STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Shrewsbury LLC	89 Avenue at the Common Shrewsbury, NJ 07702

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one resident of three (Resident (R)53) of 33 sampled residents were treated with dignity in toileting. This failure had the potential to negatively impact the quality of life and self-esteem for the affected resident.Findings include: Review of R53's admission Record located in the resident's EMR section titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia with lower urinary tract symptoms. Review of R53's annual MDS with an ARD of 05/10/25 located in the resident's EMR tab titled MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out 15 points which indicated the resident's cognition was intact and able to make his own decisions. The resident was assessed to have an indwelling catheter and was always incontinent of bowel. The resident required substantial assistance with toileting. Review of R53's Care Plan with a revision date of 06/11/15 located in the resident's EMR tab titled Care Plans revealed the resident required one person assistance with toileting and transfers. Observation on 09/22/25 at 11:30 AM revealed R53 was in his wheelchair trying to get into his room to use the bathroom. Certified Nursing Assistant (CNA)1 told the resident that he could not use the bathroom in his room since housekeeping was cleaning his bathroom. CNA1 also stated the resident would have to wait until she finished taking another resident to the shower. The CNA further told the resident that she would put him to bed and clean him up afterwards. During an interview on 09/22/25 at 1:55 PM, R53 revealed he had just returned from an appointment and needed to use the bathroom. R53 stated that he was upset by the CNA response to his need for the bathroom. The resident stated this was not a dignified response and felt humiliated by the CNA's statement that he could use the bathroom in his briefs. R53 stated that he had been trying to toilet himself in a timely manner to avoid having any bowel movement accidents. During an interview on 09/22/25 at 2:30 PM, CNA1revealed that she was getting another resident ready for a shower when R53 was attempting to get to the bathroom in his room. The CNA stated that she did not have time to stop what she was doing to assist R53. CNA1 stated the resident is usually incontinent of bowel and she thought he already had an incontinent episode. CNA1 stated that she did not realize that she had humiliated the resident by her statements. During an interview on 09/25/25 at 3:30 PM, Licensed Practical Nurse (LPN)3 revealed that CNA1 was a good worker but at times she could be a bit brisk with the residents without realizing it. The observation and resident interview was explained to LPN3; LPN3 stated that CNA1's response to the resident's request for assistance was a violation of his dignity. Review of the facility policy titled Promoting/Maintaining Resident Dignity with a revision date of 03/10/25 directs the staff .All staff members are involved in providing care to residents to promote and maintain resident's dignity and respect residents' rights.Respond to resident's for assistance in a timely manner. NJAC 8:39-4.1(a)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for five residents (Residents (R)44, R9, R133, R6, and R80 in a total sample of 33 residents. This failure placed residents at risk of unmet care needs.Findings include: 1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R44 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure with hypoxia (an inadequate oxygen supply to the body). Review of an 06/16/25 Nursing Progress Note located in the Progress Notes tab of the EMR revealed, .Patient received via stretcher from [hospital name withheld] at approximately 11:35 PM. Patient is alert and awake. Noted with moments of forgetfulness. Respirations easy and unlabored on oxygen at 2L [liters] via nasal cannula. Review of a modified quarterly MDS located in the MDS tab of the EMR with an ARD of 08/12/25 revealed R44 was not coded for the use of oxygen. Review of an 08/17/25 Order Summary located in the Orders tab of the EMR after R44 returned from a hospital stay revealed, 'Oxygen at 2L/min via Nasal Cannula, continuously. Review of the 5-day PPS [prospective payment system-a required assessment for Medicare A residents] located in the MDS tab of the EMR with an ARD of 08/24/25. revealed that R44 was not coded for oxygen use. During an observation on 09/22/25 at 11:55 AM, R44 was observed wearing oxygen and was not able to respond to questions due to significant shortness of breath. During an interview on 09/25/25 at 11:23 AM, the MDS Coordinator (MDSC) stated, I did not code her oxygen, and I need to make a correction. 2. Review of the admission Record located in the Profile tab of the EMR revealed R9 was admitted to the facility on [DATE] with diagnoses that included a stroke and diabetes. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 07/11/25 revealed R9 had a BIMS score of nine out of 15 which indicated R9 was moderately impaired in cognition and had received radiation therapy during the observation period. Review of the EMR including the Assessments tab and Nursing and Provider Progress Notes did not show documentation as to why R9 had received radiation therapy. During an interview on 09/25/25 at 11:27 AM, the MDSC stated, That was coded inaccurately. 3. Review of the admission Record located in the Profile tab of the EMR revealed R133 was admitted to the facility on [DATE] with a diagnosis of dementia. Review of the admission MDS located in the MDS tab of the EMR with an ARD of 01/29/25 revealed R133 had a BIMS score of five out of 15 which indicated R133 was severely impaired in cognition. Review of the discharge return anticipated MDS located in the MDS tab of the EMR with an ARD of 02/17/25 revealed R133 had a weight of 166 pounds and had not sustained weight loss. Review of the weights located in the Weights/Vitals tab of the EMR revealed indicated that on 02/03/25 weight was listed as 177.3 pounds. During an interview on 09/24/25 at 10:37 AM, Registered Dietician (RD)2 was asked if she was responsible for coding the MDS for nutrition. RD 2 stated, Yes. RD2 further stated, She was refusing weights, and the assessment should have reflected the 166 pounds and the weight loss. I am not sure that 177.3 pounds was an accurate weight. 4. Review of R6's admission Record located in the EMR tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease. Review of R6's Physicians Orders dated 05/01/25 and located in the EMR tab titled Orders revealed an order for Affinity Hospice to evaluate and treat. Review of R6's Affinity Care Facility Notification of Admission dated 05/05/25 located in the EMR tab titled Miscellaneous revealed the resident was accepted into the hospice program on 05/05/25.Review of R6's quarterly MDS with an ARD 08/20/25 located in the EMR tab titled MDS documented the resident as not receiving hospice services. During an interview on 09/25/25 at 11:13 AM, the MDS Coordinator (MDSC) and the two corporate MDS (CMDS)1 and CMDS2 verified that the quarterly MDS for R6 inaccurately documented that she was not receiving hospice services. 5. Review of R80's admission Record located in the EMR tab titled Profile revealed the resident was admitted to the facility 05/28/25 with diagnoses that included age (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related osteoporosis with a pathological fracture. Review of R80's admission Fall dated 06/30/25 located in the EMR tab titled Assessments documented that the resident sustained a fall on 06/30/25. The resident was assessed to have a fall risk score of 19 indicating the resident was a high fall risk. Review of R80's quarterly MDS with an ARD 09/04/25 located in the resident's EMR tab titled MDS revealed the resident was assessed as not having any fall since admission to the facility. During an interview on 09/25/25 at 11:13 AM, the MDS Coordinator (MDSC) and the two Corporate MDS coordinators (CMDS)1 and CMDS2 confirmed the quarterly MDS was inaccurate as it did not capture the resident's fall in June. Review of the October 2024 RAI, manual, page 1-5 revealed, .An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations.It is important to note here that information obtained should cover the same observation period as specified by the MDS (minimum data set) items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) by the IDT (interdisciplinary team) completing the assessment. NJAC 8:39-33.2(d)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and review of facility policy, the facility failed to ensure care plans were developed and/or implemented for five residents (Residents (R) R1, R7, R14, R36, and R104) from a total sample of 33 residents. This failure had the potential that residents would not receive all necessary care and services.Findings include: 1. Review of R1's admission Record located in the electronic medical record (EMR) tab titled Profile revealed the resident was admitted to the facility initially on 03/28/21 and readmitted [DATE] with diagnoses that included Asperger's syndrome (developmental disorder to effectively socialize and communicate. Review of R1's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/11/25 located in the EMR tab titled MDS revealed for Active Diagnosis listed the resident with Asperger's syndrome. Review of R1's Care Plan with a revision date of 09/15/25 located in the EMR tab titled Care Plans revealed the care plan did not address the resident's diagnosis of Asperger's syndrome and the signs and symptoms of this syndrome. During an interview on 09/25/25 at 4:06 PM, Licensed Practical Nurse (LPN)3 stated she was aware of R1's diagnosis of Asperger's syndrome and felt it should have been included in the resident's care plan to make the other care givers aware of the resident's symptoms. 2. Review of R7's admission Record located in the EMR tab titled Profile' revealed the resident was admitted to the facility 07/03/24 with diagnosis that included conversion disorder with seizures or convulsions, a functional neurological symptom disorder, is a psychiatric condition in which psychological stress manifests itself as physical symptoms. Review R7's Care Plan with a revision date 07/15/25 located in the EMR tab titled Care Plans revealed the care plan did not reflect the resident's diagnosis of conversion disorder and what signs and symptoms to observe. During an interview on 09/25/25 at 4:06 PM, LPN3 revealed that she was aware of the R7's diagnosis of conversion disorder related to seizures. LPN3 stated that while talking to the resident she would suddenly blink and say that she's had a seizure. LPN3 stated the resident's diagnosis of conversion disorder should be included in the care plan so the staff would know what to expect and how to react. Interview with the Director of Nursing on 09/24/25 at 11:20 AM revealed the R1 had the diagnosis of Asperger's syndrome and R7's diagnosis of conversion disorder prior to admission to the facility however felt that there was not a need to develop a care plan unless the residents exhibited those signs and symptoms while admitted to the facility. 3. Review of R14's admission Record located in the EMR tab titled Profile revealed the resident was admitted to the facility 04/28/25 with diagnoses that included chronic kidney failure with dependance on renal dialysis. Review of R14's admission MDS with an ARD of 05/05/25 located in the EMR tab titled MDS revealed the resident was assessed to receive dialysis. Review of R14's Physicians Orders dated 06/04/24 located in the EMR tab titled Orders revealed the resident was to receive dialysis on Tuesday, Thursday, and Saturday. Monitor dialysis site left internal jugular permacath for signs / symptoms of infection and/or bleeding. Assess site for any changes in skin condition. Report any noted redness, edema or increased skin temperature to MD. External hemodialysis permacath do not change end caps or dressing. Review of R14's Care Plan with a revision date of 09/23/25 located in the EMR tab titled Care Plans revealed the resident's dialysis care interventions failed to include orders not to change the end caps on the external permacath. During an interview on 09/25/25 at 4:06 PM, LPN3 revealed the physician's orders not to change the end caps on the resident's permacath should have been included on the care plan. 4.Review of the admission Record located in the Profile tab of the EMR revealed R36 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly) and a stroke. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 08/26/25 revealed R36 had a BIMS score of three out of 15 which indicated R36 was severely impaired in cognition and had one non-injury fall during (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the observation period. Review of an 09/11/25 Fall Investigation Report provided by the DON revealed, .Writer was alerted that resident was on the floor. Resident lying supine [on his back] position on the floor with his head facing the headboard of the bed.Resident stated, I got up to get my food and fell. The intervention for preventions to place mats next to the bed. Review of the revised 09/11/25 Fall Care Plan revealed, R36 had an actual fall with no injury. The 09/11/25 interventions included, Floor mats placed at both sides of the bed. During an observation on 09/23/25 at 3:00 PM, there was a floor mat located on the door side of the bed and there was no fall mat on the wall side of the bed. During an interview on 09/23/25 at 3:04 PM, LPN 6 confirmed that there was only one fall mat next to his bed. During an interview on 09/23/25 at 3:09 PM, LPN/Unit Manager 2 confirmed that there was only one fall mat next to his bed and there should have been two per the Care Plan. 5. Review of the admission Record located in the Profile tab of the EMR revealed R104 was admitted to the facility on [DATE] with a diagnosis of transient cerebral ischemic attacks (TIAs-a temporary disruption of blood flow to the brain) and progressive bulbar palsy (a condition that attacks the nerves). Review of the admission MDS located in the MD tab of the EMR with an ARD of 07/25/25 revealed R104 had a BIMS score of 10 out of 15 which indicated R104 was moderately impaired in cognition and received an anticoagulant (blood thinner) during the observation period. Review of the 08/15/25 Order Summary located in the Orders tab of the EMR revealed, Warfarin [a blood-thinning medication] 6 MG [milligrams]. Give one tablet by mouth in the evening every Monday, Wednesday, Friday, and Sunday for DVT [deep vein thrombosis-a blood clot] prophylaxis May increase risk of bleeding. In addition, Warfarin 6 mgs. Give one tablet by mouth in the evening every Tuesday, Thursday, and Saturday for DVT prophylaxis. Monitor for bleeding, tarry stools. Give with 2.5 mg to 8.5mg in total. Review of the Comprehensive Care Plan did not show a focus/goal or interventions for the use of the Warfarin. During an interview on 09/25/25 at 1:23 PM, LPN/UM 3 was asked who was responsible for developing the care plans. The LPN/UM 3 stated, We do the baseline care plan and then add to it to make the Comprehensive Care Plan. LPN/UM 3 was asked why there was no Care Plan for the use of Warfarin since it was a significant medication. UM verified there was no care plan for Warfarin usage. Review of the facility's policy titled Comprehensive Care Plans with a revision date of 03/01/25 directs the staff as follows: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.The comprehensive care plan will describe at a minimum the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well. NJAC 8:39-11.2(e)thru (i)NJAC 8:39-27.1(a)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure four of five residents (Resident (R)12, R82, R89, and R129) reviewed for immunizations out of a total sample of 33 residents had been offered and/or provided a pneumococcal immunization This failure increased the risk of residents contracting pneumonia.Findings include: 1. Review of R12's electronic medical record (EMR), located under the Census tab revealed R12 was admitted to the facility on [DATE] with diagnoses found under the Medical Diagnosis tab included encounter for surgical aftercare following surgery of the digestive system, colostomy, and an incisional site infection. Review of R12's paper medical record revealed no documentation that the resident had been offered a pneumococcal immunization. 2. Review of R82's EMR , located under the Census tab of the EMR, revealed R82 was admitted to the facility on [DATE] with diagnoses found under the Medical Diagnosis tab included acute cystitis without hematuria, unspecified injury to the head, muscle weakness, dysphagia, and severe protein calorie malnutrition. Review of R82's paper medical record revealed authorization for the pneumococcal immunization had been signed by his representative on 09/05/25. 3. Review of R89's EMR located under the Census tab of the EMR, revealed R89 was admitted to the facility on [DATE] with diagnoses found under the Medical Diagnosis tab included encounter for aftercare from surgery on the circulatory system. Review of R89's paper medical record revealed she had signed the consent form on 08/23/25 for a pneumococcal immunization but did not indicate whether she had wanted the immunization or not. 4. Review of R129's EMR, located under the Census tab of the EMR, revealed R129 was admitted to the facility on [DATE] with diagnoses found under the Medical Diagnosis tab included enterocolitis, acute kidney failure, and chronic obstructive pulmonary disease. Review of R129's medical record revealed no documented evidence that pneumococcal immunization had been offered. During an interview on 09/23/25 at 2:00 PM, Licensed Practical Nurse (LPN) 2, who was the unit manager for the second floor, stated when a new resident was admitted , the admitting nurse was responsible for providing education to the resident and/or representative on the pneumococcal immunizations. LPN2 stated the nurse would also have the forms signed with the choice made. LPN2 confirmed the immunization forms for the above residents had not been signed and/or no choice had been made. During an interview on 09/23/25 at 3:30 PM, the Director of Nursing (DON) stated the admitting nurse was responsible for offering the pneumococcal vaccine and for completing the consent form. The DON stated the Infection Preventionist(IP) followed up with an audit of the records to ensure the forms had been signed and the residents had chosen whether or not to receive the vaccination. During an interview on 09/24/25 at 1:16 PM, the IP stated her role was to ensure the immunization forms had been filled out completely. The IP confirmed the staff were not ensuring the resident and/or their representatives had been offered the vaccines. Review of the facility's policy titled, Infection Prevention and Control Program, dated 09/01/24, revealed, . Residents will be offered the pneumococcal vaccines recommended by the Centers for Disease Prevention and Control (CDC) upon admission, unless contraindicated or received the vaccines elsewhere . NJAC 8:39-19.4

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual the facility failed to ensure that a Significant Change Minimum Data Set (MDS) was completed for one resident (Resident (R)6) from a total sample of 33 residents. This failure had the potential for residents not to receive appropriate care in timely manner.Finding include: Review of R6's admission Record located in the electronic medical record (EMR) tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease, bipolar disorder, moderate protein calorie malnutrition, and heart failure.Review of R6's Physicians' Orders dated 05/01/25 located in the resident's EMR tab titled Orders revealed Affinity Hospice was to evaluate and treat.Review of R6's Affinity Care Facility Notification of Admission dated 05/05/25 located in the resident's EMR tab titled Miscellaneous revealed the resident was accepted into the hospice program on 05/05/25.Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/20/25 located in the resident's EMR tab titled MDS revealed the resident was assessed as receiving hospice services.Review of R6's quarterly MDS with an ARD of 08/20/25 located in the resident's EMR tab titled MDS revealed the resident was not receiving hospice services.Additional review of R6's MDS section failed to reveal a Significant Change MDS for the resident being placed on hospice services.During an interview on 09/25/25 at 3:00 PM with the Corporate MDS 1 and the MDS Coordinator (MDSC) confirmed a Significant Change MDS should have been completed in the allotted time after the resident was started on hospice services.Review of the RAI Manual revealed a significant change in a resident's status triggers the need for a Significant Change in Status Assessment (SCSA). This assessment, part of the Minimum Data Set (MDS) 3.0, must be completed within 14 calendar days following the determination that a significant change has occurred. A significant change in the context of MDS assessments refers to a major decline or improvement in a resident's condition that impacts multiple areas of health and requires intervention.Definition of Significant Change: According to the Centers for Medicare & Medicaid Services (CMS), a significant change is defined as a major decline or improvement in a resident's physical or mental condition that meets the following criteria.1.Non-Self-Limiting: The change will not typically resolve itself without further intervention by staff or through standard clinical interventions. 2.Impact on Multiple Areas: The change affects more than one area of the resident's health status.3. Interdisciplinary Review Required: The change necessitates a review or revision of the resident's care plan by an interdisciplinary team (IDT). NJAC 8:39-11.2(i)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to revise care plans for two residents (Residents (R) 137 and R9) from a total sample of 33 residents. This failure had the potential for residents to have unmet care needs. Findings include: 1.Review of R137's admission Record located in the electronic medical record (EMR) tab titled Profile revealed the resident was admitted initially to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included end stage renal disease with dialysis dependency. Review of R137's Physicians Orders dated 12/17/24 and located in the EMR tab titled Orders revealed the resident was to receive dialysis Tuesday, Thursday, and Saturday. The order included for nursing to Monitor Bruit and Thrill to Left arm fistula every shift. Monitor Hemodialysis site for signs/symptoms of complications (e.g., bleeding, swelling, pain, drainage, odor, hardness, or redness at site). Notify the physician and dialysis center immediately with any urgent problems every shift. No Blood Pressure on Left arm secondary to fistula every shift. Review of R137's Five Day Medicare Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/24 located in the EMR tab titled MDS revealed the resident was coded for dialysis. Review of R137's Nursing Notes dated 01/02/25 located in the EMR tab titled Progress Notes revealed the resident was sent to the emergency room for excessive bleeding from the dialysis fistula caused by the resident picking at the site. Review of R137's Nursing Notes written by the MDS Coordinator located in the EMR tab titled Progress Notes revealed the resident had returned to the facility after hospitalization for a rupture of the fistula caused by the resident's picking at the fistula. The MDS Coordinator documented plans to revise the resident's care plan to monitor the resident for picking at the fistula. Review of R137's Care Plan with a revision date of 01/05/25 located in the EMR tab tilted Care Plans revealed the care plan interventions had not been revised to reflect the resident's behavior of picking the fistula graft site. Interview on 09/24/25 at 1:45PM with LPN3 revealed the nurses can revise the resident's care plan at the time of an incident or change in the condition and thought it had been revised during the care plan meeting Interview on 09/25/25 at 11:15AM with the Director of Nursing revealed the resident's care plans are developed during the resident's care plan meeting with the interdisciplinary team. The floor nurses can revise a resident's at the time of the resident's change in condition. 2. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R9 was admitted to the facility on [DATE] with diagnoses that included a stroke and an acute kidney injury. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 07/11/25 revealed R9 had a Brief Interview of Mental Status (BIMS) score of nine out of 15 which indicated that R9 was moderately impaired in cognition, weighed 129 pounds and had sustained weight loss. Review of the 04/04/25 Nutrition Care Plan located in the Care Plan tab of the EMR revealed, R9 is at risk for malnutrition R/T [related to] ascites [abdominal swelling] which may mask weight loss-need for ONS [oral nutritional supplement]-below UBW [usual body weight]-varied intake R9 has allergy to mushrooms and is on a diuretic, weight may change due to fluid/edema. Significant weight loss unplanned. Revised on 09/23/25. Interventions included:1. Provide diet as ordered liberalized, regular, thin. Dated 04/04/25.2. Provide supplements as ordered Glucerna 1.5. Dated 04/04/25 Revised on 09/23/25. Review of an 09/08/25 Nutrition Note located in the Progress Notes tab of the EMR revealed, .Nutrition follow-up. Current body weight is 114.6 pounds. She had a significant 10 pounds/7% weight loss x one month, unplanned, likely secondary to decreased appetite/intake.She will be evaluated by speech therapy. Recommend health shake 4oz daily, and super mashed potatoes 4 oz daily to help meet needs. Recommend changing Glucerna 1.5 8oz order from PM to AM to ensure she is drinking it. During an interview on 09/24/25 at 10:30 AM, Registered Dietician (RD) 1 was asked if she was responsible for updating and revising the Nutrition (continued on next page)

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Complete Care at Shrewsbury LLC	89 Avenue at the Common Shrewsbury, NJ 07702

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan. RD1 stated, Yes. RD1 was asked about the update to R9's diet per her 09/08/25 to R9's diet and should the Care Plan be updated to reflect her current nutritional requirements. RD1 stated, Yes, I should have changed that. Review of the facility policy titled Care Plan Revisions Upon Status Change with a revision date of 03/01/25 directs staff .The comprehensive care plan will be reviewed, and revised as necessary when a resident experience a status change.The care plan will be updated with new or modified interventions. NJAC 8:39-11.2(e)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure nursing assessments of a surgical incision were provided for one resident (Resident (R)132) in a total sample of 33. This failure placed residents at risk of health complications and hospitalization.Findings include: Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R132 was admitted to the facility on [DATE] with a diagnosis of a right hip fracture with surgical repair. Review of the 09/16/25 admission Comprehensive Nursing Assessment located in the Assessments tab of the EMR revealed under the Skin Assessment section revealed that R132 had a surgical wound. There was no further documentation to show an assessment of the surgical site. Review of the 09/16/25 admission Nursing Progress Note located in the Assessments tab of the EMR revealed, .XXX[AGE] year-old male patient arrived at facility via wheelchair accompanied by one transport from [hospital name withheld] with primary diagnosis of closed right hip fracture.Right hip surgical incision with dressing intact. There was no further documentation of an assessment of the surgical site. Review of the September 2025 Treatment Administration Record (TAR) and the Medication Administration Record (MAR) revealed no documentation of a daily assessment or monitoring of the right hip surgical wound. Review of the 09/18/25 Care Plan located in the Care Plan tab of the EMR revealed, R132 has an actual impairment to skin integrity of his right hip r/t surgical wound. Interventions included:1. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short.2. Educate resident/family/caregivers of causative factors and measures to prevent skin injury.3. Encourage good nutrition and hydration in order to promote healthier skin. Review of an 09/22/25 Provider Note located in the Progress Notes tab of the EMR revealed, Resident seen and examined at nursing request for fever of 102.7. Heart rate 110, respirations 30, blood pressure 101/62. Oxygen sat was 87% placed on oxygen at two liter per nasal cannula came up to 96%. The resident laying [sic] in bed eyes are [sic] open but did not answer any questions, has dementia. The right hip surgical site with staples swollen with warmth noted s/p [status post] right femur fracture surgery repair. Told Licensed Practical Nurse/Unit Manager (LPN/UM) 2 and Director of Nursing (DON) to send the resident to the hospital for possible sepsis [a life-threatening condition that occurs when the body's immune system overreacts to an infection]. Review of a 09/22/25 Sepsis Protocol was completed and documented in the EMR under the Assessments tab. The protocol states, All subacute patients will be screened for the possibility of sepsis at least daily and as needed. There were no other Sepsis Protocols completed prior to 09/22/25. During an interview on 09/24/25 at 11:32 AM, the Director of Nursing (DON) was asked when a resident entered the facility having had surgical repair of the hip with an obvious incision, what is the expectation to assess and monitor that incision site for signs/symptoms of infection. The DON stated, First, there should be an order to monitor the surgical site for signs/symptoms of infection. The DON stated, The staff should be utilizing the Sepsis Protocol. The DON was asked when staff were to implement the Sepsis Protocol. The DON stated, Generally, it should be done on admission for a baseline assessment. In addition, there needs to be a progress note or documentation on the Comprehensive Nursing Assessment. The DON confirmed that assessing and monitoring of the surgical site should have begun for R132 at the time of admission. Review of the 09/22/25 Hospital emergency room Report provided by the Administrator revealed that R132 was admitted with sepsis related to a urinary tract infection and pneumonia. NJAC 8:39-27.1

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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, record review, interviews, and policy review, the facility failed to monitor the effectiveness of wander guards and modify interventions for two of 33 sampled residents (Resident (R)16 and R69). This failure had the potential to interfere with the residents' right to self-determination and their right to make choices about significant aspects of their life in the facility. Findings include: 1. Review of R16's Resident Face Sheet, located in the electronic medical record (EMR) under the Resident tab, revealed an admission date of 10/21/23 with diagnoses of Parkinson's disease. Review of R16's quarterly Minimum Data Set (MDS), located in the EMR under the RAI (Resident Assessment Instrument) tab with an Assessment Reference Date (ARD) of 08/01/25, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R16 was moderately cognitively impaired. This same MDS indicated there were no changes in R16's mental status and there were no wandering behaviors. The MDS indicated a wander guard was in use daily. Review of R16's Care Plan, dated 01/27/25, located in the EMR under the RAI tab, revealed R16 was an elopement risk with a history of attempts to leave the facility. A wander guard was placed on 12/03/24. A review of R16's progress notes located in the EMR under the Progress Notes tab dated 12/02/24 indicated R16 was found by the front door of the facility attempting to stand up from his wheelchair and stating he had a car waiting for him. The Director of Nursing (DON) was notified, and she placed a wander guard on his left ankle. There were no other attempts of elopement documented in R16's EMR. A review of R16's elopement assessments located under the Assessment tab of the EMR revealed an elopement assessment dated [DATE] indicating R16 was a high risk for elopement related to wandering in the past month. A review of R16's behavior tracking dated 09/01/25 to 09/25/25 revealed no documented behaviors of wandering. During an interview on 09/22/25 at 3:29 PM, R16 stated he had the wander guard on to keep him inside because he was not supposed to go out. R16 stated he did not try to go outside because he was not supposed to. A review of R16's EMR revealed no discussion of his wander guard and whether it was effective or if other interventions should be attempted during the care plan meetings on 02/06/25 and 05/02/25. 2. Review of R69's Resident Face Sheet, located in the EMR under the Resident tab, revealed an admission date of 08/15/22 with diagnoses of bi-polar disorder, anxiety disorder, and major depressive disorder. During the initial tour of the facility on 09/22/25, R69 was observed with a wanderguard in place. R69 declined to talk with the surveyor during the investigation. Review of R69's annual MDS, located in the EMR under the RAI tab with an ARD of 06/26/25, revealed the resident had a BIMS score of 13 out of 15, indicating R69 was cognitively intact. This same MDS indicated there were no changes in R69's mental status and there were no wandering behaviors. The MDS indicated a wander guard was not in use. Review of R69's Care Plan, dated 12/25/25, located in the EMR under the RAI tab, revealed R69 was an elopement risk and had attempted to leave out the front door. A wander guard was placed on 03/04/25. A review of R69's progress notes located in the EMR under the Progress Notes tab dated 03/03/25 indicated R69 had a wander guard to the left ankle. There was no documentation as to why the wander guard was placed. Continued review of the EMR revealed a progress note dated 07/22/25 noting R69 with several attempts to get on the elevator. The progress note indicated that R69 became upset and stated she felt trapped and locked on the unit and was treated like an animal. A review of R69's' elopement assessments located under the Assessment tab of the EMR revealed an elopement assessment dated [DATE] indicating R69 was a high risk for elopement with no reported incidents of wandering in the last month. There was no other elopement assessment for R69 located in the EMR indicating why the wander guard was placed. A review of R69's EMR revealed there was no behavior monitoring or intervention report implemented for the behavior of wandering or elopement. A review of R69's EMR revealed no discussion of his wonder guard and whether it was effective or if other (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions should be attempted during the care plan meetings on 06/04/25. During an interview on 09/25/25 at 10:45 AM the DON stated that she will be notified of any attempt to elope and will place the wander guard. The DON stated that assessments are completed for the wander guard and wandering risk but were not completed prior to or when these wander guards were placed. The DON stated wander guards were discussed during the care plan meeting and if the behavior increased or decreased the risk should be re-evaluated to see if the wanderguard was effective. A review of the facility policy titled Elopement and Wandering Residents dated 03/05/25 indicated that all residents will be assessed for elopement upon admission and throughout their stay. Additionally, the facility is responsible to establish a systematic approach to monitoring and managing residents at risk for wandering an assessment of the risks, evaluation of the risks, implementing interventions to reduce the risks and monitoring for the effectiveness of the interventions and modifying the interventions when necessary. NJAC 8:39-5.1(a)NJAC 8:39-27.1(a)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Social Service Director job description, the facility failed to ensure the Comprehensive Social Services Assessment was completed upon admission for one resident (Resident (R)66) in a total sample of 33 residents. This failure placed residents at risk of unmet psychosocial needs.Findings include: Review of an undated Social Services Director job description revealed, .The Social Services Director (SSD) is responsible for overseeing the development, implementation, supervision and ongoing evaluation of the Social Services.The Social Services Director will complete and/or delegate the completion of the social services component of the comprehensive assessment. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed that R66 was admitted to the facility on [DATE] with diagnoses that included a recent stroke with left-sided paralysis, major depressive disorder, and adjustment disorder with depression. Review of the Comprehensive Social Services Assessment located in the Assessments tab of the EMR, dated 08/14/25, was documented as incomplete. There was no documentation on the assessment to show the SSD had completed the Comprehensive Assessment. Review of the 08/19/25 Psychiatric Visit Note located in the Progress Notes tab of the EMR revealed, Resident presents as calm and cooperative. He notes a past history of anxiety and severe depression including two past attempts to end his life. He reports having a difficult time coping with having to rely on others after his stroke. He reports sleeping well. The resident denies experiencing any suicidal or homicidal ideation, auditory or visual hallucinations, or side effects from his psychotropic medications. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 08/20/25 revealed R66 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R66 was cognitively intact, had no behaviors and was administered an antipsychotic and an antidepressant medication during the observation period. During an interview on 09/22/25 at 9:32 AM, R66 was asked about his psychosocial well-being and if the facility met his needs. R66 stated, I was raped when I was in the army, and I have PTSD [post-traumatic stress disorder]. I can't take showers. R66 was asked if he is seeing a psychiatrist or psychologist helping him deal with his PTSD. R66 stated that he used to see a VA [Veterans Association] psychiatrist. During an interview on 09/24/25 at 8:52 AM, the SSD was asked about her incomplete Comprehensive Assessment and when this assessment should be completed. The SSD stated, 'It should have been done after admission. The SSD confirmed that it was not completed. The SSD was asked if she was aware that R66 had voiced that he had PTSD. The SSD stated, No, I wasn't aware of it. The SSD was asked if she performs, upon admission, a Trauma Informed Care assessment to determine any past trauma. The SSD stated, No, I don't do those unless the resident brings it up. NJAC 8:39-27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure staff wore the proper Personal Protection Equipment (PPE) when caring for two of two residents (Resident (R)6 and R14) identified as requiring Enhanced Barrier Precautions (EBP) out of a total sample of 33 residents. This failure increased the risk of cross-contamination of microorganisms to other residents. Findings include: 1. Review of R6's admission Record located in the EMR tab titled Profile' revealed the resident was admitted to the facility on [DATE] with diagnoses that include moderate protein calorie malnutrition. Review of R6's Weekly Skin Review dated 08/27/25 located in the EMR tab titled Assessment revealed the resident had developed a pressure ulcer to the left buttocks. Review of R6's Physician Orders' dated 09/07/25 located in the EMR tab titled Orders revealed the resident was on Enhanced Barrier Precautions (EBP) related to wounds. Observation on 09/24/25 at 8:20 AM revealed Certified Nursing Assistant (CNA)4 entering R6's room carrying linen supplies without donning a gown and gloves. There was EBP signage posted on the resident's door and a cart that contained face masks, gloves, and gowns. CNA4 reentered the resident's room again without donning gown and gloves. Upon entering the room CNA4 was observed preparing to give R6 a bed bath.During an interview on 09/24/25 at 8:42 AM, CNA4 revealed that she was an agency CNA and had worked with the resident for the past month and was not aware the resident was on EBP and that she should wear personal protective equipment (PPE) when providing resident care. 2. Review of R14's admission Record located in the EMR tab titled Profile revealed the resident was admitted to the facility on [DATE] with diagnoses that included acute/chronic kidney failure with dependance on renal dialysis.Review of R14's Physicians Orders dated 06/05/25 located in the EMR tab titled Orders revealed the resident required EBP related to having a foley catheter, a permacath for dialysis, and history of vancomycin resistant enterococci (VRE) infection.Observation during the initial tour on 09/22/25 at 11:35 AM revealed R14's room did not have EBP signage or a cart containing PPE outside his room. Observation on 09/22/25 at 1:10 PM revealed Licensed Practical Nurse (LPN)8 entering R14's room without donning personal protective equipment to administer medications and to check the resident's permacath dressing. Observation on 09/23/25 at 9:30 AM revealed R14 was in his room preparing for his dialysis appointment.During an interview on 09/23/25 at 9:30 AM, R14 revealed staff did not always wear a gown and gloves when entering the room to provide care such as checking his permacath dressing or emptying his urinary drainage bag.During an interview on 09/23/25 at 1:48 PM, LPN8 stated R14 had been on EBP precautions since admission to the facility for his foley catheter and dialysis permacath. LPN8 was also reminded that she was observed entering the resident's room to provide medications on 09/22/25 without donning PPE. LPN8 stated that she was unaware of that this surveyor was observing her on 09/22/25 Review of the facility's policy titled, Infection Prevention and Control Programs, dated 09/01/24, revealed, . This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The policy indicated that all staff were responsible for following all policies and procedures related to the program. Review of the facility's policy titled, Enhanced Barrier Precautions, dated 09/01/24, revealed, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug organisms . An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO . PPE for enhanced barrier precautions is only necessary when performing high-contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care activities . High-contact resident care activities include a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting . NJAC 8:39-19.4

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure four of five residents (Residents(R) 12, R82, R89, and R129) reviewed for COVID-19 immunizations out of a total sample of 33 were offered a COVID-19 immunization and/or chose to have the immunization but had not received it. Failure to offer and administer could result in the residents acquiring COVID-19.Findings include: 1. Review of R12's electronic medical record (EMR) Census tab revealed R12 was admitted to the facility on [DATE] with diagnoses found under the Medical Diagnosis tab included encounter for surgical aftercare following surgery of the digestive system, colostomy, and an incisional site infection. Review of R12's paper medical record revealed no documentation to show that the COVID-19 vaccine was offered. 2. Review of R82's EMR Census tab of the EMR, revealed R82 was admitted to the facility on [DATE] with diagnoses found under the Medical Diagnosis tab included acute cystitis without hematuria, unspecified injury to the head, muscle weakness, dysphagia, and severe protein calorie malnutrition. Review of R82's paper medical record revealed authorization for a COVID-19 immunization had been signed by his representative on 09/05/25. 3. Review of R89's EMR Census tab of the EMR, revealed R89 was admitted to the facility on [DATE] with diagnoses found under the Medical Diagnosis tab included encounter for aftercare from surgery on the circulatory system, Review of R89's paper medical record revealed she had signed the consent form on 08/23/25 for COVID-19 immunization but did not indicate whether she had wanted the immunization or not. 4. Review of R129's EMR Census tab of the EMR, revealed R129 was admitted to the facility on [DATE] with diagnoses found under the Medical Diagnosis tab included enterocolitis, acute kidney failure, and chronic obstructive pulmonary disease. Review of R129's medical record revealed no documentation to show the COVID-19 vaccine was offered. During an interview on 09/23/25 at 2:00 PM, Licensed Practical Nurse (LPN) 2, who was the unit manager for the second floor, stated when a new resident was admitted , the admitting nurse was responsible for providing education to the resident and/or representative on the immunizations. LPN2 stated the nurse would also have the forms signed with the choice made. She confirmed the immunization forms for the above residents had not been signed or no choice had been made for the COVID-19 immunizations. During an interview on 09/23/25 at 3:30 PM, the Director of Nursing (DON) stated the admitting nurse was responsible for ensuring the immunizations had been offered and the form completed with their choice and signature. The DON stated the Infection Preventionist (IP) followed up with an audit of the records to ensure the forms had been signed and the residents had made a choice related to vaccines. During an interview on 09/24/25 at 1:16 PM, the IP stated her role was to ensure the immunization forms had been filled out completely. She confirmed the staff were not ensuring the resident and/or their representatives had been asked about immunizations. Review of the facility's policy titled, Infection Prevention and Control Program, dated 09/01/24, revealed, . Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance . NJAC 8:39-5.1(a)