STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barn Hill Care and Rehab Center	249 High Street Newton, NJ 07860

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34421 Based on the interview and record review, it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, accurately for 1 of 28 residents reviewed (Resident # 132). The deficient practice was evidenced by the following: The surveyor reviewed Resident # 132's records. The resident was discharged from the facility and according to the Discharge Return Not Anticipated MDS, an assessment tool used to facilitate the management of care, dated 5/3/24, the resident was assessed as being discharged to the hospital. A review of Resident # 132's progress notes dated 5/3/24 revealed the resident was discharged home with family. On 8/8/24 at 12:50 PM, the surveyor interviewed the MDS Coordinator, who stated that the MDS dated [DATE] should have indicated discharge to home or lesser care and that it was an error that it indicated discharge to the hospital. During an interview on 8/8/24 at 1:30 PM, the surveyor brought the above concerns to the attention of the Director of Nursing and Administrator. NJAC 8:39-11.2(e)1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48781 Complaint #NJ00174420 Based on interviews, and record reviews, it was determined that the facility failed to provide pharmaceutical services by ensuring the resident did not receive a medication not ordered by the physician. The medication, metformin, (medication used to help lower blood sugar levels in people with type two diabetes- a chronic condition that happens when you have persistently high blood sugar levels) was given to Resident #395 without a valid physician order. The deficient practice was identified for one (1) of 28 residents, (Resident #395) reviewed for medication management. The deficient practice was evidenced by the following: Resident #395 was not in the facility; the surveyor conducted interviews and investigated the closed records. A review of the electronic health records (EHR) revealed the resident with a diagnosis of but not limited to diabetes mellitus II with hyperglycemia (a condition in which the level of glucose in the blood is higher than normal). According to the order summary in the EHR revealed orders for: tradjenta 5mg one tablet a day for diabetes; insulin glargine solution 100 unit/ml, inject 22 units subcutaneously at bedtime for diabetes; Humalog injection solution 100 unit/ml (Insulin Lispro) as per sliding scale and every 4 hours insulin check x 24 hours ordered on 6/1/24. The admission minimum data set (MDS), an assessment tool, dated 5/6/24 revealed a brief interview mental status (BIMS) score of 11 out of 15 indicating moderate impaired cognition. A review of the care plan revealed care plan for diabetes, diabetes medication as ordered by doctor. According to the nurse's progress notes, a registered nurse (RN) on 6/1/24 stated, Followed up for the report by the other nurse of administering the metformin 500 mg PO @ 17:18 PM. Resident's blood sugar was checked after taking the said medication & showed a result of 131 mg/dl, rechecked again 19:35 = 162 mg/dl & @ 21:32 is 177 mg/dl. Remains alert & oriented x3, claim he/she does not feel any side effects. Blood sugar is monitored every 4 hours. A review of the progress notes from 6/1/24 through 6/4/24 revealed resident had no negative outcome or issues of low blood sugar with the incident. The surveyor reviewed documentation titled, Employee Medication Error dated 6/3/24, which revealed on 6/1/24 an agency LPN #1 nurse accidentally administered metformin 500mg to resident in room [ROOM NUMBER]-D thinking it was resident in 14-W. The resident's spouse, assistant director of nursing (ADON) and medical doctor were notified. The physician ordered to monitor blood sugar every four hours for 24 hours and the resident had no negative outcomes. The nurse who admitted to giving the metformin to the wrong resident was educated and medication pass was completed on 6/3/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 11:00 AM, the surveyor interviewed the unit manager (UM) in the [NAME] Unit, LPN #2, who has been working in the facility for two years. The UM stated, The patient was pleasant, I don't recall having any complaints from the resident, he/she would be smiling. I was told that the patient was given the wrong medication. The process is to contact the doctor when there is a medication error, make the Director of Nursing (DON) aware, and follow doctor's orders. Inform emergency contact if patient is not alert and oriented. The nurse stated that she went into the wrong room thinking it was another room. The patient was monitored, checking the blood sugars a few times and no abnormalities found and patient remained stable. On 8/7/24 at 11:53 AM, the surveyor interviewed the DON, who started working in the facility since last February of 2024. The DON stated, The resident had no other complains or grievances. It was reported to me that the LPN #1 went to the room and gave the medication to the wrong patient. I think the nurse realized the wrong medication was given when she signed it on the medication administration record (MAR) and realized it was the wrong patient. She's a very good nurse. Upon coming here, the agency nurse usually gets an orientation packet. They must be med pass and we have a schedule for the med pass. The nurse did not have any previous infractions. The surveyor requested for the LPN's #1 medication pass and medication administration education on policies. On 8/7/24 at 12:30 PM, the DON provided the medication pass observation for LPN #1 which was completed before this incident on 9/11/23, with no issues. On 8/7/24 at 1:30 PM, in the presence of the survey team, the surveyor discussed the concern of metformin administration to the wrong resident, to the administration: License Nursing Home Administrator (LNHA), DON, Director of Clinical Services, MDS Regional, Regional Nurse, and Administrator in Training (AIT). No additional documentations were provided. On 8/8/24 at 9:26 AM, the DON provided the most current facility policy and procedure titled, Medication Administration and reviewed on 7/1/24. The policy stated, Ensure that the rights of medication administration are followed: right resident; right drug; right dosage; right route; and right time. NJAC 8:39-29.2(b), (d); 29.3(a)6

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45208 Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen equipment in a clean and sanitary manner as evidenced by the following: On 08/01/24 at 10:29 AM in the presence of the Food Service Director (FSD) and the Regional FSD (RFSD) the surveyor observed the following: 1. Inspection of the Microwave unit revealed the interior to have multi-colored splattered food debris stuck to the interior upper wall. 2. During inspection of the oven the surveyor observed 3 cast iron grill plates that were visibly used, dirty with solidified grease in the oven. The FSD stated they had been used the night before. On 08/05/24 at 10:15 AM, the surveyor interviewed the FSD. who stated that the cooking equipment should have been removed from the oven and cleaned after use. It needs to be cleaned and maintained in a sanitary way to prevent food borne illness and contamination. The microwave should be thoroughly cleaned daily in the evening. The FSD acknowledged that the above items should have been cleaned. On 08/05/24 10:30 AM, the surveyor interviewed the RFSD. who stated that the cooking equipment should have been cleaned and maintained in a sanitary way to prevent food borne illness and contamination according to regulations. It did not meet supervisory expectations, facility policy or regulations. A review of the facilities General Kitchen Cleaning Policy, dated revision February 2024, revealed . Policy: The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. A review of the facilities Food Borne Illness Policy, dated revision 1/2024, revealed . Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Definitions: Contamination means the unintended presence of potentially harmful substances including, but not limited to microorganisms, chemicals, or physical objects. Policy Explanation and Compliance Guidelines: 1) Food safety practices shall be followed throughout the facility's entire food handling process. Elements of the process include the following: c.) Preparation of food, including thawing, cooking, cooling, holding, and reheating. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6) All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. a) Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment. NJAC 8:39-17.2(g)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 34421 Based on interview, and review of other facility documentation, it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and apply for a change in name to include Doing Business As in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: (a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76 (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (continued on next page)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	(2) All other changes in enrollment must be reported within 90 days. A review of the facility Admission agreement revealed under the facility name section as Complete Care at Barn Hill Center. A review of the Census Report revealed the name of the facility as Complete Care at Barn Hill Center. The Business cards provided to the surveyors upon entrance reflected the facility name as Complete Care at Barn Hill. During an interview with the surveyor on 8/6/24 at 11:04 AM, an interview with Licensed Nursing Home Administration (LNHA) stated that the Facility is called Complete Care at Barn Hill and this is according to signage outside of the facility, it is also documented on the facility's policies and procedures and printed clinical documentation. The surveyor indicated that the above noted documents do not match the documentation according to CMS Novitas, dated October 2026, whcih revealed Legal Business Name (LBN): COMPLETE CARE AT BARN HILL LLC Doing Business As Name: BARN HILL CARE AND REHAB CENTER. The surveyor asked if the facility had filed a 855 B form and the LNHA explained that they have not done the 855B form and that they would need to do one to change the DBA name to Complete Care at Barn Hill. The LNHA was only able to provide the surveyor with a LSC-9 application for a long term care facility license which revealed DBA Barn Hill Care and Rehab Center. A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of April 1, 2024, and an expiration date of March 31, 2025 revealed under name licensed to operate Barn Hill Care and Rehab Center and not Complete Care at Barn Hill. NJAC 8:39-5.1 (a)