

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 04/23/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964</p> <p>Repeat Deficiency</p> <p>Based on observation and interview it was determined that the facility failed to maintain the facility in a clean and sanitary environment. This deficient practice was identified for 2 of 2 units, (Noble and [NAME]) and was evidenced by the following:</p> <p>1. On 04/14/25 at 10:27 AM, during initial tour of the Noble unit, the surveyor noted dark scuff marks in the hallway outside room [ROOM NUMBER]. Inside room [ROOM NUMBER], the surveyor observed the heater unit with a dark brown/reddish substance noted on the fins of the heater and brownish/blackish marks on the body of the heater unit. At 10:40 AM, the surveyor noted multiple cracked floor tiles in room [ROOM NUMBER]. At 10:49 AM, the surveyor observed the heater in room [ROOM NUMBER] with brown/black substances in fins of unit and on body of heater unit. The closet doors were noted to be off the track and bottom dresser drawer front was broken and askew. Also, in this room the surveyor noted a missing section of floor tile and cracks in the tile were noted under the bed.</p> <p>On 4/16/25 at 10:34 AM, the surveyor reviewed the work order report dated 4/15/25. Heaters in rooms [ROOM NUMBERS], cracked tiles in room [ROOM NUMBER], and cracked/missing tile in room [ROOM NUMBER] were not found on list.</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/25 at 12:41 PM, the surveyor interviewed the Director of Maintenance/Housekeeping/Laundry (DMHL). When asked about the floors on the Noble unit, specifically the scuff marks by room [ROOM NUMBER], the DMHL stated the floors are mopped daily and the scuff marks don't come up with mopping. He stated those marks were from bed swaps. When the surveyor asked about the heaters in rooms [ROOM NUMBERS], the DMHL stated they (heater units) all need to be painted. The DMHL further stated regarding the heater units, This is certainly not ok, they're on the list. When the surveyor asked about the closet doors and drawer front in room [ROOM NUMBER], he stated they are currently addressing the closet doors. The DMHL further explained that the closet doors are about forty years old and have exceeded their life expectancy. He went on to explain that the closet doors aren't an easy thing to fix, it's an involved process. When the surveyor asked about the missing tile on floor in room [ROOM NUMBER] and cracked tiles in room [ROOM NUMBER], he stated it's on the list. The surveyor mentioned that these items were not on the list he provided to the team, he stated he has other lists, in addition to the one provided to surveyors the day before. He then showed the surveyor his phone with a long list between himself and his assistant. The DMHL further explained that he stars the priorities and can move the items around as needed. He further explained that he just discovered a cache of tiles that matched the ones on the floors and that the work just needs to be scheduled to be done.</p> <p>On 4/17/25 at 11:25 AM, the surveyor observed the drawer front and closet doors were repaired. The scuff marks in Noble hallway outside room [ROOM NUMBER] are no longer present and area of lighter colored floor noted in that area.</p> <p>40042</p> <p>2. On 4/14/25 at 11:50 AM, the surveyor observed fluid leaking from the ceiling tiles in the hallway that leads to the main dining room on the first floor, in the presence of the Food Service Director (FSD). The FSD acknowledged the leak and stated the Noble unit was above this area and he thought there were leaking sinks on the unit. He further stated the new maintenance director was aware.</p> <p>On 4/15/25 at 10:00 AM, the surveyor observed the back wall inside the elevator. To the right of a frame there was a large circle-like area that had multiple layers of peeled paint. In addition, the interior wooden guard rails around the perimeter of the elevator were scratched and gouged.</p> <p>On 4/17/25 at 12:22 PM, the DMHL acknowledge the new pictures in the elevator were covering the peeled paint and stated, I have to do what I have to do.</p> <p>41858</p> <p>3. On 4/14/25 at 11:52 AM, during the initial tour of the [NAME] unit, the surveyor noted room [ROOM NUMBER] had missing floor tile under the sink and brown discolored ceiling tiles with a vent, that had a buildup of black debris, at the nurse's station.</p> <p>On 4/15/25 at 11:58 AM, the surveyor observe the corner end of the hand rail, between the [NAME] Nurse's station and the pantry, was missing and the corner piece of the lower portion of the column at the nurse's station was pulled away from the column and there was exposed white spackle and debris.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/15/25 at 12:00 PM, the surveyor interviewed the DMHL, who stated he did environment tours daily. He explained he does a visual inspection of each unit every day. He stated he looks up and down the walls of the units and stands in the doorway of every room looking for something out of place. He stated staff can enter maintenance requests directly into the maintenance computer system.</p> <p>At that time, the DMHL toured the [NAME] unit with the surveyor. He observed the missing floor tiles in room [ROOM NUMBER] and stated the tiles are [AGE] years old and I can't find matching tiles. He acknowledged the brown discolored ceiling tiles and the black debris on the vent at the nurse's station. He stated, there was a terrible leak here about 2 weeks ago and I did not replace tiles. He stated, the vent was not clean but they should be done quarterly when we do the filters.</p> <p>On 4/15/25 at 12:22 PM, the DMHL toured the Noble unit with the surveyor. He acknowledged the missing end cap of the hand rail at the nurse's station and stated they are [AGE] year old railings and it's difficult to find replacement pieces. He acknowledged the corner of the column at the nurse's station and stated, it's on my list.</p> <p>On 4/17/25 at 12:22 PM, the surveyor interviewed the Certified Nursing Aid (CNA #1), who stated he would try to fix things himself and if he couldn't fix it, he would call maintenance.</p> <p>On 4/17/25 at 12:28 PM, the surveyor interviewed CNA #2, who stated if she identified something was in disrepair, she would report it to the nurse or the supervisor.</p> <p>On 4/17/25 at 12:32 PM, the surveyor interviewed the Licensed Practical Nurse (LNP #1), who stated if something needed to be repaired she would enter it directly into the maintenance computer system and if maintenance didn't respond within 30 minutes, she would call them because they usually fixed things right away.</p> <p>34033</p> <p>4. On 4/15/25 at 8:00 AM, during the morning medication administration observation, the surveyor observed a brown stain on two (2) of the ceiling tiles that were to the right of the door when entering inside room [ROOM NUMBER]. The brown stains covered a majority of the tiles.</p> <p>On 4/15/25 at 8:06 AM, during the morning medication administration observation, the surveyor observed, a brown stain on one (1) ceiling tile above the doorway inside room [ROOM NUMBER]. The brown stain covered the majority of the tile.</p> <p>On 4/16/25 at 12:25 PM, the surveyor observed again, the same brown stained ceiling tiles, as described above, in room [ROOM NUMBER] and 233.</p> <p>On 4/17/25 at 12:22 PM, the DMHL acknowledged the brown stained ceiling tiles in room [ROOM NUMBER] and 233 and stated, I will add them to my list.</p> <p>On 4/22/25 at 4:26 PM the Licensed Nursing Home Administrator (LNHA), Corporate Clinical Officer (CCO), and Director of Nursing were notified of the above concerns. The LNHA stated the facility had a system of non-clinical rounds by the department heads and the DMHL does his own rounds as well. The CCO stated they (the management company) buys buildings that need to be spruced up and then manage or buy them and fix them up, but it takes time, not everything can be done at once.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48964</p> <p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to post the nurse staffing report daily. This deficient practice was evidenced by the following:</p> <p>On 4/14/25 at 9:31 AM, the surveyor did not observe the nursing staffing report posted at the front reception desk, the time clock, the elevator, or at either nursing unit. The receptionist was present at the front desk.</p> <p>On 4/15/25 at 9:31 AM, the surveyor did not observe the nursing staffing report posted at the front reception desk, the time clock, the elevator, or on the Noble nursing unit. The receptionist was present at the front desk.</p> <p>On 04/16/25 at 9:44 AM, the surveyor observed the nursing staffing report posted at the front desk dated 4/15/25 for the 7-3 shift.</p> <p>On 4/16/25 at 11:16 AM, the surveyor observed the nursing staffing report posted at the front desk dated 4/16/25 for the 7-3 shift.</p> <p>On 04/17/25 at 9:24 AM, the surveyor observed the nursing staffing report posted at the front desk dated 4/17/25 for the 7-3 shift.</p> <p>On 4/22/25 at 9:32 AM, the surveyor observed the nursing staffing report posted at the front desk dated 4/22/25 for the 7-3 shift.</p> <p>On 4/15/25 at 11:00 AM, the surveyor interviewed the staffing coordinator (SC), who stated staffing was usually posted at the front desk. She further stated I am responsible, I have been gone for 2 weeks. I just got back yesterday. Nobody posted the staffing while I was gone. The staffing was not posted yesterday or today, until I got it here. I just now printed it. I usually wait until after morning meeting to post it so it's accurate. I give it to the lady at the front desk but doesn't look like she did it.</p> <p>On 4/22/25 at 4:26 PM, the survey team met with the Director of Nursing (DON), who stated she was not sure who was responsible to post the nursing staffing report when the SC was away. She further stated maybe the receptionist was responsible.</p> <p>On 4/23/25 at 11:10 AM, the survey team met with the DON, who stated the staffing report was not posted on Monday (4/14/24).</p> <p>A review of undated facility provided policy Staffing Policy Statement included:</p> <p>Our facility provides adequate staffing to meet needed care and services for our resident population.</p> <p>Policy</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. Staffing will be posted in a visible location.</p> <p>NJAC 8:39-41.2 (a)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34033</p> <p>Based on observation, interview, record review, and facility documentation it was determined that the facility failed to: a.) maintain receipt, accountability, reconciliation, secure storage and removal from active inventory of controlled drugs, (Lorazepam (Ativan) (benzodiazepine Schedule IV), Fentanyl Patches (opioid Schedule II), Methadone (opioid Schedule II), Hydrocodone/Acetaminophen (opioid/analgesic Schedule II), and Morphine Sulfate (opioid Schedule II), for three (3) residents, (unsampled Residents #201, #203, #204) that were discharged [DATE], 5/7/24 and 9/6/24 respectively, until surveyor inquiry, stored in one (1) of two (2) medication rooms, b.) maintain accurate accountability, reconciliation and removal from active inventory upon discontinuation for controlled drugs, (Diazepam gel (benzodiazepine Schedule IV) and Nayzilam (Diazepam nasal spray), stored in the medication cart, for one (1) of four (4) medication carts from 2/2/25 and 3/3/23 respectively, until surveyor inquiry for one (1) resident (unsampled Resident #202) and c.) accurately document the disposition of a controlled drug (Buprenorphine (opioid Schedule III) patch) stored in one (1) of four (4) medication carts for one (1) resident, (unsampled Resident #34).</p> <p>The deficient practices were evidenced by the following:</p> <p>1. On 4/17/25 at 10:45 AM, the surveyor with a Licensed Practical Nurse (LPN #1) inspected the medications stored in the locked refrigerator on the Noble unit.</p> <p>At that time, the surveyor with LPN #1 observed a 30 milliliter (ML) opened bottle of Lorazepam (Ativan) solution 2 milligram (MG)/per ML labeled for Resident #201. The bottle had no date when opened and had approximately 20 ML remaining.</p> <p>On 4/17/25 at 10:47 AM, LPN #1 could not speak to the Ativan bottle for Resident #201 and referred to the Unit Manager/Registered Nurse (UM/RN). UM/RN stated that Resident #201 no longer resided in the facility and that the Ativan bottle should have been dated when opened and discarded 90 days after opening or when Resident #201 was discharged .</p> <p>At that time, UM/RN was unable to provide the Individual Patient Controlled Substance Administration Record (IPSCAR) for Resident #201 that corresponded with the Ativan bottle. The UM/RN acknowledged that without an IPSCAR, the Ativan was not being counted during the shift-to-shift count of controlled medications.</p> <p>On 4/17/25 at 11:05 AM, during further inspection of the medication room on the Noble unit, the surveyor, with UM/RN, observed in an unlocked cabinet, a clear plastic bag that contained the following controlled drugs labeled for Resident #204: three (3) unopened boxes of Fentanyl 50 microgram (MCG) patches (5 patches per box), one (1) opened box labeled Fentanyl 50 MCG patches contained three (3) patches (1 patch was 50 MCG and 2 patches were 100 MCG), two (2) unopened boxes of Fentanyl 100 MCG patches (5 patches per box), a bottle of 21 Hydromorphone 2 MG tablets, a bottle of 58 Hydromorphone 4 MG tablets, a bottle of two (2) Hydrocodone/Acetaminophen 5-325 MG tablets, a 20 ML bottle of Morphine Sulfate solution 100 MG/5 ML with approximately 19 ML remaining and 15 unopened and sealed bottles each with 6 ML of Methadone liquid 10 MG/ML.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In addition, in the clear plastic bag, labeled for Resident #203: a bottle of five (5) Alprazolam 0.5 MG tablets.</p> <p>At that time, the UM/RN stated that she had been the UM for approximately three (3) weeks and was unaware of the clear plastic bag with controlled drugs kept in the unlocked cabinet in the medication room. The UM/RN stated that all the controlled drugs should have been returned to the provider pharmacy or destroyed and that it was ridiculous.</p> <p>On 4/17/25 at 11:35 AM, the surveyor interviewed the Director of Nursing (DON) who stated she was DON for the past month and had not had any reports of discrepancies regarding controlled drugs. The DON also stated all the above controlled drugs in the bag should have been destroyed by the previous DON with another nurse. The DON acknowledged controlled drugs were not to be stored in the medication room in an unlocked cabinet and required double locked storage. The DON was unable to provide an IPCSAR for Resident #203 and #204 corresponding to each controlled drug in the bag and stated she would have to check. The DON acknowledged the controlled drugs in the bag were not being accounted for during the shift-to-shift count of controlled medications. The DON stated she was unaware of the controlled drugs in the cabinet and would have to begin an investigation.</p> <p>On 4/17/25 at 1:25 PM, the surveyor interviewed LPN #2 who had completed the admission records for Resident #204. LPN #2 looked at the controlled drugs labeled for Resident #204 in the bag and stated that she could not remember the resident coming to the facility with the medications in the bag.</p> <p>On 4/17/25 at 1:45 PM, the surveyor interviewed the DON who provided the surveyor with an IPCSAR labeled for Ativan 2 MG/ML for Resident #201. The surveyor with the DON reviewed the IPCSAR which revealed that 30 ML of Ativan was received on 6/26/24 and a declining inventory was documented from 6/26/24 until 7/3/24. The remaining balance was 20.5 ML of Ativan on 7/3/24. Further review of the IPCSAR, revealed the date of disposition was 10/4/24 and signed by the former DON and former ADON. The DON verified the IPCSAR inaccurately documented the Ativan remaining amount of 20.5 ML was destroyed on 10/4/24.</p> <p>A review of the Admission Record (AR) for Resident #201 revealed that the resident had expired at the facility on 7/3/24.</p> <p>The DON was unable to provide documentation or an IPCSAR that would indicate receipt, accountability and reconciliation of the above listed controlled drugs that were contained in the clear plastic bag.</p> <p>A review of the AR for Resident #204 revealed that the resident had expired at the facility on 9/6/24.</p> <p>A review of the AR for Resident #203 revealed that the resident was discharged from the facility on 5/7/24.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/17/25 at 2:06 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Corporate Clinical Officer (CCO) and DON. The CCO stated the UM/RN was new to the facility and would not have knowledge of the controlled drugs found in the medication room. The CCO acknowledged that the medication room should have been checked for proper storage. The DON stated that a unit inspection was performed monthly by the Consultant Pharmacist (CP) and reviewed those reports. The DON acknowledged that controlled drugs should not have been stored in the medication room in an unlocked cabinet and accurate records were supposed to be maintained.</p> <p>A review of CP Unit Inspection reports from May 2024 to March 2025 had not identified the above findings.</p> <p>On 4/22/25 at 8:49 AM, the surveyor interviewed the CP via telephone. The CP stated that she was not the CP who had completed the unit inspection reports but was able to speak to any questions. The CP explained that medication room cabinets and medication refrigerators were checked as part of the unit inspection and any concerns identified would be listed on the reports. In addition, the CP stated controlled drug accountability and reconciliation was spot checked once a month, meaning on the day of the inspection at that moment the controlled drugs were reviewed. The CP added that she may not have the knowledge of residents who had been discharged but if the medication was expired would bring that to the attention of nursing right away. The CP could not speak to what happens after bringing expired medications or medications that needed to be disposed of to nursing. The CP also added that the current DON was more receptive to the reports than the previous DON.</p> <p>On 4/22/25 at 9:56 AM, the survey team met with LNHA, CCO, Assistant Administrator (AA) and DON. The DON stated the controlled drugs for Resident #204 that were in the bag were brought in the facility by the family and there was a nursing progress note indicating that the family was called to pick up the controlled drugs after Resident #204 expired. The DON also stated that usually medications from home would not be accepted and was unable to verify when the controlled drugs were accepted in September 2024. The DON acknowledged there was no system of receipt, accountability and reconciliation that had been done. The DON could not speak to why the Ativan bottle for Resident #201 was not removed from active inventory when there was no corresponding IPSCAR on the unit and the opened bottle had no open date and was expired. The DON also could not speak to why there were no records for the bottle of five (5) Alprazolam 0.5 MG tablets for Resident #203. CCO added that the nurses were inserviced by the DON and the controlled drugs that needed to be destroyed were documented.</p> <p>A review of the facility undated policy titled Storage of Medications provided by the CCO/RN reflected Controlled Substances will be stored in a separate container under double lock.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility policy titled Controlled Substances updated 8/22/24 provided by CCO reflected the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled substances. In addition, Controlled substances will be counted upon delivery. The nurse receiving the order, along with the person delivering the medication order, will count the controlled substances together. Both individuals will sign the designated narcotic record for the pharmacy records. Also, Accurate accountability of the inventory of all controlled substances is maintained. Nursing staff will count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty will complete the count together. They must document and report any discrepancies to the Director of Nursing Services. Further review reflected, When a resident or patient is transferred or discharged , controlled substances may not be given to the resident to take with them and may not be returned to the pharmacy, but must be destroyed in accordance with established policies.</p> <p>A review of the manufacturer specifications for Lorazepam (Ativan) Intensol Oral Concentrate 2 MG/ML reflected that the Ativan solution be stored in the refrigerator and Discard opened bottle after 90 days.</p> <p>2. On 4/17/25 at 11:33 AM, the surveyor with LPN #1 inspected the controlled drugs on the medication cart for Resident #202, which revealed an IPCSAR labeled for Resident #202 for Nayzilam spray 5 MG, two (2) solutions and indicated that the remaining balance was one (1). LPN #1 was unable to show the surveyor the remaining one (1) Nayzilam spray. LPN #1 thought there was only one (1) sent by the provider pharmacy. LPN #1 verified that her signature was on the IPCSAR as receiving the drug but had not signed the date received or amount received but the provider pharmacy label indicated two (2) solutions, the number two (2) was circled and there was a Nurse Administering signature for the number (2) indicating removal of one (1) and remaining balance of one (1). LPN #1 stated that she had not reported any discrepancies regarding controlled drugs for the medication cart. LPN #1 verified that she had signed the Resident Controlled Substance Accountability Log for the Incoming Nurse for 4/17/25 for the 7 AM to 3 PM shift with another nurse who signed the Outgoing Nurse and neither had a discrepancy.</p> <p>Further review of controlled drugs for Resident #202 revealed two (2) IPCSAR for Diazepam gel 20 MG as indicated:</p> <ul style="list-style-type: none"> -IPCSAR #1 with a prescription (RX) number ending in 244 dated as received 8/19/24 with an amount received of two (2) indicated that the remaining balance was one (1). The surveyor with LPN #1 observed two (2) Diazepam gel 20 MG rectal dispensers labeled for Resident #202 with corresponding RX number ending in 244. - IPCSAR #2 with RX number ending in 149 dated as received 10/5/24 with an amount received of two (2) indicated that the remaining balance was (2). The surveyor with LPN #1 observed one (1) Diazepam gel 20 MG rectal dispenser labeled for Resident #202 with corresponding RX number ending in 149. In addition, there was a partially torn paper wrapped around the dispenser titled Return (discontinued crossed out) Medication Form dated 10/15/24. LPN #1 stated she was not sure why the form was there but thought the medication was to be returned to the provider pharmacy. <p>At that time, LPN #1 verified IPCSAR#1 and IPCSAR#2 were not accurately corresponding to the remaining balances. LPN #1 also verified that the nurses should be corresponding the RX numbers of the controlled drug to the IPCSAR.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/17/25 at 11:35 AM, the surveyor interviewed the DON who stated she was the DON for the past month and had not had any reports of discrepancies regarding controlled drugs.</p> <p>On 4/17/25 at 11:42 AM, the surveyor interviewed the DON and UM/RN regarding the IPSCAR labeled for Resident #202 for Nayzilam spray with a remaining balance of one (1). The DON stated Resident #202 was admitted to the hospital last night and would have to look for the Nayzilam spray if two sprays were received. DON acknowledged that the Diazepam gel IPSCAR #1 and IPSCAR #2 were inaccurate and that the nurses were to check the corresponding RX numbers. The DON was unable to speak to the paper tilted Return Medication Form. The DON added that controlled drugs were not returned to the pharmacy.</p> <p>On 4/17/25 at 2:06 PM, survey team met with LNHA, CCO and DON. DON acknowledged that the IPSCAR for Nayzilam spray should be completed for received date and amount received. The CCO stated that they were reviewing the shift to shift Resident Controlled Substance Accountability Log that the nurses signed when counting controlled drugs and had identified that the form was not being completed properly and needed to be changed.</p> <p>On 4/22/25 at 8:49 AM, the surveyor interviewed the CP via telephone. CP stated that she was not the CP who had completed the unit inspection reports but was able to speak to any questions. The CP explained that medication room cabinets and medication refrigerators were checked as part of the unit inspection and any concerns identified would be listed on the reports. In addition, the CP stated controlled drug accountability, and reconciliation was spot checked once a month, meaning on the day of the inspection at that moment the controlled drugs were reviewed. The CP added that she may not have the knowledge of residents who had been discharged but if the medication was expired would bring that to the attention of nursing right away. The CP could not speak to what happens after bringing expired medications or medications that needed to be disposed of to nursing. The CP also added that the current DON was more receptive to the reports than the previous DON. The CP also stated that the RX number for the IPSCAR must match the controlled drug count for accuracy.</p> <p>A review of CP Unit Inspections from May 2024 to March 2025 had not identified the above findings.</p> <p>On 4/22/25 at 9:56 AM, the survey team met with LNHA, CCO, AA and DON. CCO stated that Nayzilam spray for Resident #202 was not found because the night nurse had discarded the Nayzilam spray without documentation and was unsure what had happened. CCO added that the nurse was written up. CCO acknowledged that destruction of controlled drugs was to be documented on the IPSCAR. CCO stated Diazepam gel should not have had a form for return because controlled drugs were not returned to the pharmacy. CCO added that the nurses were inserviced by the DON and the controlled drugs that needed to be destroyed were documented.</p> <p>A review of the physician's orders for Resident #202 revealed that Nayzilam was discontinued on 3/3/23.</p> <p>On 4/22/25 at 11:52 AM, the surveyor interviewed a Pharmacist (RP) representative from the provider pharmacy via telephone. The RP stated that Nayzilam spray was dispensed for Resident #202 on 12/6/22 in a box containing two (2) sprays. The RP was unable to identify an expiration date on the nasal sprays dispensed at that time.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/22/25 at 1:19 PM, the surveyor interviewed LPN #3 who stated that she had worked last week 11 PM to 7 AM and on the morning of 4/15/25 she was cleaning out the medication cart for any expired medications. LPN #3 added that when she counted the controlled drug inventory with LPN #1 she had noticed that the Nayzilam spray was expired and remembered removing the spray and carrying other expired medications with her to go to the computer to reorder the Nayzilam spray where she realized there was no current physician's order. LPN #3 then stated that she thinks she accidentally discarded the Nayzilam spray with the other medications that she had removed from the medication cart. I made a stupid mistake.</p> <p>On 4/22/25 at 4:27 PM, the survey team met with LNHA, CCO, AA and DON. The CCO stated Resident #202 was in the hospital currently and the Diazepam gels were destroyed and documented. The CCO added that she would check regarding the physician's order dating for the Diazepam gel.</p> <p>A review of the physician's orders for Resident #202 revealed Diazepam gel was discontinued 2/2/25.</p> <p>A review of the IPCSAR #1 and IPCSAR #2 labeled for Resident #202 for the Diazepam gels provided by the DON indicated that the DON and UM/RN had destroyed the Diazepam gel dispensers on 4/17/25.</p> <p>On 4/23/25 at 11:14 AM, the survey team met with LNHA, CCO, AA and DON. CCO stated with UM/RN in place now, if a resident was discharged all medications would be removed. The DON added that it was the responsibility of the nurses to remove from active inventory any medications for discharged residents or for any discontinued physician's orders.</p> <p>A review of the facility policy titled Controlled Substances updated 8/22/24 provided by CCO reflected the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled substances. In addition, Controlled substances will be counted upon delivery. The nurse receiving the order, along with the person delivering the medication order, will count the controlled substances together. Both individuals will sign the designated narcotic record for the pharmacy records. Also, Accurate accountability of the inventory of all controlled substances is maintained. Nursing staff will count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty will complete the count together. They must document and report any discrepancies to the Director of Nursing Services. Further review reflected, When a resident or patient is transferred or discharged , controlled substances may not be given to the resident to take with them and may not be returned to the pharmacy, but must be destroyed in accordance with established policies.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 4/17/25 at 11:24 AM, the surveyor with LPN #2 inspected the controlled drugs in the medication cart for Resident #34 which revealed a Controlled Substance Administration Record for Patches (CSARP) labeled for Buprenorphine (Butrans) Patch 10 MCG/hour dated as received 4/15/25 with the amount received as three (3) patches. Further review, revealed that at 10:41 AM on 4/17/25 LPN #2 signed on line three (3) indicating the patch was removed from inventory and applied. In addition, on the same date and time the patch the LPN #2 signed for was removed and wasted. LPN #2 stated she had first removed an old Butrans patch from last week and put the new patch on Resident #34. LPN #2 added she had just started the new CSARP and showed the surveyor the remaining balance of (2) patches in the medication cart. The surveyor, with LPN #2, reviewed the current physician's order which indicated a start date of 3/20/25 for Butrans Transdermal Patch Weekly 10 MCG/HR (Buprenorphine) Apply 1 patch transdermally one time a day every Thu (Thursday) for pain management. LPN #3 acknowledged the patch she had applied today, 4/17/25, would be removed and wasted next Thursday. LPN #2 acknowledged that the documentation on CSARP indicated the same patch she applied had been removed and discarded today. LPN #2 stated she would have to review with DON. In addition, LPN #2 stated she had wasted the old patch that she removed from the resident and showed LPN #1, but that LPN #1 had not signed the CSARP yet. LPN #2 acknowledged that when the patch was wasted both signatures were needed.</p> <p>On 4/17/25 at 11:42 AM, the surveyor interviewed the DON and UM/RN regarding the CSARP labeled for Resident #34 for Butrans patch. The DON stated there should be two nurses' signature for the wastage of the controlled drug. DON acknowledged that the CSARP had not reflected the application and removal properly and would have to look into it.</p> <p>On 4/17/25 at 2:06 PM, the survey team met with LNHA, CCO and DON. The DON stated that she would have to review and /or change the process of the controlled drug patch wastage signatures.</p> <p>On 4/22/25 at 9:56 AM, the survey team met with LNHA, CCO, AA and DON. The CCO stated LPN #2 had signed for the removal of the Butrans patch but had not wasted the patch and was holding the patch in a cup in the medication cart until LPN #1 was available to destroy the patch. The CCO added the regulation, and our policy requires signing at the time of destruction. The CCO was unable to speak to the interview with the surveyor and LPN #2 at the medication cart. The CCO stated LPN #2 was on vacation now. The CCO also stated the corresponding IPSCAR for the old Butrans patch that was removed by LPN #2 was not in the controlled drug binder at the time LPN #2 removed the patch to waste. The CCO added that the nurses were inserviced by the DON.</p> <p>On 4/22/25 at 10:41 AM, the CCO stated that the policy for documenting the destruction of a controlled drug patch was reflected in the policy titled Controlled Substances updated 8/22/24 7. When a resident refuses a non-unit dose medication or it is not given, or receives partial tablets or single dose ampules, or it is not given, the medication shall be destroyed with two witnesses and may not be returned to the container.</p> <p>NJAC 8:39- 29.4(g), 29.4(i), 29.4(k), 29.7(c)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>40042</p> <p>Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) the facility's Registered Dietitian (RD) reviewed and approved the four week cycle menus for nutritional adequacy in accordance with nationally accredited standards and the facility provided Diet Manual, b.) residents consistently received the standard serving of the main entree/protein (16 out of 56 lunch and dinner meals were inadequate) or an alternate item (2 out of 9 were inadequate) for high biological value protein (proteins of high biological value, also known as complete proteins, are those that contain all the essential amino acids in the appropriate proportions that the body needs to carry out its functions optimally), c.) alternate menu items were available as posted, and d.) that a resident (Resident #54) consistently received breakfast meat daily as requested as well as receive a nutritionally equivalent protein food as a menu substitute from the facility Always Available List (a list of foods available for lunch and dinner besides the menu choice for that day). This deficient practice was also identified by 7 out of 7 residents that attended the Resident Council Meeting on 4/15/25.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 4/14/25 at 10:05 AM, the surveyor conducted an initial kitchen tour with the Food Service Director (FSD). The surveyor observed an empty metal rack to the right of the kitchen entrance which the FSD identified as a bread rack. The surveyor observed a few cardboard boxes with bread. The FSD stated it was delivered that morning and that they received bread deliveries every three days. He further stated, we have to stay in budget.</p> <p>Towards the end of this tour, the FSD stated that they followed a four-week cycle menu, and they were currently on cycle 4. He provided the surveyor with a copy of these menus on 4/14/25 at 11:36 AM. There was one meal option offered for lunch and dinner. At that same time, the FSD provided an Always Available Items (only for lunch and dinner) list which included Chicken, Hamburger, Hot Dog, Tuna Sandwich, Ham and Cheese Sandwich, Turkey and Cheese Sandwich, Peanut Butter and Jelly Sandwich, Egg Salad Sandwich, Fruit Cup, Fresh Fruit (Apple, Orange, Banana), Garden Salad, Tuna Platter, and Grilled Cheese.</p> <p>On 4/14/25 at 10:20 AM, the surveyor conducted an entrance conference with the Director of Nursing (DON) and the Corporate Clinical Officer (CCO). They stated the facility census was 99 residents.</p> <p>On 4/14/25 at 11:39 AM, the surveyor interviewed Resident #54. The resident stated that they were unable to choose their meals and if they called for something else, the kitchen staff would tell them that one hot dog was available.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/15/25 at 10:17 AM, the surveyor conducted a group meeting with seven residents. 7 out of 7 residents had the following concerns; there were limited food choices, the quality of the food was poor, always available items were not consistently available, sandwiches were available if there was bread, the kitchen never have buns for hamburgers or hot dogs, they can't order something if it's not on the menu, the fish patty had very little fish, the chicken patty was all breading, the burgers tasted like they had fillers and were not real meat, and when spaghetti and meatballs were served they received three meatballs which was not enough and did not taste like real beef.</p> <p>On 4/16/25 at 9:13 AM, the surveyor interviewed Resident #54, who stated they had spoken to the Registered Dietitian (RD) to request a serving of a breakfast meat each morning. The resident stated they did not always receive breakfast meats daily.</p> <p>On 4/16/25 at 12:14 PM, the surveyor interviewed Resident #54 who stated there was only one menu choice and even if you requested an alternate item, it was not always available.</p> <p>On 4/16/25 at 12:36 PM, the surveyor observed Resident #54 in their room who stated they received chili but did not want that and the nurse ordered hotdogs as a substitute.</p> <p>On 4/16/25 at 1:01 PM, the surveyor observed one hotdog in a bun brought up by kitchen staff on a plate for Resident #54.</p> <p>On 4/22/25 at 1:15 PM, the surveyor observed a food service staff member deliver two hot dogs on bread (not hotdog buns) to a resident on the Noble unit.</p> <p>On 4/22/25 at 10:24 AM, the surveyor interviewed the FSD who stated he did not have a diet manual, and that the RD may have one. He stated that he thought his Regional FSD and the Regional RD developed and reviewed the menus, but he could not really speak the process.</p> <p>On 4/22/25 at 5:17 PM, the CCO stated that the menus were developed as a team and the Regional RD approved the menus for adequacy. At this same time the FSD entered the conference room and provided the surveyor with the last three months' worth of food purchase invoices.</p> <p>On 4/22/25 at 1:01 PM, the surveyor conducted an additional kitchen tour in the presence of a second surveyor. The FSD acknowledged that the facility did not provide residents with a selective menu. He stated the facility made macaroni and cheese from scratch, and they used 2-5 pound (lb.) bags of cheddar cheese to prepare the cheese sauce. He stated that when they served manicotti on the menu, they provided two per serving and they provided four to five ravioli per serving when on the menu. The FSD also acknowledged that on Tuesday mornings they may not have breakfast meats available for resident who requested it daily. He stated that they are light on meat at times because meat deliveries were on Tuesdays.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During this kitchen tour the surveyors reviewed some items on the Always Available list as well as other menu items for nutritional adequacy. There was a box of frozen hamburgers and a box of frozen manicotti (60 per box) that did not have nutritional information nor ingredients listed on the box. There were [name redacted] hotdogs and the nutritional information on the package indicated one hotdog provided 6 gms of protein. The FSD stated that if a resident wanted hotdogs to replace a meal, they would have provided two. He acknowledged 6 gms of protein would not have been adequate and that a minimum of 3 ounces (oz.) of protein should be provided at the lunch and dinner meals. He further acknowledged that 3 oz. of protein was equivalent to 21 gms. The FSD also acknowledged that food items that provided less than that would not be an adequate serving of protein as a main meal or alternate/substitute. There was a plastic 5 lb. sleeve of sliced cheese which had the nutritional information on the package and indicated two slices of cheese provided 4 gms of protein. The FSD stated that when the kitchen prepared cheese sandwiches or grilled cheese, two slices of cheese were used. There were frozen chicken patties and the nutritional information on the box indicated that one patty provided 11 gms of protein. The FSD stated that one patty was served per meal and acknowledged that was an inadequate amount of protein. A few other menu items in question regarding protein content per serving were the breaded fish, meatballs, manicotti and ravioli, which were not available for review. The surveyor requested the FSD for the nutritional information. The surveyor observed that the bread rack did not have hot dog or hamburger buns. The FSD acknowledged the same and stated he would give a slice of bread instead and that a delivery would arrive tomorrow.</p> <p>On 4/22/25 at 2:40 PM, the surveyor interviewed the RD. She stated that the menus were developed by the Regional FSD and that she and the FSD also reviewed them and collectively they approved the menus for nutritional adequacy. She stated she would provide the surveyor with the Diet Manual for review. She stated that she was aware there were no selective menus and that residents could choose from the Always Available list. The RD stated she was unaware of concerns about always available items not being available as well as bread and buns. She could not speak to who ensured food products were nutritionally adequate. She acknowledged that 3 oz. or 21 gms of protein should be provided for lunch and dinner. She acknowledged that one hotdog which provided 6 gms of protein was not an adequate substitution.</p> <p>On 4/22/25 at 2:35 PM, the FSD provided the surveyor with copies of the nutritional information for the frozen manicotti, breaded fish and ravioli.</p> <p>On 4/22/25 at 5:30 PM, the CCO provided the surveyor with a copy of an undated [name redacted] Dietary Manual and a [name redacted] Cycle Menu Recipe Book.</p> <p>On 4/23/25 at 10:47 PM, the surveyor interviewed the FSD in the presence of the Regional FSD. The FSD stated that when they make pizza for the residents, they used nine-inch round pie crusts and 12-13 lbs. of mozzarella cheese. He acknowledged that if a resident ordered a substitute it was required to be nutritionally equivalent and that some prepared products that were used did not meet protein requirements. He also acknowledged that recipes provided to the surveyor, as an example Breaded Baked Fish, was for a scratch recipe (which was not used) and only had instructions for a one serving recipe and indicated that the fish ingredient would be a four oz. portion of cod fillet (which would have provided 28 gms of protein).</p> <p>On 4/23/25 at 1:04 PM, the Regional FSD provided the surveyor with a copy of cycle 1 and 2 of the menus signed and undated by the facility RD.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/23/25 at 1:21 PM, the surveyor interviewed the RD and Regional FSD in the presence of the survey team. The RD stated, she signed cycle 1 and 2 within the last week (but could not speak to date) and that her signature attested to the fact that cycle 1 and 2 were nutritionally adequate. Both stated that they were still working on cycle 3 and 4. The RD stated she could not attest to whether or not they were nutritionally adequate. They acknowledged that a 3 oz. portion of protein equaled 21 gms of protein. They acknowledged the surveyor had previously discussed examples of menu items did not meet nutritional requirements for protein. The RD stated the menus were nutritionally adequate for protein.</p> <p>The Always Available list provided hotdog and grilled cheese; already established to have inadequate protein per serving during survey which yielded 6 and 4 gms of protein, respectively.</p> <p>During interviews with the FSD, he stated that he used 10 lbs. of cheddar cheese to make macaroni and cheese for the building (99 residents/census). That would yield approximately 12 gms of protein per person. He also stated that when cheese pizza was prepared, he used 12-13 lbs. of mozzarella cheese for the building. If 13 lbs. were used, that would yield approximately 15 gms of protein per person.</p> <p>A review of the food purchase invoices the FSD provided reflected that on 3/20/25, the facility received 3 cases of frozen manicotti. There were 60 manicotti per case which yielded 180 pieces. That would provide 1.8 manicotti per person. The nutritional information provided to the surveyor indicated that 1 manicotti provided 7 gms of protein. Therefore approximately 2 manicotti provided 14 gms of protein per person.</p> <p>A review of a food purchase invoice dated 3/27/25, reflected the facility received 3 cases of frozen medium cheese ravioli. The invoice indicated the brand [redacted] and that there were 200 ravioli per case. The FSD provided the surveyor with nutritional information for a different brand [name reacted] and there were 100 ravioli per case and were Jumbo verse the invoice Med (medium). Investigation for the brand [name redacted] ravioli indicated on the invoice, would have provided 9.1 gms of protein per 1 cup portion of those ravioli, which was the portion size indicated on the cycle menus.</p> <p>A review of the food purchase invoice dated 4/1/25, reflected the facility received 3 cases of 1 oz meatballs from brand [name redacted]. Investigation for the brand [name redacted] meatballs revealed 12 gms of protein would have been provided if 3 meatballs were served, which was the portion size indicated on the cycle menus as well as verbalized by residents in the Resident Council Meeting.</p> <p>A review of the nutritional information for the Breaded Fish provided by the FSD, indicated a 4 oz. portion (1 piece) provided 14 gms of protein.</p> <p>A review of the facility's Week-At-A-Glance [name redacted] Spring/Summer 2025 four-week cycle menus reflected the following items served 16 meals out of 56 provided an inadequate amount of protein:</p> <p>Week 1</p> <p>Monday Lunch Cheese Pizza (15 gms)</p> <p>Dinner Breaded Baked Fish (14 gms)</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Tuesday Dinner Chicken Patty on a Bun (11 gms)</p> <p>Thursday Dinner Manicotti (14 gms)</p> <p>Friday Dinner 1 All Beef Hot Dog on a Bun (6 gms)</p> <p>Week 2</p> <p>Wednesday Lunch Baked Macaroni and Cheese (12 gms)</p> <p>Thursday Dinner Manicotti (14 gms)</p> <p>Week 3</p> <p>Sunday Dinner Cheese Ravioli (9.1 gms)</p> <p>Monday Lunch Breaded Baked Fish (14 gms)</p> <p>Dinner Macaroni and Cheese (12 gms)</p> <p>Friday Dinner Cheese Ravioli (9.1 gms)</p> <p>Week 4</p> <p>Sunday Dinner Spaghetti with Meatballs (12 gms)</p> <p>Monday Lunch Breaded Baked Fish (14 gms)</p> <p>Dinner Cheese Pizza (15 gms)</p> <p>Wednesday Lunch 1 All Beef Hot Dog on a Bun (6 gms)</p> <p>Friday Lunch Cheese Pizza (15 gms)</p> <p>A review of the Dietary Manual [name redacted] provided by the facility, included the Regular diet portion sizes for protein at lunch and dinner should be 3 oz.</p> <p>In addition, the section titled Quality of Life reflected, The obligation of Nutrition Professionals is to ensure and enhance the quality of life for each resident in the nursing facility by providing appropriate nutrition care and by recognizing and honoring the individuality of each person.</p> <p>The section titled Resident Rights and Responsibilities included the following rights:</p> <p>To make choices about where, when and what to eat.</p> <p>To be served attractive, well-seasoned food in portions acceptable.</p> <p>To be offered substitutes of similar nutritive value when food served is refused.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>NJAC 8:39-17.1 (b), 17.4 (a) (1) (3) (c) (e)</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40042</p> <p>Based on interviews, and review of pertinent facility documents, it was determined that the facility failed to serve and document residents received a nourishing snack in the evening when there was more than a 14-hour span between dinner and breakfast mealtimes. This deficient practice was identified for 6 of 7 alert and oriented residents (Resident's #4, #22, #53, #58, #70, and #81) during the resident council meeting and was evidenced by the following:</p> <p>On 4/14/25 at 10:05 AM, the surveyor conducted a kitchen tour with the Food Service Director (FSD). At the end of the initial tour, the surveyor requested a copy of residents who received labeled snacks, as well as a list of snacks that were sent to the units in the evening to be distributed after dinner. The FSD stated, we really don't send HS (evening) snacks, there was no list. He further stated, we send labeled snacks and if another resident wanted something before the kitchen closed, we would provide it; and if a resident wanted something later there was a key at the front desk, and a supervisor could get a snack.</p> <p>On 4/15/25 at 9:00 AM, the surveyor reviewed an undated Mealtime and Delivery Schedule, which the facility provided to the survey team. There was more than a 14-hour span between dinner and breakfast service.</p> <p>On 4/15/25 at 10:17 AM, the surveyor conducted a resident council meeting with 7 residents invited by the President of Resident Council. 6 of 7 residents had a Brief Interview for Mental Status of 15 out of 15, which indicated their cognition was intact.</p> <p>On 4/15/25 at 10:57 AM, 7 of 7 residents stated that labeled HS snacks were put on the nursing station or in the pantry after dinner. They stated that Certified Nurse's Aides (CNA) were supposed to give out labeled snacks, which was done inconsistently. They agreed that when the snacks were left on the nurse's station, other residents would take the snacks. They agreed that there were no extra items delivered or available to provide to residents without a labeled snack.</p> <p>On 4/22/25 at 9:36 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 on the [NAME] Unit. They both stated that there was no accountability system in place to account for the provision of HS snacks to residents in the electronic medical record (EMR) or on paper.</p> <p>On 4/22/25 at 9:50 AM, the surveyor interviewed RN #2, who was the Unit Manager for both the [NAME] and Noble Units. She stated that some residents received labeled snacks, however there was no accountability system to record the provision of HS snacks to residents. She stated residents should be provided HS snacks and if they refused, it should be documented.</p> <p>On 4/22/25 at 10:24 AM, the surveyor interviewed the FSD. He stated that there should be no more than a 10-12-hour span between dinner and breakfast service. He could not speak to further requirements if the span of time was greater.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/22/25 at 12:43 PM, the Corporate Clinical Officer, stated in presence of survey team, that the facility would be installing kiosks (an electronic accountability system which would provide CNAs the ability to record the provision of HS snacks to residents) for CNAs. At that time, she could not speak to whether or not there was an accountability system on paper.</p> <p>On 4/22/25 at 2:40 PM, the surveyor interviewed the Registered Dietitian (RD). She stated that if there was more than a 14-hour span between dinner and breakfast service, the residents should be provided with a nutritious snack like a half of a sandwich. The RD stated there should be accountability; however, she stated there was no accountability in the EMR and she did not think there was accountability on a paper system.</p> <p>A review of the minutes from Resident Council Meetings dated 1/30/25, 2/26/25 and 3/27/25, all included [name redacted], and other residents reported CNAs do not distribute the snacks when the kitchen brings up the snacks.</p> <p>The facility was unable to provide policy's related to mealtimes and HS snacks.</p> <p>NJAC 8:39-17.2 (f) (1) (i) (ii)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40042</p> <p>Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, and b.) failed to maintain the kitchen equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following:</p> <p>On 4/14/25 at 10:05 AM, the surveyor toured the kitchen with the Food Service Director (FSD). The following was observed:</p> <ol style="list-style-type: none"> 1. Inside the ice machine there was a reddish like substance on the bottom of the white baffle (a flow-directing panel that restrained ice), as well as both sides of the interior walls of the ice machine near screws. The FSD took a clean towel and wiped both areas. The discoloration was removable and the FSD acknowledged that it needed to be cleaned. 2. There was a two door reach in refrigerator in which the FSD stated was for the cooks. The surveyor observed built up debris on the inside and gasket of the left door as well as the bottom of the unit. The FSD acknowledged the debris and stated, It's Monday. 3. There was a large exhaust fan near two prep sinks, which had a heavy buildup a fuzzy grey/brown debris. The FSD acknowledged the debris and stated that maintenance needed to clean it. 4. There were two prep sinks which had a broken handle plastic spatula on the bottom of the right sink. The top of the spatula was discolored and disfigured. The FSD acknowledged it was broken and the front was melted and should not be used. In addition, there was a soiled rag with debris draped over the divider between the two sinks. The FSD acknowledged it was soiled and should not have been there. 5. There was a metal covering to a grease trap on the floor, which had a heavy buildup of a black sticky-like substance, which the FSD acknowledged. 6. There were two green, one blue and one yellow cutting boards observed on a clean dry equipment rack which had gouging. The FSD acknowledged the same and stated they should be changed since gouging was where bacteria can collect and could cause cross contamination. 7. The bottom of the spice rack had built up debris. The FSD stated the rack was old and would, take a long time to clean. 8. There was a soiled mop head on the floor near the right side of a griddle. The FSD stated the griddle leaked grease and they keep the mop head there, so we don't fall or slip. 9. There was a plastic scoop stored inside the flour bin, the handle was in direct contact with the flour. The FSD stated it should not be stored inside the bin. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>10. The base of the can opener had a buildup of a black sticky substance. The FSD acknowledged the buildup and stated, it needed to be cleaned.</p> <p>11. Three wells of a four well steam table, had a heavy buildup of brown debris on the bottom. On top of each the four wells were stainless steel folding covers which had a reddish/brown built up substance. The FSD stated they were old, and that it would take a long time to clean.</p> <p>12. In the first walk-in refrigerator, the surveyor observed a case of raw eggs stored above a case of liquid pasteurized eggs. The FSD stated that the raw eggs were pasteurized yet was unable to show where that was indicated on the case.</p> <p>13. In the second walk-in refrigerator, the surveyor observed 3 metal shelves that had a buildup of black debris. The FSD wiped the shelving with a clean wet pink and wipe cloth towel. The debris was removable and the FSD acknowledged it needed to be cleaned.</p> <p>14. The towel dispenser above the hand washing sink was broken and empty. The towel ring was exposed and placed on the metal post of the spice rack for use, opposite the hand washing sink.</p> <p>On 4/22/25 at 2:02 PM, the FSD provided the surveyor with vendor invoices from January 2025 to present. Invoices from [name redacted] indicated, MEDIUM EGGS GRADE A were delivered. There was no indication that they were pasteurized.</p> <p>A review of an undated facility policy Ice Machines and Ice Storage Chests, reflected that ice machines will be used and maintained to ensure a safe and sanitary supply of ice. It also included that ice could become contaminated by unsanitary manipulation by employees, water-borne microorganisms, colonization by microorganisms, and improper storage or handling of ice.</p> <p>A review of an undated facility policy Sanitation, reflected the food service area will be maintained in a clean and sanitary manner. It also reflected all kitchen areas should be kept clean, including shelves, counters, utensils and equipment. This included maintaining food service items in good repair so as not to affect their use and proper cleaning. Additionally, it reflected that ice that is used in connection with food and drink should be handled in a sanitary manner.</p> <p>A review of an undated facility policy Food Storage, reflected that food storage areas should be maintained in a clean, safe, and sanitary manner; and that food service staff should maintain clean food storage areas at all times.</p> <p>NJAC 8:39-17.2(g)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>40042</p> <p>REPEAT DEFICIENCY</p> <p>Based on observations, interviews and review of pertinent facility documents, it was determined that the facility failed to have a system in place to ensure that facility garbage receptacles were covered, and all garbage was contained and removed timely to prevent a buildup of refuse, and that the receptacles including a trash compactor and the surrounding areas were maintained in a clean manner to prevent the accumulation of debris.</p> <p>The deficient practice was evidenced as follows:</p> <p>On 4/14/25 at 9:00 AM, the survey team arrived at the facility. From the parking lot, the surveyor was able to view the dumpster area, in the presence of the survey team. There were two oversized uncovered dumpsters overflowing with waste/debris and had black garbage bags around and between the two dumpsters, as well as debris on the ground. Up against the building loading dock there was a compactor, and an uncovered cardboard dumpster overflowing with cardboard.</p> <p>On 4/14/25 at 10:05 AM, the surveyor conducted a kitchen tour with the Food Service Director (FSD).</p> <p>During this tour, the surveyor and FSD went outside the building and onto the loading dock to view the receptacle area for refuse. The cardboard container was uncovered and overflowing. The FSD stated it did not need to be covered. The compactor had a buildup of discolored liquid underneath. The FSD stated the compactor was picked up once every week or week and a half. There were two oversized dumpsters overflowing with debris to the right of this area along a back fence. There was debris on the ground around the three dumpsters as well as the compactor. The FSD acknowledged there was debris on the ground and could not speak to who was responsible to ensure the area was clean, maintained and free of debris on the ground.</p> <p>On 4/22/25 at 2:26 PM, the surveyor interviewed the Director of Environmental Services (DES). He stated he was ultimately responsible to ensure the dumpster area was clean and maintained. He stated he had porters that clean that area however, the observation was made early Monday, and he was unable to get that done. The DES further stated the cardboard dumpster was picked up once a week and when the compactor was picked up, staff would clean underneath. He stated, [name redacted] company was used for removal of the cardboard dumpster and compactor; however, he was unable to speak to the responsibility for the two other oversized dumpsters.</p> <p>On 4/22/25 at 5:29 PM, the surveyor reviewed the above concern with the Administrative team (Licensed Nursing Home Administrator, Director of Nursing and the Chief Clinical Officer), in the presence of the survey team.</p> <p>On 4/23/25 at 11:30 AM, the survey team met with the Administrative team for responses or additional information. Nothing further was provided.</p> <p>A review of an undated facility policy Maintenance Service, reflected that maintenance service would be provided to all areas of the building and grounds, which included the parking lot.</p> <p>(continued on next page)</p>

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NJAC 8:39-31.4(b)

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>41858</p> <p>Based on interview and review of facility documentation, it was determined that the facility failed to employ a full time Social Worker (SW) from 12/7/24 to 4/16/25.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 4/15/25 at 10:17 AM, the surveyor met with seven residents for a resident council meeting. During that meetin, 6 out of the 7 alert and oriented residents voiced concerns that the facility did not have a full-time social worker. The residents explained for the last 2 or 3 months there was a social worker that worked only Saturdays/Sundays for about 5 hours.</p> <p>On 4/15/25 at 1:05 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated there was a new social worker starting this week. He confirmed the current social worker (SW#2) usually comes in a few hours on Saturday's and Sundays. He verified the last SW's (SW#1) last day was 12/6/24.</p> <p>A review of the facility provided time clock punches for SW #2 revealed SW #2 worked as follows:</p> <ul style="list-style-type: none"> -12/7/24 to 12/29/24 a total of: 31.5 hours -1/8/25 to 1/25/25 a total of: 22.58 hours -2/1/25 to 2/15/25 a total of: 23.41 hours -3/1/25 to 3/29/25 a total of: 37.61 hours -4/5/25 to 4/12/25 a total of: 10.68 hours <p>On 4/16/25 at 1:35 PM, the surveyor interviewed SW#2 via telephone. SW #2 stated that he had a full-time position at another facility and had been helping by working on Saturdays for five (5) hours since the middle of January. SW #2 stated that his responsibilities on Saturday were to complete any needed social histories, social determinants of health, Minimum Data Set (an assessment tool used to facilitate the management of care for a resident) requirements and/or obtain signed pertinent paperwork for identified residents. SW #2 added that his responsibilities were based on a list or print out of identified residents he received. In addition, he stated that he would try to spend time with any resident that wished to speak with him. SW #2 also stated, I do what I can in 5 hours. He added that when residents spoke with him and had a concern that he was unable to follow up with, he would refer the resident's concern to a full-time administrative staff that could handle what the resident needed. SW #2 explained for example that if a resident wished to be discharged or transferred then he would let the Admissions staff member know because they worked Monday through Friday and would be able to handle those type of requests.</p> <p>(continued on next page)</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/22/25 at 11:46 AM, the surveyor interviewed the Admission Director (AD), who stated her role was to bring the residents in, and the SW brings them out. She stated if a resident wanted to transfer to another facility the resident or family would let her know what facility and she would facilitate the transfer. The AD explained that the rehabilitation department would set up durable medical equipment if a resident needed to be discharged home and nursing would do the actual discharge paperwork.</p> <p>On 4/22/25 at 4:28 PM, during a meeting with the survey team, the Corporate Clinical Officer, the Director of Nursing, the LNHA, and the Assistant Administrator were made aware of the above concerns.</p> <p>The facility was on record as being licensed for 180 beds. The CMS guidelines implemented 11/28/17, included but were not limited to a qualified SW full-time for a facility with over 120 beds.</p> <p>A review of the facility's Social Worker job description revealed The primary purpose of your job position is to assist in the planning, organization, and developing of the Social Services Department in accordance with current federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis.</p> <p>N.J.A.C. 8:39-9.3(a); 39.2; 39.4(i)</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41858</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and review of pertinent facility documentation, the facility failed to ensure the required committee members, the Infection Preventionist (IP), was present for two out of four Quality Assurance and Performance Improvement (QAPI) meetings reviewed and was evidenced by the following:</p> <p>04/23/25 11:33 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated QAPI meetings were held at least quarterly and as needed, he added we also meet monthly. He stated the required members were the administrator (LNHA), the director of nursing (DON), the medical director and other staff were required to attend the meetings at least quarterly. The LNHA stated also will be including a certified nursing assistant in the meetings.</p> <p>At that time, the LNHA reviewed the facility provided QAPI sign in sheets, he removed the sign in sheets for the quarterly QAPI meetings. A review of the Quarterly QAPI Meeting Attendance sign in sheets revealed meeting were conducted on 4/17/2024, 7/17/2024, 10/16/24 and 1/15/2025. The surveyor asked the LNHA to identify the IP on the sign in sheets. After reviewing the sheets, he was unable to identify the IP was present at the 4/17/2024, 10/16/24 and 1/15/2025 meetings.</p> <p>During the same interview, the LNHA stated he was not aware the IP was required to be in attendance.</p> <p>At 12:32 PM, the LNHA provided evidence that the IP was off on 1/15/2025 but was able to provide evidence that infection control was reviewed with the committee. At that time, the surveyor requested evidence of infection control review for the 4/17/204 and 10/16/24 QAPI meetings.</p> <p>No additional information was provided.</p> <p>A review of the facility's policy Quality Assurance and Performance Improvement Plan revealed III. Guidelines for Governance and Leadership .b. i. The QAPI committee provides the organization structure for QAPI. This group includes administrator, DON, medical direction and/or designee, at least three other members of the facility's staff and the infection control and prevention officer .ii. Currently QAPI committee maintains record of attendance and minutes with supporting documentation.</p> <p>NJAC 8:39-33.1(b)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51500</p> <p>Repeat Deficiency</p> <p>Based on observation, record review, interview, and review of pertinent facility documents, it was determined that the facility failed to prevent the potential for cross contamination by not placing a resident with open wounds on Enhanced Barrier Precautions (EBP- a gown and gloves be worn when performing high contact care), for one of two residents (Resident #45) reviewed for pressure ulcers.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 4/16/25 at 9:33 AM, during a wound treatment observation, the surveyor observed the Certified Nurse Aide (CNA) holding Resident #45 on their right side with their sacral and right heel wound exposed. The CNA was wearing gloves. The surveyor then observed the Licensed Practical Nurse (LPN) cleanse the sacral wound and apply the treatment and dressing. The LPN was wearing gloves. After performing hand hygiene, the LPN donned (put on) gloves and the LPN cleansed the right heel wound and applied the treatment.</p> <p>The surveyor had not observed EBP signage at the resident's doorway or in the room.</p> <p>The surveyor reviewed the electronic medical record (EMR) for Resident #45.</p> <p>A review of the Order Summary Report revealed a physician orders (PO) dated 4/14/25 for Zinc Oxide External Paste 20%. Apply to buttocks . and Medihoney Wound/Burn Dressing External Gel Apply to right heel .</p> <p>A review of the Admission Record, (an admission summary), reflected diagnoses that included but not limited to; Dementia (brain disorder), hypertension (elevated blood pressure) and diabetes (elevated blood sugar).</p> <p>The Individual Comprehensive Care Plan (ICCP) included a focus area of potential impairment to skin integrity. Interventions included medihoney to left heel after cleansing and zinc oxide to buttocks.</p> <p>On 4/16/25 at 9:48 AM, the surveyor interviewed the LPN. The LPN stated that Resident #45 should not be on EBP because there was no discharge from the wounds. She further stated that EBP was important if fluid was involved.</p> <p>On 4/16/2025 at 10:10 AM, the surveyor interviewed the CNA. The CNA stated that she should not have worn a gown when caring for Resident #45. She further added that she knew who was on isolation from report and signage on the door.</p> <p>On 4/16/2025 at 12:11 PM, the surveyor interviewed the Unit Manager Registered Nurse (UM/RN). She acknowledged that Resident #45 should have been on EBP because they had a wound.</p> <p>(continued on next page)</p>		

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 04/23/2025
NAME OF PROVIDER OR SUPPLIER Abingdon Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 303 Rock Ave Green Brook, NJ 08812	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/25 at 10:10 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse, who stated that if a resident had a wound, EBP were needed.</p> <p>A review of facility policy PPE for MDRO Updated December 15, 2024 revealed:</p> <p>Enhanced Barrier Precautions</p> <p>Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi-drug-resistant organisms) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.</p> <p>Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: . Wound care: any skin opening requiring a dressing.</p> <p>N.J.A.C. 8:39-19.4 (a)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>40042</p> <p>Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain an effective pest control program so that the kitchen was free of pests.</p> <p>The deficient practiced was evidenced by the following:</p> <p>On 4/14/25 at 10:05 AM, the surveyor conducted a kitchen tour with the Food Service Director (FSD). During this tour, he stated that he used a [name redacted] electronic communication system as well as verbal communication with the Director of Environmental Services (DES) when there was a maintenance concern in the kitchen.</p> <p>The surveyor observed an open drain on the floor next to a grease trap. The surveyor observed many flies in this area, coming from the drain, in the air and on the wall. The FSD acknowledged this and stated they were drain flies, and that the grease trap needed to be cleaned. In addition, the FSD stated the exterminator treated the area and that it did not help since there was an open drain.</p> <p>On 4/22/25 at 1:01 PM, the surveyor conducted a second kitchen tour with an additional surveyor and the FSD. The FSD provided a pest control logbook to the surveyor for review. The form indicated the last visit from the exterminating company was on 4/1/25; however, there was no indication of what or where treatment was performed in the kitchen. The FSD stated that the exterminator conducted weekly visits every Tuesday. During this tour, both surveyors observed the same type of flies on the wall just outside the dish machine room.</p> <p>On 4/22/25 at 2:26 PM, the surveyor interviewed the DES. He stated that the pest control company came in weekly and there was a logbook for the kitchen. He stated that he was unaware there were drain flies in the kitchen.</p> <p>On 4/22/25 at 3:36 PM, the DES provided the surveyor invoices from the exterminating company from 2/18/25 through 4/8/25 which revealed kitchen pests had not been addressed. In addition, there was an invoice dated 4/15/25, which indicated No service was performed due to state conducting survey.</p> <p>On 4/22/25 at 3:51 PM, the surveyor interviewed the Regional Property Manager, who was unaware of a fly issue in the kitchen.</p> <p>On 4/22/25 at 5:29 PM, the surveyor reviewed the above concern with the administrative team (Licensed Nursing Home Administrator, Director of Nursing and the Chief Clinical Officer), in the presence of the survey team.</p> <p>On 4/23/25 at 11:26 AM, the LNHA stated that the exterminator treated for flies in the kitchen about a month and a half ago but nothing specific to flies were recorded on paperwork.</p> <p>A review of the facility Work Orders between the kitchen and maintenance department from 3/18/24 through 3/31/25, did not address flies.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of an undated facility policy Pest Control, reflected the facility would maintain an effective pest control program. It also reflected the facility maintained an on-going pest control program to ensure the building was kept free of insects.</p> <p>A review of an undated policy Sanitation, reflected kitchen areas would be kept clean and protected from flies and other insects.</p> <p>N.J.A.C. S 8:39-31.5</p>