

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Abingdon Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  303 Rock Ave Green Brook, NJ 08812	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Abingdon Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  303 Rock Ave Green Brook, NJ 08812	
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Complaint #NJ184191/394091Based on, interviews, and record review, it was determined that the facility failed to administer medications according to the acceptable standards of nursing practice for 1 of 7 residents (Resident #5).This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem.According to the facility admission Record, Resident #5 was admitted to the facility with diagnoses which included: atherosclerosis of native arteries of other extremities with ulceration ( a condition where plaque buildup in the natural arteries of the limbs narrows the blood vessels, reducing blood flow and causing skin or tissue ulcerations due to a lack of oxygen and nutrients), muscle weakness, and type 2 diabetes mellitus (chronic condition where the body resists insulin or doesn't produce enough, leading to high blood sugar levels ) without complications.A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 09/11/25, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated an intact cognition.On 09/26/25 at 09:10 A.M., the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that his medication process consisted of verifying that he had the correct resident, then checking the order, and then signing out his medications for residents one by one. When questioned regarding if medications should be left at bedside, the LPN stated that it was a no-no to leave medications at bedside because the nurses would not know if the resident took their medications. The LPN further stated that nurses should stay with residents until the nurse could make sure the residents have taken their medications.On 09/26/25 at 10:43 A.M., the surveyor interviewed the Unit Manager (UM) who stated that she expected her staff to go into a resident's room, introduce themselves, verify they have the correct resident, and to check the medication orders. The UM further stated that she expected her nursing staff to inform and educate the residents on the medications being administered and that the nurse administering the medication should stay with the resident to make sure they swallow their medication. The UM also stated that meds should never be left at bedside, under no circumstances.On 09/26/25 at 11:44 A.M., the surveyor interviewed the Director or Nursing (DON) and Licensed Nursing Home Administrator (LNHA) together and they confirmed that LPN #2 left Resident #5's medication at bedside on 09/14/25.On 09/26/25 at 12:04 P.M., the surveyor interviewed LPN #2 who was the LPN who had left medications at bedside via phone call. LPN #2 stated she left medications at bedside on 09/14/25 while she was looking for Resident #5's eyedrops. She stated that the Assistant Director of Nursing (ADON) notified her that she had left medications unattended at bedside and educated her that medications should never be left at bedside.A review of the facility's policy titled Administering Medications, revealed under Policy Statement, Medications shall be administered in a safe and timely manner, and as prescribed.NJAC 8:39-29.2(d)</p>		