap bell, which was on their roommate's nightstand, not within their reach. The LPN/UM confirmed that the two tap bells were out of reach for both residents and that both residents should have their tap bells within reach.<br><br>On [DATE] at 12:30 PM, the surveyor discussed the above concerns with the facility administration team, which consisted of the Licensed Nursing Home Administrator (LNHA), Director of Nursing, Regional Clinical Director, Regional Director of Operations, and the [NAME] President of Quality and Performance Improvement.<br><br>A review of the facility policy titled Call Lights dated [DATE], provided by the LNHA revealed the following:<br><br>A call bell will be available within reach and operational for each resident.<br><br>NJAC 8:39- 27.1(a); 31.8 (c)(9) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on observation, interview, record review and review of facility provided documents, it was determined the facility failed to a.) ensure the timeliness of each resident's person-centered comprehensive care plan (PCCP), that is reviewed and revised by an interdisciplinary care team, (IDCP) during the IDCP meeting with the resident and a resident representative (if applicable) every quarter, and b) updating the care plan to reflect new physician orders. The deficient practice was identified for 2 of 30 residents reviewed for Comprehensive Care Plan (Resident #11 and Resident #168). These deficient practices were evidenced by the followinga. Resident #11<br><br>On 02/4/26 at 10:45 AM, the surveyor observed Resident #11 in their room.<br><br>A review of the medical records revealed Resident #11 had diagnoses which included but were not limited to; hemiplegia and hemiparesis, cerebral vascular accident (CVA) (a loss of blood flow to part of the brain), chronic obstructive pulmonary disease (condition involving constriction of the airway and difficulty or discomfort in breathing) (COPD).<br><br>A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.<br><br>A review of MDS submissions for Resident #11 from the facility are as follows.<br><br>02/15/26 -- in progress<br><br>11/16/25-- quarterly<br><br>08/17/25—annual, IDCP meeting not done<br><br>05/18/25-- quarterly<br><br>02/16/25— quarterly, IDCP meeting not done<br><br>11/17/24-- quarterly<br><br>08/18/24—annual, IDCP meeting not done<br><br>A review of the IDCP meeting progress notes revealed that the IDCP meetings were not done according to facility policy and Center of Medicare regulations to be done quarterly following MDS schedule. For the year of 2025 there were only two IDCP meetings; 11/17/25 and 5/21/25.For the year of 2024, 11/24/24. The not completed IDCP meetings are as follows.8/17/25, 2/16/25, and 8/18/24 in accordance with MDS submissions.<br><br>On 02/9/26 at 11:15 AM, the surveyor interviewed the social worker who stated, she knew the IDCP meeting should be done quarterly but sometimes things happen and they need to be canceled. When asked if documented such issue to indicate in the electronic medical record (eMR) her response was no. The system generated responses are from her adding a date or something to the MDS and the eMR auto populates a system generated system note.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/09/26 at 12:57 PM, the Director of Nursing (DON) stated that resident care plans are revised as needed and quarterly. The DON further stated, the care plan represents what care the resident was being provided and that the care plans were patient centered. The DON acknowledged and agreed with the surveyors' findings.<br><br>On 02/10/26 at 10:12 AM, the surveyor interviewed the DON who stated that the care plan is completed by each department by discipline. Allowing it to be patient centered on admission, quarterly, and significant event timeframe. IDCP meetings are held according to MDS timing. The Care Plan is officially reviewed with the residents during their IDCP meetings.<br><br>On 2/11/26 at 12:15 PM, the above concerns were addressed to the facility administration.<br><br>A review of the Comprehensive care Plan policy, dated 9/1/24 and revised 3/6/25, revealed.it is the facility policy to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights.person- centered care means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives.comprehensive care plan will be prepared by an IDC team, that includes, but is not limited to: family members, surrogate, or others desired by the resident.The comprehensive care plan will be reviewed and revised by the IDC team after each comprehensive and quarterly MDS assessment.<br><br>NJAC 8:39-11.2, 12.1, 13.2<br><br>b. Resident #168<br><br>On 2/5/26 9:30 AM, the surveyor observed Resident #168 in their room watching television. During interview Resident #168 stated they go to dialysis three times per week and is on a specialized diet including a fluid restriction.<br><br>On 2/5/2026 9:41 AM, the surveyor reviewed the medical records of Resident #168 which revealed diagnoses which included but were not limited to; end stage renal disease (a chronic kidney disease which includes the gradual loss of kidney function), dependence on renal dialysis (a medical treatment that performs the essential blood-filtering functions of failing kidneys by removing waste, toxins, and excess fluids from the body), and protein-calorie malnutrition (a condition characterized by a deficiency of both protein and calories to meet the body's nutritional needs).<br><br>A review of the most recent comprehensive Minimum Data Set (MDS), reflected the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated a cognitively intact cognition<br><br>A review of the monthly summary revealed a Physician Order (PO) dated 1/28/26, Fluid Restriction 1500 milliliters (ml): Dietary: 1080ml, Nursing 420ml: 7am-3pm = 180ml, 3pm-11pm = 180ml and 11pm-7am= 90 ml.<br><br>A review of Resident #168's Care Plan (CP) revealed a CP with an initiated date of 1/23/26, I am on a fluid restriction 1500ml: Dietary: 1000ml, Nursing: 500ml, 7am-3pm = 200ml, 3pm-11pm = 200ml, 11pm-7am = 100ml.<br><br>On 2/9/26 at 9:31 AM, the surveyor interviewed the Registered Dietitian (RD#1) who stated the nursing staff puts the FR and fluid breakdown in the PO initially and RD#1 will adjust the FR<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | breakdown to accommodate the resident's specific needs and fluid requests. The nursing staff puts the FR CP into the system and the nurse will adjust the CP as needed. RD#1 stated there was a miscommunication between her and the nursing staff and that is why the CP was not updated to reflect the latest FR PO.<br><br>A review of the Comprehensive care Plan policy, dated 9/1/24 and revised 3/6/25, revealed under the policy explanation and compliance guidelines: 3. The comprehensive care plan will describe, at a minimum, the following: f. Resident specific interventions that reflect the resident's needs and preferences.5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.<br><br>On 2/9/26 at 12:56 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Clinical Director (RCD), Regional Director of Operations (DOO), and [NAME] President of Quality and Performance Improvement (VPQPI) to review concerns found during the survey. The DON stated the care plans should match the physician orders in terms of the fluid restriction.<br><br>On 2/11/26 at 12:06 PM, the surveyor met with the LHNA, DON, RCD, and DOO for exit conference. No further pertinent information was provided.<br><br>NJAC 8:39-11.2, 12.1, 13.2 |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on observation, interview and review of facility policy, it was determined that the facility failed to maintain the confidentiality of the resident information and properly dispose of paperwork with resident information. This deficient practice was observed during kitchen observation around the dumpster area of the building.On 2/4/26 at 9:30 AM, during observation of the garbage/dumpster area and in the presence of the Food Service Director (FSD), the surveyor observed an open carboard box with multiple papers. Upon further observation and investigation, the surveyor observed multiple printed papers dated 8/12/25 and 8/18/25 that contained resident names and room numbers as well as a list of residents who were under enhanced barrier precautions ((EBP) infection control measures that require healthcare staff to wear gowns and gloves during high-contact care activities for residents at risk of or colonized with multidrug-resistant organisms.)On 2/4/26 at 9:35 AM, the Assistant Director of Nursing (ADON) confirmed the papers in the cardboard box had resident information and that paperwork should have been disposed of properly which included being placed into a designated disposable box that is later shredded by an outside company.On 2/9/26 at 9:53 AM, the surveyor interviewed the Director of Nursing (DON), who stated all paper medical records should be placed in the designated area and all records should be shredded to protect patient information. The DON was unable to state how and why the resident paperwork was incorrectly disposed of. On 2/9/26 at 10:00 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Confidentiality of Personal Medical Records) with a revised date of 3/6/25. The policy explanation and compliance guidelines revealed, 8. Paper notes or reminders with residents' personal or medical information shall not be left unattended or viewable by unauthorized persons. These paper notes and reminders will be disposed of in a way that will not compromise resident's personal or medical information.On 2/9/26 at 12:56 PM, the surveyor met with the LHNA, DON, ADON, Regional Clinical Director (RCD), Regional Director of Operations (DOO), and [NAME] President of Quality and Performance Improvement (VPQPI) to review concerns found during the survey. The LNHA stated the paper documents with resident information was not disposed of correctly and a facility wide in-service had been conducted.On 2/11/26 at 12:06 PM, the surveyor met with the LHNA, DON, RCD, and DOO for exit conference. No further pertinent information was provided.NJAC 8:39-4.1 (a) 18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315134 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Complete Care at Green Knoll | 875 Route 202-206 North<br>Bridgewater, NJ 08807 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, it was determined that the facility failed to provide a homelike environment in resident rooms. The deficient practice was observed on 1 of 3 nursing units (3rd floor) and was evidenced by the following:On 2/4/26 at 11:53 AM, the surveyor toured the 3rd floor nursing unit on the 3rd floor nursing unit and observed the following: In room [ROOM NUMBER], the heater was heavily rusted, the heating vent cover was missing, and theCove base molding was pulled away from the wall.In room [ROOM NUMBER] D, the electrical outlet was cracked.In room [ROOM NUMBER] B, the cove base molding under the sink was pulled off.In room [ROOM NUMBER], the wall behind the bed by the door had chipped paint, and the molding along the wall was cracked. The bathroom door had a large crack at the bottom.On 2/9/26 at 10:10 AM, the surveyor showed the Director of Maintenance (DOM) the above observations and concerns. The DOM stated that he was not aware of the above areas in disrepair and confirmed that they should have been repaired, as this does not provide residents with a homelike environment. On 2/9/26 at 1:56 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Clinical Director, Regional Director of Operations, and VP of Quality and Performance Improvements to discuss the above observations and concerns. A review of the facility's policy, Safe and Homelike Environment dated as reviewed 9/1/2025, reflected.In accordance with the residents' rights, the facility will provide a safe, clean, comfortable and homelike environment. NJAC 8:39-4.1(a)11. 31.4 (a), (b), (c), (f) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>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 5 of 30 residents (Resident #9, #39, #111, #131 and #134) during the review of resident assessment. 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 2/9/26 at 11:30 AM, the surveyor provided the MDS Coordinator/Registered Nurse (MDSC/RN) with the list of 5 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 2/9/26 at 12:15 PM, the surveyor interviewed MDSC/RN, who stated that she started working in the facility in November 2025 and is aware that there were MDS assessments that were late. The MDSC/RN revealed there were some MDS that were late prior to her starting. The surveyor reviewed the final validation report from CMS with the MDSC/RN, the 5 residents' MDS assessments that were not submitted within fourteen days of completion, as follows: 1. Resident #39 had an Annual MDS assessment with an assessment reference date (ARD, the last day of the observation period) of 1/1/26 but not transmitted until 1/30/26, a Modification of End of PPS Part A Stay MDS with an ARD of 7/28/25 but was not submitted until 8/17/25, a Quarterly MDS with an ARD of 7/3/25 but was not submitted until 7/20/25 and a Quarterly MDS with an ARD of 4/3/25 but was not submitted until 4/27/25. 2. Resident #9 had a Quarterly MDS with an ARD of 12/5/25 but was not submitted until 1/9/25 and an admission MDS with an ARD of 9/5/25 but was not submitted until 9/20/25. 3. Resident #111 had a Quarterly MDS with an ARD of 12/30/25 but was not submitted until 1/30/26, a Quarterly MDS with an ARD of 7/1/25 but was not submitted until 7/20/25, a Quarterly MDS with an ARD 4/1/25 but was not submitted until 4/27/25 and a Quarterly MDS with an ARD of 12/31/24 but was not submitted until 2/1/25. 4. Resident #131 had an Annual MDS with an ARD of 1/3/26 but was not submitted until 1/31/26, a Quarterly MDS with an ARD of 7/5/25 but was not submitted until 7/20/25, a Quarterly MDS with an ARD of 4/5/25 but was not submitted until 4/27/25 and an admission MDS with an ARD of 1/4/25 but was not submitted until 1/22/25. 5. Resident #134 had a Quarterly MDS with an ARD of 12/30/25 but was not submitted until 1/30/26, an Annual MDS with an ARD of 9/30/25 but was not submitted until 10/21/25, a Quarterly MDS with an ARD of 7/1/25 but was not submitted 7/20/25 and a Quarterly MDS with an ARD of 4/1/25 but was not submitted until 4/27/25. On 2/9/26 at 12:50 PM, the [NAME] President of Quality and Performance Improvement (VPQPI) provided the surveyor with a facility policy titled, MDS 3.0 Completion, with revised dated 3/2025. Under the policy explanation and compliance guidelines it was revealed, 2. admission Assessment - completed within 14 days of admission counting the day of admission as day #1.7. Transmission Requirements: a. All assessments shall be transmitted to the designated CMS system within 14 days of completion. On 2/9/26 at 12:56 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Clinical Director (RCD), Regional Director of Operations (DOO), and VPQPI to review concerns found during the survey. The DON stated Admission, Quarterly and Annual MDS should be completed within 14 days of the ARD.On 2/11/26 at 12:06 PM, the surveyor met with the LHNA, DON, RCD, and DOO for exit conference. No further pertinent information was provided.NJAC 8:39-11.1 |

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| | 315134 | A. Building<br>B. Wing | 02/11/2026 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a low air loss mattress was accurately set and monitored according to the resident's weight and or comfort. This deficient practice was identified for 4 of 5 residents reviewed (Resident #15, # 92, 152, and #163. This deficient practice was evidenced by the following:1. On 2/4/26 at 11:09 AM, the surveyor interviewed Resident #163 in their room. Resident stated their air mattress was very stiff and caused back pain. The surveyor observed the air mattress setting at 380 lbs. During interview Resident #163 stated they weighed around 130 pounds (lbs.)<br><br>At 2/4/26 at 11:12 AM, Resident #163's Registered Nurse (RN#1) entered the room, the surveyor interviewed RN#1 who stated, air mattresses should be set per the resident's current body weight and acknowledged the air mattress setting was incorrect. RN#1 stated he had not checked the air mattress setting during his shift and was unable to state if the staff has been checking the air mattress setting.<br><br>The surveyor reviewed Resident #163's medical record.<br><br>A review of the admission Record (AR) reflected Resident #163 was admitted to the facility with diagnoses that included but were not limited to; multiple fractures of the ribs left side (crack or break in one or more of the rib bones), anxiety (a feeling of fear, dread, and uneasiness) and history of falls.<br><br>A review of Resident #163's admission Minimum Data Set (MDS), an assessment tool dated 12/19/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no cognitive impairment.<br><br>A review of Resident #163's Order Summary Report (OSR) did not reflect an active Physician's Order (PO) for an Air Mattress. The OSR did reflect an a PO for , Pain assessment every shift with an order date of 1/7/26, Tramadol HCl Tablet 50 milligram (MG), Give 1 tablet by mouth every 8 hours as needed for Severe pain (7-10) Monitor for resp depression, sedation, constipation, Acetaminophen Tablet 325 MG, Give 3 tablet by mouth every 8 hours as needed for Mild Pain(1-3) to equal 650mg. Do not exceed 3 grams per day with an order date of 1/9/26, and Lidoderm Patch 5 % (Lidocaine) Apply to lower back topically in the morning for lower back pain and remove per schedule with an order date of 1/8/26.<br><br>A review of the January and February Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed Resident #163's Lidoderm patch was applied daily, pain assessment was completed every shift, Acetaminophen and Tramadol were provided as ordered.<br><br>On 2/6/26 at 9:00 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Use of support surfaces with revised date of 3/6/25. Under the policy explanation and compliance guidelines it revealed, 3. Support surfaces will be chosen by matching the potential therapeutic benefit with resident's specific situation. Considerations for utilizing specialized support surfaces: e. Risk for developing a pressure injury or at high risk for additional pressure injuries. f. Pain or discomfort. 4. The goal and preferences of the resident and/or authorized representative will be included in the plan of care and support surface selection.6. Support surfaces will be utilized in accordance with manufacturer recommendations. 7. For powered devices, or those requiring air, the licensed nurse will check each shift and prn for proper functioning and/or<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | inflation.10. The effectiveness of support surfaces will be monitored through ongoing assessment of the resident and/or wound. Considerations for alternate surfaces include: a. Pain or discomfort associated with use. b. Development of a new pressure injury.<br><br>On 2/9/26 at 12:56 PM, the surveyor met with the LHNA, DON, ADON, Regional Clinical Director (RCD), Regional Director of Operations (DOO), and [NAME] President of Quality and Performance Improvement (VPQPI) to review concerns found during the survey. The DON stated the air mattresses should be set to the resident's weight.<br><br>On 2/11/26 at 12:06 PM, the surveyor met with the LHNA, DON, RCD, and DOO for exit conference. No further pertinent information was provided.<br><br>2. On 2/4/26 at 11:53 AM, the surveyor observed Resident #92 in bed with their eyes closed on a specialty air mattress. The resident's air mattress pump was set to a weight of 180-250 #'s.<br><br>On 2/5/26 at 1:08 PM, the surveyor observed Resident #92 in bed with their eyes closed on a specialty air mattress. The resident's air mattress pump was set to a weight between 180-250 #'s.<br><br>The surveyor reviewed Resident #92's medical record.<br><br>A review of the admission Record reflected Resident #92 was admitted to the facility with diagnoses that included but were not limited to; Alzheimer's Disease (a progressive, irreversible neurological brain disorder that slowly destroys memory and thinking skills) and hypertension (high blood pressure, where the force of blood against artery walls is too high).<br><br>A review of Resident #92's Quarterly Minimum Data Set (MDS), an assessment tool dated 12/19/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated a severe cognitive impairment.<br><br>A review of Resident #92's Order Summary Report (OSR) reflected an active Physician's Order for an Air Mattress: Check for placement and functioning every shift with an order date of 12/5/25. The PO was transcribed into the February Medication Administration Record (MAR) and signed by the nurses each shift, with placement and function checked.<br><br>On 2/5/26 at 1:09 PM, the surveyor asked the Licensed Practical Nurse (LPN) assigned to Resident #92's care if the gauge should be set to the resident's weight. The LPN replied yes, and further stated that the resident definitely did not appear to weigh 190 pounds but that it was the maintenance departments responsibility to set and monitor the specialty mattresses.<br><br>On 2/5/26 at 1:12 PM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager on the 3rd floor stated that nursing was not responsible for monitoring the specialty mattresses. It was the responsibility of the maintenance staff and the hospice staff. The nurses called the maintenance staff if the mattress beeped, otherwise it was maintenance responsibility to ensure it was set up and working properly.<br><br>3. On 02/04/2026 at12:10 PM, the surveyor observed Resident #15 in bed with their eyes closed and positioned on their right side. The surveyor observed the Air mattress setting with 4 green circles on.<br><br>On 2/5/26 at 1:00 PM, the surveyor observed Resident #15 in bed with their eyes closed and the<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | specialty air mattress with 1 light on.<br><br>The surveyor reviewed the medical record for Resident #15.<br><br>A review of the admission Record reflected Resident #15 was admitted to the facility with diagnoses that included but were not limited to; Alzheimer's Disease and hypertension.<br><br>A review of Resident #15's Quarterly MDS dated [DATE] reflected the resident's cognitive skills for daily decision making were severely impaired, and that Resident #15 was dependent on staff for ADL care.<br><br>A review of Resident #15's current OSR reflected an active PO for Air Mattress every shift for preventative; to check for placement and function with an order date of 3/21/25. The order was transcribed on the February Treatment Administration Record (TAR) and signed by the nurses as checked on every shift.<br><br>A review of Resident #15's Care Plan Report reflected that there was no care plan initiated for the use of a specialty air mattress.<br><br>On 2/5/26 at 1:02 PM, during an interview with the surveyor, the Certified Nursing Assistant (CNA #1) assigned to Resident #15's care stated that she didn't know anything about the mattress, and that maintenance checked it.<br><br>4. On 2/5/26 at 12:38 PM, the surveyor observed Resident #152 in bed on a specialty mattress. The resident was eating lunch independently and greeted the surveyor. The surveyor observed that all the lights on the mattress were on.<br><br>The surveyor reviewed the medical record for Resident #152.<br><br>A review of the admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; dementia and hypertension.<br><br>A review of the quarterly MDS dated [DATE] reflected that Resident #152 had a BIMS score of 1 out of 15, which indicated a severe cognitive impairment. A review of section GG indicated the resident was dependent on staff for ADL care. Section M included the resident received a pressure reducing device for their bed.<br><br>A review of the current OSR reflected a PO for a low-air-loss mattress, monitor function every shift, dated as ordered 6/4/25, and transcribed onto the TAR and signed by the nurses as being monitored.<br><br>A review of Resident #152's Care Plan Report reflected a Focus area that included impaired skin integrity initiated 6/13/25 with interventions that included but were not limited to; Low air Loss Mattress.<br><br>A review of Resident #152's Care Plan Report reflected a Focus area that included Resident was at risk for falls r/t history of falls .with interventions that included but were not limited to; be sure the resident's call light and personal items are within reach, encourage the resident to use the call bell for assistance .the resident needs prompt response to all requests for assistance.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/5/26 at 12:42 PM, the surveyor interviewed CNA #2, assigned to Resident #152's care, who stated, I have no idea what the lights on the mattress are, maintenance checks it.<br><br>On 2/5/26 at 12:45 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager who stated that hospice and maintenance set and monitor the specialty mattresses, not nursing. The LPN/UM further stated that when the lights were on, it meant it was set at the resident's weight, which was in the 90#'s.<br><br>On 2/5/26 at 1:50 PM, during an interview with the surveyor, the Regional Maintenance Director, employed for 4 months, stated that the maintenance staff should check the specialty mattresses weekly or more often if necessary.<br><br>On 2/5/26 at 1:50 PM, during an interview with the surveyor, the maintenance director confirmed that specialty mattresses were set according to the resident's weight. The surveyor asked the maintenance director about the mattresses that don't have a weight but only had small circles. The director replied that he would look into it and get back to the surveyor. The surveyor asked the director to provide the weekly monitoring sheets for the specialty mattresses, the policy, and the manufacturers' specifications. The director confirmed there was no documentation regarding the weekly monitoring of the air mattresses.<br><br>On 2/9/26 at 12:30 PM, the surveyor and Director of maintenance observed Resident #92's specialty air mattress. The surveyor observed it was a new specialty mattress. The director of maintenance confirmed that the other mattress did not meet regulations and was outdated, so he replaced it with a new one and set it to 150 pounds (the resident's current weight).<br><br>On 2/9/26 at 12:35 PM, the surveyor and the maintenance director observed Resident #15's specialty air mattress that did not have a weight setting, just small circles. The maintenance director stated that he was not familiar with the mattress, and was not sure what the lights indicated.<br><br>On 2/9/26 at 1:56 PM, the survey team met with the LHNA, DON, Regional Clinical Director, Regional Director of Operations, and VP Quality and Performance Improvements to discuss the above observations and concerns.<br><br>On 2/11/26 at 10:55 AM, during an interview with the surveyor, the DON confirmed that nurses were responsible for monitoring the specialty mattresses as they were the ones signing the Medication Administration Records and Treatment Administration Records, which indicated they were monitoring them every shift. The DON further stated that maintenance was responsible for the weekly monitoring of the specialty air mattresses and should have the inspection of the weekly rounds documented.<br><br>On 2/11/26 at 12:06 PM, no further information was provided.<br><br>NJAC: 8:39 27.1 (a) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**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 provide assessments of the resident's condition and to monitor for complications after dialysis treatments were received at a certified dialysis facility for 1 of 2 residents (Resident #55) reviewed for dialysis. This deficient practice was evidenced by the following:Based on observation, interview and record review, it was determined that the facility failed to provide assessments of the resident's condition and monitoring for complications after dialysis treatments were received at a certified dialysis facility for 1 of 2 residents (Resident #55) reviewed for dialysis. This deficient practice was evidenced by the following: On 02/04/2026 at 12:15 PM, the surveyor observed Resident #55 in bed with their eyes closed.On 2/9/26 at 9:50 AM, the surveyor observed Resident #55 in bed with their eyes closed. A review of the current physician's order (PO) reflected an order for dialysis, every Tuesday, Thursday and Saturday at 9:40 AM; Monitor right chest permacath site ( a long catheter inserted into a central vein for chronic hemodialysis) every shift for placement, bleeding, s/s of infection; do not wet permacath site. A review of Resident #55's admission Record reflected that the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but were not limited to; dependence on renal dialysis (a life-sustaining medical procedure that replaces kidney function in individuals with severe kidney failure) and hypertension (high blood pressure). A review of the quarterly Minimum Data Set (MDS) dated [DATE] reflected that the resident had a brief interview for mental status (BIMS) score of 5 out of 15 which indicated the resident had a severe cognitive impairment. Section O indicated that Resident #55 received special treatments which included hemodialysis. A review of the Resident's Care Plan reflected a focus area that indicated the resident needed hemodialysis r/t renal failure .every Tuesday, Thursday and Saturday . initiated 2/15/24 with interventions that included but were not limited to; Check right upper chest wall permacath dressing every shift .Monitor vital signs as ordered and when necessary. The surveyor reviewed the hybrid Nursing Facility/Dialysis Communication Record forms from October 2025 to February 2026 which revealed that on 10/28/25, 11/15/25 and 11/22/25 the forms were not completed by the facility nurse upon the resident's return from Dialysis. The surveyor also reviewed the resident's electronic medical which revealed there was no documentation indicating the nurse assessed Resident #55 upon return on the above dates.On 2/6/26 at 1:40 PM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) confirmed that the facility nurse who was assigned to the resident should have completed the post dialysis Facility Nurse Assessment Upon Return From Dialysis section which included Vital signs (blood pressure, heart rate, temperature, pulse oximeter) and that the dialysis access site was checked. On 2/9/26 at 1:00 PM, during an interview with the surveyor, the Director of Nursing confirmed that the facility nurses should have completed the post dialysis sections of the Dialysis Communication Record. On 2/9/26 at 1:56 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing (DON), Regional clinical Director, Regional Director of Operations and VP of Quality and Performance Improvement to discuss the above observations and concerns. A review of the facility's Dialysis Patients policy, dated as revised 11/25, reflected .Communication between the dialysis provider and center staff should include: Written communication .Post Dialysis Protocol .Blood pressure prn/daily or as the physician orders (do not take the B/P on arm that fistula is in .Check fistula for bruit (listening to fistula) or feel for a thrill (by touching the fistula) NJAC 8:39-27.1 (a) |

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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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Repeat deficiencyBased on observation, interview, and record review, it was determined that the facility failed to a). properly label, store and dispose of medications in 2 of 7 medication carts and 1 of 3 medication room refrigerators inspected and b). failed to secure 1 of 3 emergency crash carts observed.This deficient practice was evidenced by the following: This deficient practice was evidenced by the following:a). On 02/04/26 at 09:40 AM, the surveyor inspected the 2nd floor medication cart #1 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed two (1) loose medications in tablet form (not in pharmaceutical packaging) in the 2nd drawer of the medication cart and one (1) loose medication in tablet form in the 3rd drawer of the medication cart. The surveyor also observed two bottles of Velphoro 500mg chewable tablet (supplement for dialysis) that contained no pharmacy label (required for prescription medication). The bottle contained only the resident's name, written on both bottles. At that time, LPN#1 acknowledged that the loose medication, not in an identifiable pharmacy package, should have been destroyed per facility policy. LPN#1 also stated that the two bottles of Velphoro 500 mg chewable tablets were not supplied by the pharmacy. The medication was ordered by dialysis and came to the facility in two boxes. LPN#1 acknowledged that the medication did not contain a pharmacy label.On 02/04/26 at 10:15 AM, the surveyor inspected the 1st floor medication cart #3 in the presence of LPN#2. The surveyor observed one Enoxaparin 40mg/0.4 mL injection in the medication cart that had no pharmacy label or resident name. At that time, the surveyor interviewed LPN#2, who stated that Enoxaparin 40m/0.4ml was a discontinued medication and should have been removed from the medication cart. LPN#2 further stated that all medication should contain a pharmacy label and the resident's name.On 02/04/26 at 10:25 AM, the surveyor inspected the first-floor medication room refrigerator in the presence of LPN#2. The surveyor observed that the medication refrigerator had a temperature of 50 degrees and contained a vial of influenza vaccine. A further review of the 1st-floor medication room refrigerator temperature log revealed that no temperatures were documented for 2/3/26 and 2/4/26 in the February 2026 temperature log. At that time, the surveyor interviewed LPN#2, who confirmed that the refrigerator temperature was outside the 36-to-46-degree range and that no one had documented the temperature for the last 2 days. LPN#2 also stated that the influenza vaccine should be stored at the proper temperature. b) On 02/04/26 at 10:10 AM, the surveyor inspected the first-floor nursing unit and observed an open emergency crash part; there were no residents in the vicinity. The surveyor notified the Registered Nurse (RN)/Unit Manager (UM) about the emergency crash cart, and the RN/UM acknowledged that the cart should have been locked. A review of the Manufacturer's Specifications for the following medications revealed the following:Influenza Vaccines should be stored in a refrigerator at 36 to 46 degrees Fahrenheit (2 to 8 degrees Celsius).A review of the NJ state pharmacy law revealed the following key requirements for New Jersey Prescription labels:Pharmacy information, which includes the name, address, and telephone number.Patient and Provider information that includes the full patient's name and the prescribing practitioner's name.Drug information, including the Brand name and the medication's strength.Dispensing details, which included the dispensing date of the medication.Usage instructions.Safety/expiration, which includes the use by date (earlier of one year from dispensing or the manufacturer's expiration date. On 2/10/25 at 12:45 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator, Director of Nursing (DON), Regional Director of Operations, [NAME] President of Quality and Performance Improvement, and the Regional Clinical Director.There was no additional information provided.A review of the facility's policy titled Medication Storage that was dated 9/1/24 and was provided by the DON included the following: All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315134 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Green Knoll | 875 Route 202-206 North<br>Bridgewater, NJ 08807 |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | temperature controls. Refrigerator Products: b. Temperatures are maintained within 36-46 degrees Fahrenheit. Charts are kept on each refrigerator, and temperature levels are recorded daily by the charge nurse or designee. 8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. NJAC: 8:39-29.4 (a) (h) (d) |