STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Orange Park	140 Park Ave East Orange, NJ 07017

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 39399 Based on observation, interview, and record review, it was determined that the facility failed to provide reasonable accommodation of resident needs specifically by failing to ensure that assistance was provided to open a mail for a resident with bilateral hand contractures for 1 of 39 residents, Resident #23, reviewed for resident rights. The deficient practice was evidenced by the following: 1. On 5/1/24 at 10:48 AM, the surveyor observed Resident #23 in bed, awake. The surveyor also observed that the resident was wearing hand splint (an orthotic device that is used to support and immobilize the hand, fingers and wrist) to both hands. The surveyor observed several unopened mails placed on top of the resident's nightstand and another one unopened mail placed on top of the bedside table. The surveyor interviewed the resident who stated that he/she would love for someone to open his/her mails for them in his/her presence. Resident #23 further stated that there were no staff who offered to open the mails for him/her. A review of the facility Admission Record for Resident #23 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Contracture right and left hand, Generalized Osteoarthritis, Major Depressive Disorder and Dysphagia. A review of Resident #23's Quarterly Minimum Data Set (MDS) an assessment tool used to facilitate management of care, dated 4/27/24, reflected that the resident had a Brief Interview Mental Status (BIMS) score of 10 out of 15, which indicated that the resident had moderate cognitive impairment. A review of the physician's order (PO) dated 3/5/24 reflected a PO to Don right and left hand palmar grip splint after AM care as tolerated. Doff with PM care. On 5/2/24 at 10:35 AM, the surveyor interviewed Unit Manager #3 who stated that Resident #23 does not have any family or responsible party and was unaware who delivers the mail to the resident. On 5/2/24 at 2:11 PM, the surveyor discussed the above concern with the facility's Regional Registered Nurse (RRN), Licensed Nursing Home Administrator (LNHA), Assistant LNHA, and Regional LNHA. The RRN stated that the activity staff were responsible to distribute all the mails to the residents. (continued on next page)

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: 315178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/24 at 10:02 AM, the surveyor interviewed the facility's Director of Recreation and Volunteers (DRV) who stated that as soon as the receptionist/front lobby received the mails, any activity staff on duty will be responsible of delivering mails to the resident's room. The DRV further stated that if the resident was unable to open their mail, the staff will ask and offer to the resident if they would like assistance in opening mails. A review of the facility's Policy and Procedure titled, Mail, Email and Package Distribution indicaed under Action Plan #3. Provided the resident with the choice of privately opening the mail or receiving assistance from the staff. There was no additional information provided. NJAC 8:39-27.5

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on the interview and record review, it was determined that the facility failed to complete and submit electronically the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within 14 days of completing the resident's assessment and in accordance with the Center's for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. This deficient practice was identified for 4 of 35 residents (Residents #18, 22, 57, and 64). This deficient practice was evidenced by the following: 1. Resident #18 was observed to have an Annual MDS (AnMDS) with an Assessment Reference Date (ARD) on 6/30/23 was due to be transmitted to CMS no later than 7/14/23. However, the AnMDS was not submitted to CMS until 8/4/23. A review of Quarterly MDS (QMDS) with an ARD on 8/20/23 was due to be transmitted to CMS no later than 9/3/23. However, the QMDS was not submitted until 9/12/23. A review of QMDS with an ARD on 11/16/23 was due to be transmitted to CMS no later than 11/29/23. However, the QMDS was not submitted until 12/6/23. 2. Resident #22 was observed to have an AnMDS with an ARD on 1/1/23 was due to be transmitted to CMS no later than 1/20/23. However, the AnMDS was not submitted to CMS until 2/02/23. A review of Significant Change MDS (ScMDS) with an ARD on 1/13/23 was due to be transmitted to CMS no later than 1/26/23. However, the ScMDS was not submitted until 2/3/23. A review of QMDS with an ARD on 4/8/23 was due to be transmitted to CMS no later than 4/21/23. However, the QMDS was not submitted until 5/8/23. A review of QMDS with an ARD on 7/2/23 was due to be transmitted to CMS no later than 7/15/23. However, the QMDS was not submitted until 7/28/23. A review of QMDS with an ARD on 9/15/23 was due to be transmitted to CMS no later than 9/28/23. However, the QMDS was not submitted until 10/3/23. A review of AnMDS with an ARD on 12/12/23 was due to be transmitted to CMS no later than 12/25/23. However, the AnMDS was not submitted until 1/3/24. 3. Resident #57 was observed to have an Admission MDS (AdMDS) with an ARD on 12/20/23. The AdMDS was due to be transmitted to CMS no later than 1/4/24. However, the AdMDS was not submitted to CMS until 1/17/24. 4. Resident #64 was observed to have an AnMDS with an ARD on 10/28/23 was due to be transmitted to CMS no later than 11/12/23. However, the AnMDS was not submitted to CMS until 11/17/23. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Complete Care at Orange Park		STREET ADDRESS, CITY, STATE, ZIP CODE 140 Park Ave East Orange, NJ 07017	

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the undated Final Validation Report for Residents #18, 22, 57, and #64 given by the MDS Coordinator/Registered Nurse (MDSC/RN) revealed that Assessment Completed Late: Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date). On 5/06/24 at 10:15 AM, the surveyor interviewed the MDSC/RN, who stated that she worked in the facility for almost [AGE] years and followed the RAI Manual. She was aware that the MDS assessments were all submitted and accepted late. On 5/07/24 at 1:27 PM, the survey team met with the Licensed Nursing Home Administrator and Director of Nursing. The surveyor notified the facility management of the above findings and concerns. NJAC 8:39 - 11.2(e)3

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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** 44605 Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 1 of 39 residents, Resident #207 reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 5/03/24 at 11:16 AM, the surveyor reviewed the closed medical chart for Resident #207 whose discharge MDS was coded for discharge to an acute hospital. The surveyor reviewed the 2/27/24 progress notes under general notes (GN), indicating that Resident #207 Left Against Medical Advice (AMA) around 2:30 pm with all his/her belongings. Review of Resident #207's Face Sheet (FS) (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility with diagnosis that included but were not limited to lymphedema, sequelae of cerebral infarction, and mood disorder. Review of the A section of the 2/27/23 Discharge MDS for Resident #207 revealed that section A2105 Discharge Status documented, 04. Short-Term General Hospital. On 5/03/24 at 12:08 PM, the surveyor interviewed the Register Nurse(RN), MDS coordinator (MDS #1). MDS#1 explained, That Resident #207 left the facility AMA. MDS#1 revealed that the facility social worker (SW) who entered their information must have entered that incorrectly. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 . According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023). This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board, and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. Code 04, Short-Term General Hospital (acute hospital/IPPS): if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care and accepts a predetermined rate as payment in full. Code 99, Not Listed On 5/6/24 at 9:50 AM, the Regional Clinical Nurse (RCN) provided the surveyors with a facility policy titled, Certifying Accuracy of the Resident Assessment with a revision date of 1.2024. Review of the section, Policy interpretation and implementation section, 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/07/24 at 1:02 PM, the surveyor team met with the RCN, licensed Nursing Home Administrator (LNHA), and Assistant Administrator (AA) regarding concerns. The RCN stated all MDS assessment and paperwork should be filled out correctly and acknowledged there was an error regarding Resident #207 discharge status. No further information provided. 46889 2. On 5/02/24, at 1:00 PM, the surveyor observed Resident #57 sitting in the wheelchair, alert and oriented, and able to answer the surveyor's inquiry. Resident #57's medical records revealed the following information: According to the Admission Record (an admission summary) (AR), Resident #57 was admitted to the facility with diagnoses that included but were not limited to acute pyelonephritis (kidney infection). The Quarterly Minimum Data Set (QMDS), dated [DATE], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored 14 out of 15, which indicates that the resident is cognitively intact. Review of Section D Resident Mood Interview (PHQ-2 to 9) of the 3/15/24 MDS, signed by the SW on 3/21/24, revealed that there was no documentation of a PHQ-2 to 9 assessment interview performed on the ARD of 3/15/24. A review of Admission MDS (AdMDS) dated [DATE], section D PHQ-2 to 9, signed by the social worker (SW) on 1/09/24, revealed that the CSC- PHQ-2 to 9 Evaluation Effective Date: 12/13/2023 17:25 given by the SW was done eight (8) days before the ARD of 12/20/23. 3. On 4/29/24 at 11:44 AM, the surveyor observed Resident #64 in bed, awake, and unable to answer the surveyor's inquiry. Resident #64's medical records revealed the following information: According to the AR, Resident #64 was admitted to the facility with diagnoses that included but were not limited to dementia (impairment of memory) unspecified severity with agitation. The QMDS, dated [DATE] for Resident #64, indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 0 out of 15, which indicates that the resident's cognition is severely impaired. Review of Section D Staff Assessment of Resident Mood (PHQ-9-OV) of the 3/31/24 QMDS for Resident #64, signed by the SW on 4/24/24, revealed no record of a PHQ-9-OV interview performed for the ARD dated 3/31/24. A review of Modification (02) of Significant Change MDS (ScMDS) dated [DATE] for Resident #64, section D PHQ-9-OV, signed by the SW on 1/30/24, revealed no record of a PHQ-9-OV interview done on the ARD 1/09/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 4/29/24 at 11:09 AM, the surveyor observed Resident #37, who had just come out from the bathroom, sitting in a wheelchair. Resident #37's medical records revealed the following information: Review of Resident #37's AR revealed that they were admitted to the facility with diagnoses that included but were not limited to mental disorders not otherwise specified. The AdMDS dated [DATE] for Resident #37, indicated that the facility assessed the resident's cognitive status using BIMS. The Resident #64 scored 15 out of 15, which indicates that the resident's cognition is intact. Review of Section D PHQ-2 to 9 of the 4/05/24 AdMDS for Resident #37, reveals that it was signed by the SW on 4/11/24, but the CSC- PHQ-2 to 9 Evaluation Effective Date: 4/01/2024 14:07 submitted by the SW was done five (5) days before the ARD of 4/05/24. 5. On 4/29/24 at 10:21 AM, the surveyor observed Resident #22 lying in bed, awake and alert but unable to answer the surveyor's inquiry. Resident #22's medical records revealed the following information: Review of Resident #22's AR reveals that they were admitted to the facility with diagnoses that included but were not limited to dementia. Review of the QMDS dated [DATE] for Resident #22, indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 0 out of 15, which indicates that the resident's cognition is severely impaired. A review of the Annual MDS (AnMDS), dated [DATE] for Resident #22, section M, Determination of Pressure Ulcer (PU) Risk/Injury Risk, does not reflect the stage two (2) PU to the left buttock. The Weekly Skin Review, with effective dates of 12/19/22 and 12/26/22, is revealed under indicate site(s) below left buttock 1.5 cm x 2.5 cm. and an effective date of 12/12/22 and 12/5/22 left buttock 2 cm x 3 cm respectively. On 5/06/24 at 10:12 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) about Resident #22's stage 2 PU to the left buttock that did not reflect in the AnMDS on 1/01/23. The MDSC/RN stated that she had missed capturing the PU on the 1/1/23 MDS. 6. On 4/29/24 at 10:21 AM, the surveyor observed Resident #18 lying in bed, awake, alert, and able to answer the surveyor's inquiry. Resident #18's medical records revealed the following information: According to the AR, Resident #18 was admitted to the facility with diagnoses that included but were not limited to type 2 diabetes mellitus (too much sugar in the blood) without complication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The QMDS, dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 12 out of 15, which indicates a moderately impaired cognition. Review of the QMDS Section D PHQ-2 to 9, signed by the SW on 3/07/24, revealed that the SW PHQ-2 to 9 interviews were done twenty-five (25) days before the ARD of 3/31/24. On 5/06/24 at 10:12 AM, the surveyor interviewed the MDSC/RN about the process of PHQ-2 to 9 assessments. She stated that they do not need to follow the ARD; facility management told them that the PHQ-2 to 9 can be done before the ARD. The MDSC/RN stated that the resident could be interviewed before the ARD. On 5/06/24 at 11:30 AM, the surveyor interviewed the SW Director regarding the process of PHQ-2 to 9 assessments; she stated that her process is that she does not follow the ARD. She explained the process was to interview the residents on the first day of admission into the facility. The SW stated that the BIMS is evaluated along with the PHQ-2 of 9 at least within 48-72 hours of the resident's admission into the facility. The SW revealed that the Regional MDS educated her that the assessment, including PHQ-2 to 9, should be done at least 48 hours of a resident's admission. The SW did not provide any further information regarding the PHQ-2 to 9 interviews for Residents #57, #64, and #22. On 5/07/24 at 1:02 PM, the surveyor team met with the regional clinical nurse, administrator, and assistant administrator regarding the concern. No further information was provided. NJAC 8:39-33.2(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on observation, interview, and record review, it was determined that the facility failed to 1. follow acceptable standards of clinical practice for accurately administering and documenting medication administered for 2 of 4 residents, Resident #34, and Resident #97 observed during medication administration, and 2. follow a physician's order (PO) to treat varying pain levels for 1 of 5 residents, Resident #171, reviewed for pain management. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and 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 prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 5/1/24 at 8:35 AM, the surveyor observed the Licensed Practical Nurse (LPN) #1 prepare medications for administration to Resident #34. The surveyor observed LPN #1 remove the medication, Vimpat oral solution, (a medication used to treat seizures), from the medication cart and verify the medication dosage on the resident's electronic medication administration record (eMAR). The surveyor observed LPN #1 verify the PO for Vimpat 10mg/ml oral solution (Lacosamide) Give 12 ml via PEG-Tube ((percutaneous endoscopic gastrostomy) feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall) every 12 hours for seizure disorder documented on the May 2024 eMAR. The surveyor observed LPN #1 pour the medication into a calibrated plastic medication dose cup. LPN #1 informed the surveyor that the amount of medication is between the markings of 10 milliliters (ml) and 15 ml, assuring the surveyor that it was 12 ml. When LPN #1 was prepared to administer the Vimpat to Resident #34, the surveyor interrupted the administration of Vimpat by LPN #1. LPN #1 informed the surveyor that there was no exact mark for 12 ml. LPN #1 open the medication cart and located a calibrated dose syringe (a device used to accurately measure a specific amount) that was provided by the manufacturer for accurately dosing the Vimpat. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was observed disposing the Vimpat in the dose cup and accurately measuring the accurate dose with the calibrated dose syringe that had a marking reflecting 12 ml for administration to Resident #34. On 5/2/24 at 10:02 AM, the surveyor interviewed LPN #1 regarding measuring liquid medications. LPN #1 stated that she normally uses a medication dose cup to measure liquids if they are an amount she can see on the cup. LPN #1 added that for doses of medication not marked on the medication cup, she would use another measuring device that can measure the exact amount. LPN #1 explained that Resident #34 had a previous order for Vimpat 10 ml that was recently discontinued that she could be measured in the medication cup. The surveyor inspected a medication dose cup from a medication cart. The medication dose cup had markings that reflected 2.5 ml, 5 ml, 7.5 ml, 10 ml, 15ml, 20 ml, 25 ml, and 30 ml. A review of the Vimpat manufacturer product information reflected under Dosage and Administration, line 2, DOSAGE AND ADMINISTRATION VIMPAT may be taken with or without food. When using VIMPAT oral solution, it is recommended that a calibrated measuring device be obtained and used. A household teaspoon or tablespoon is not an adequate measuring device. Healthcare providers should recommend a device that can measure and deliver the prescribed dose accurately and provide instructions for measuring the dosage. A review of Resident #34's medical records revealed the following information: Review of Resident #1's documented admission to the facility with diagnoses that included but were not limited to Conversion Disorder with Seizures or Convulsions and Cerebral Palsy. A review of Resident #34's Most Recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate management of care, dated 3/6/24, reflected that the resident had a Brief Interview Mental Status (BIMS) score of 0 out of 15, which indicated that the resident had severe cognitive impairment. A review of Resident #34's Care Plan (CP) dated 3/15/24 reflected that the resident had a seizure disorder and will be free of seizures. In addition the CP documented, Give medications as ordered. Monitor/document for effectiveness and side effects. and, Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. with initiated dates of 2/15/22. The surveyor reviewed Resident #34's medical record. The current Physician's Order (PO) dated 4/30/24, was for Vimpat Oral Solution 10 mg/ml Give 12 ml via PEG-Tube every 12 hours for seizure was noted on the April and May 2024 electronic medical record (eMAR). The previous PO for Vimpat 10 ml was verified on the April 2024 eMAR. This PO was discontinued on 4/30/24 for Vimpat Oral Solution 10 MG/ML Give 10 ml via PEG-Tube every 12 hours for seizure. Review of the Nursing progress notes dated 4/26/24, reflected the statement resident stable, and there was no further documentation related to Resident #34 experiencing any seizure activity. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 1:30 PM, the surveyor discussed the dosing accuracy with Licensed Nursing Home Administrator (LNHA) and Regional Clinical Nurse (RCN). The LNHA and Regional Clinical Nurse acknowledged the discrepancy in dosing accuracy and did not provide any further information at that time. 2. On 5/1/24 at 9:26 AM, the surveyor observed LPN #3 administer medications to resident #97. The surveyor observed an order for Potassium Chloride Oral packet 10MEQ (potassium packet) (a medication used as a supplement or replacement of potassium to the body) documented on the resident's May 2024 eMAR. LPN #3 informed the surveyor that the potassium packet was unavailable and that he would call the pharmacy to see if it could be delivered as soon as possible. LPN #3 explained that Resident #97 had a previous order for a Potassium 20 MEQ but that it was reduced to Potassium 10 meq. LPN #3 documented on the resident's eMAR that the potassium packet was not given with a code of seven (7). The resident's May 2024 eMAR reflects that a code of seven (7) entered by the nurse indicates other/see nurse notes The surveyor reviewed Resident's eMAR for April 2024 and May 2024. The April eMAR reflected an order for Potassium ER Tablet Extended Release 20 meq, Give 1 tablet by mouth one time a day for hypokalemia, originally ordered 4/10/24, ordered and indicated as administered. The April eMAR also reflects an order for Potassium Oral packet 10 meq, Give 10 meq by mouth in the morning for prevent hypokalemia, originally ordered 4/16/24, documented as administered daily except for 4/29/24. Review of the May 2024 eMAR reflected the order for Potassium Oral packet 10 meq, ordered 4/16/24, Give 10 meq by mouth in the morning for prevent hypokalemia ordered and indicated as not given on 5/1/24. On 5/2/24 at 11:30 AM the surveyor interviewed, by telephone, the Pharmacist (RPh) employed by the provider pharmacy who services the facility. The RPh stated that the 4/16/24 order for 10MEQ dose of potassium in powder packets were not available, the facility was notified, and it was not delivered. The RPh explained that on 4/17/24, 4/18/24, 4/19/24 and 4/24/24 several calls were made to the facility, but no one was available. The RPh stated that on 4/25/24 an email referring to this matter was generated to the facility. The RPh indicated that the Potassium 10 meq packets were never delivered to the facility. The Potassium packets indicated as administered on the April 2024 eMAR were found to be unavailable but were initialed as given by the medication nurses on the eMAR. The surveyor reviewed the facility policy titled Administering Medications dated Reviewed 1/2024. The policy reflected on line 2. Medications must be administered in accordance with the orders, including any required time frame and line 5. The individual administering the medications must check the label against the Physician's order to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. On 5/6/24 the surveyor reviewed the policy for Unavailable Medications dated 1/1/2024 provided by the RCN. The RCN also provided statements from several nurses including LPN #3, that the nurses were administering divided doses of a 20MEQ potassium tablet broken in half, administered the half tablet to Resident #97 and disposed of the other half of the tablets. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Complete Care at Orange Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 140 Park Ave East Orange, NJ 07017	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy reflected at line 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications and at line 4.b. notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold. On 5/2/24 at 12:17 PM the survey team met with the Regional Clinical Nurse (RCN) and Licensed Nursing Home Administrator (LNHA). The surveyor relayed the information provided by the provider pharmacy to the RCN and administrator. No further information in reference to the medication error or unavailable medications. Surveyor: ADUNA, [NAME] 3. On 5/1/24 at 10:37AM, Resident #171 was observed in the room with eyes closed. The surveyor reviewed Resident #171's hybrid medical record. Review of Resident #171's AR revealed that they were admitted to the facility with diagnoses that included but were not limited to Cellulitis of right lower limb, Myiasis, Peripheral Vascular Disease, and Venous Insufficiency. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 3/11/24 reflected that the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating that the resident had intact cognition. On 4/30/24 at 11:48 AM, the surveyor reviewed the resident's April 2024 Order Summary Report (OSR) which revealed a PO dated 10/6/23 for Ibuprofen Oral Tablet 800mg (Ibuprofen) Give 1 tablet by mouth every 8 hours as needed for Mild Pain and a PO dated 2/14/24 for Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain. Review of the January, February, March, and April 2024 electronic Medication Administration Record (eMAR) revealed that Resident #171 received some doses of Ibuprofen Oral Tablet 800mg 1 tablet for documented pain scale rates between 4 to 8. On 5/2/24 at 10:26 AM, the surveyor interviewed Resident #171's Licensed Practical Nurse #5 (LPN #5), who was assigned to the resident. LPN #5 stated that she considered mild pain to be rated from 1-6. On 5/2/24 at 10:38 AM, the surveyor interviewed Unit Manager #3 (UM #3) who stated that she considered mild pain to be rated from 1-5. UM #3 further stated that she was not sure what pain scale level the nurses on the unit were using. On 5/2/24 at 2:11 PM, the surveyor discussed the above concern with the facility's Regional Registered Nurse (RRN), Licensed Nursing Home Administrator (LNHA), Assistant LNHA, and Regional LNHA. The RRN agreed that for a pain level between 4-8, it was not considered mild pain, but rather moderate to severe pain levels. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Pain-Clinical Protocol did not address specifically the definition and category of mild pain. NJAC 8:39- 29.2 (d) 39399

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on observation, interview, and record review, it was determined that the facility failed to ensure that pain level assessments were completed according to facility policy for 2 of 4 residents, Resident #77 and #92 who were reviewed for pain management. This deficient practice was evidenced by the following: 1. On 4/29/24 at 11:45 AM, the surveyor interviewed Resident #92 in the 1st floor dayroom, who stated they receive Methadone for daily pain management. On 5/6/24 at 11:15 AM, the surveyor interviewed the Licensed Practical Nurse #7 (LPN#7) who explained that residents on routine pain medication, pain level should be assessed and documented only if the resident appears in pain. Review of an Admission Record (an admission summary) revealed that Resident #92 was admitted to the facility with diagnoses that included but were not limited to: pain in right foot, pain in left foot, and opioid dependence. A review of the Admission Minimum Data Set Assessment (MDS), an assessment tool, used to facilitate the management of care, dated 3/11/24, revealed that the resident had a score of 14 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated that the resident had intact cognition. Review of section N (Medications) of the Admission MDS dated [DATE], also revealed that the resident received a scheduled pain medication. Review of the Physician's Orders revealed an order dated 5/6/24 for the following pain medication: Methadone HCl Oral Tablet 10 Milligram (MG) (Methadone HCl). Give 9 tablet by mouth one time a day for Pain Management. Further review of the physician's order, March 2024, April 2024, and May 2024 electronic medication administration records (eMAR) which did not show an order or documentation for pain assessment and monitoring. Review of the resident's March 2024, April 2024, and March eMARs revealed that Resident #92 received the Methadone medication every day with no pain assessment documented. A review of resident's care plan (CP) with a completion date of 3/18/24 revealed a CP for pain with an intervention that stated, complete pain assessment on admission and per facility policy to determine the nature of the discomfort. 19106 2. On 4/29/24 at 11:16 AM, the surveyor interviewed Resident #77 in their room. The resident stated they experienced leg pain for which they received Methadone three times daily for pain management. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's medical record revealed the following information. The 2/15/24 Quarterly MDS revealed the resident scored of 14 out of 15 on the BIMS test indicating the resident had an intact cognition. Review of Section I (Active Diagnoses) of the 2/15/24 Quarterly MDS indicated the resident had diagnoses of contracture of the right knee and arthritis. Review Section J (Health Conditions) of the 2/15/24 Quarterly MDS indicated the resident had not experienced pain in the past five days. Review of the April 2024 Physician's Orders included an order for the following pain medication: Methadone HCl Oral Tablet 10 Milligram (MG) (Methadone HCl). Give 4 tablet by mouth three times a day for Pain Management. Further review of the physician's order failed to reveal an order for pain assessment and monitoring. A review of the resident's pain care plan, initiated 11/16/23 and revised 4/29/24, included an intervention complete pain assessment on admission and per facility policy to determine the nature of the discomfort . On 4/29/24 at 12:00 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Pain-Clinical Protocol with a revised date of 1/2024. Under the monitoring section of the policy it stated, 1. The staff will reassess the individual's pain and related consequences at regular intervals; at least each shift. On 5/1/24 at 10:18 AM the surveyor interviewed Registered Nurse #1. She stated the resident gets a once a week pain assessment which is not documented. On 5/1/24 at 10:32 AM the surveyor interviewed Unit Manager #1. She stated a quarterly pain assessment is documented in the electronic medical record. She further stated that a daily, weekly, or monthly pain assessment is not done. On 5/7/24 at 10:10 AM the surveyors discussed concerns regarding missing pain assessments with the Licensed Nursing Home Administrator and the Regional Clinical Nurse. On 5/8/24 at 12:00 PM the Regional Clinical Nurse stated that pain assessments by nursing should be completed at each shift utilizing the facility pain scale. No further information was provided. NJAC 8:39-27.1(a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19106 Based on interview and record review it was determined that the facility failed to ensure that a). the residents' primary physician signed and dated monthly physician orders for residents under their care and b). facility failed to ensure that the resident's nurse practitioner (NP) accurately dated physician progress notes (PPN) during their visit to ensure that the resident's current medical regimen was up to date. The deficient practice was identified for 19 of 35 residents, Residents #53, #77, #172, #183, #86, #134, #105, #30, #171, #460, #92, #56, #57, #64, #37, #22, #18, #109, and #144 reviewed for physician orders and NP visits. The findings are as follows. 1. The surveyor interviewed Resident #53 on 4/30/24 at 10:00 AM. The resident was awake and alert in bed. A review of the medical record revealed the following information. The resident was admitted with diagnoses including but not limited to spina bifida and peripheral vascular disease. The 4/26/24 Quarterly Minimum Data Set (QMDS), assessment tool reflected the resident scored a 15 out of 15 for the Brief Interview for Mental Status (BIMS) test indicating the resident had no cognitive deficits. A review of monthly physician orders revealed the primary physician had not hand-signed or electronically-signed monthly orders for December 2023, February 2024, March 2024, and April 2024. 2. The surveyor interviewed Resident #77 on 5/1/24 at 10:00 am. The resident was awake and alert in bed. A review of the medical record revealed the following information. The 2/15/24 QMDS, assessment tool reflected the resident scored 14 out of 15 on the BIMS test indicating the resident had no cognitive deficits. Section I indicated the resident had diagnoses including but not limited to contracture of the right knee and pyogenic arthritis. A review of monthly physician orders revealed the primary physician had not hand-signed or electronically-signed monthly orders for December 2023 and February 2024. 34421 3. On 4/29/24 at 11:16 AM, the surveyor observed Resident # 172 in bed in their room with their eyes closed and the resident was unable to be interviewed. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #172 which revealed that the resident's primary care physician had not signed the resident's monthly orders from the months of September 2023 through March 2024. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's Face Sheet with diagnoses that included Anoxic Brain Damage, Chronic Respiratory Failure, Cardiac Arrest, Tracheostomy, Gastrostomy, and Dependence on Respirator Ventilator Status. A review of the QMDS, an assessment tool used to facilitate care management dated 4/1/24, indicated that the resident was severely cognitively impaired. 4. On 4/29/24 at 11:06 AM, the surveyor observed Resident # 183 in bed in their room with their eyes closed and the resident was unable to be interviewed. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #183 which revealed that the resident's primary care physician had not signed the resident's monthly orders from the months of February 2024 and March 2024. A review of the resident's Face Sheet with diagnoses that included Anoxic Brain Damage, Asthma, Epilepsy, Quadriplegia, Tracheostomy, and Gastrostomy. A review of the QMDS, an assessment tool used to facilitate care management dated 3/31/24, indicated that the resident was severely cognitively impaired. 5. On 4/30/24 at 9:45 AM, the surveyor observed Resident # 86 in bed in their room and was pleasant upon interview. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #86 which revealed that the resident's primary care physician had not signed the resident's monthly orders from the months of October 2023 through March 2024. A review of the resident's Face Sheet with diagnoses that included Heart Failure, Dependence eon renal Dialysis, Peripheral Vascular Disease, Chronic Viral Hepatitis C, and End Stage Renal Disease. A review of the Annual Minimum Data Set (AMDS), an assessment tool used to facilitate care management dated 3/8/24, indicated that the resident was cognitively intact. 6. On 4/29/24 at 10:59 AM, the surveyor observed Resident # 134 in bed in their room and was pleasant upon interview. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #134 which revealed that the resident's primary care physician had not signed the resident's monthly orders from the months of October 2023 through March 2024. A review of the resident's Face Sheet with diagnoses that included Chronic Respiratory Failure, Tracheostomy, Gastrostomy, Dependence on Ventilator, Peripheral Vascular Disease and Hydronephrosis. A review of the QMDS, an assessment tool used to facilitate care management dated 2/12/24, indicated that the resident was severely cognitively impaired. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/2/24 at 12:23 PM, the surveyor interviewed the Licensed Practical Nurse (LPN # 1), who stated that the physician's sign monthly orders in the electronic medical record and could not provide any further information. 34033 7. On 5/1/24 at 10:12 AM, the surveyor observed Resident #105 self propelling in a wheelchair. When interviewed, Resident #105 was noted alert and responsive. The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #105. The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #105. A review of the Admission Record (one page summary of important information about a resident) for Resident #105. The resident was admitted to the facility with diagnoses that included but were not limited to anemia, asthma, major depressive disorder, adjustment disorder with anxiety, other psychoactive substance dependence, hypertension (high blood pressure) and low back pain. A review of the QMDS, an assessment tool used to facilitate the management of care, dated 3/28/24, reflected that Resident #105 had a Brief Interview for Mental Status score of 15 out of 15, indicating an intact cognition. A review of the resident's monthly physician's orders (PO) revealed that the attending physician (MD#4) had electronically signed the monthly PO on 4/19/24, 12/12/23 and 8/17/23. In addition, the Nurse Practitioner (NP#2) who collaborated with MD#4 had signed the monthly PO on 3/12/24, 2/8/24, 11/11/23 and 9/26/23. There were no monthly PO signed in January 2024. On 5/2/24 at 1:06 PM, the surveyor interviewed the NP#2 who worked in collaboration with the MD#4 via a telephone call. The NP#2 informed the surveyor that she completed an electronic progress note each time she visited which was monthly and as needed. The NP#2 added that she also signs monthly physician's orders but was unsure if there was a timeframe that the physician completed visits and progress notes and signed the monthly orders. The NP#2 further stated that everything was electronic, and that administration would be able to provide me with the documentation. On 5/2/24 at 2:09 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator (LNHA), Assistant Administration (AA), Regional Clinical Nurse (RCN) and Assistant Director of Nursing. The RCN stated that she thought the monthly PO were electronically signed by MD and NP and would have to check. On 5/7/24 at 10:10 AM, the survey team met with the LNHA, AA and RCN. The AA stated that the physician visits had not been completed timely or sequenced with the NP and that all the physicians were reeducated. The AA added that he thought the physician orders could be signed every other month by the NP. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/8/24 at 11:57 AM, the survey team met with the LNHA, RCN, AA and [NAME] President of Clinical Nursing. The RCN stated that the facility policy for physician orders being signed was included in the undated facility policy for Physician Visits that had been provided. There was no further documentation provided by the facility. 8. On 5/1/24 at 11:00 AM, the surveyor observed Resident #30 self propelling in a wheelchair. When interviewed, Resident #30 was noted alert and responsive. The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #30. A review of the Admission Record (one page summary of important information about a resident) for Resident #30. The resident was admitted to the facility with diagnoses that included but were not limited to pneumonia, malnutrition, cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD), schizophrenia and human immunodeficiency virus (HIV). A review of the Quarterly Minimum Data Set , an assessment tool used to facilitate the management of care, dated 3/31/24, reflected that Resident #30 had a Brief Interview for Mental Status score of 15 out of 15, indicating an intact cognition. A review of the resident's Order Review revealed that as of 4/12/24 the next order review was 20 days overdue. A review of the electronic Order Review History revealed that the attending physician (MD#1) had reviewed the PO and signed by Wet Ink on the following dates: 10/2/23 11/17/23 12/1/23 1/24/24 3/12/24 A review of the monthly PO titled Order Summary Report that were in the resident's physical chart revealed the following: -the active orders as of 10/1/23 were signed electronically on 11/17/23 by the MD#1. -the active orders as of 11/1/23 were physically signed on 12/1/23 by NP#1. -the active orders as of 12/1/23 were physically signed on 1/24/24 by MD#1. -the active orders as of 2/29/24 were physically signed on 3/12/24 by NP#1. -the active orders as of 3/31/24 were physically signed on 4/17/24 by NP#1. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were no Order Summary Reports physically signed in the resident's chart for April and January 2024. On 5/2/24 at 9:48 AM, the surveyor, in the presence of the survey team, interviewed the NP#1 who worked in collaboration with the attending physician (MD#1) via a speaker telephone call. The NP#1 stated that he entered all visits electronically and could not speak to the frequency of physician visits. The NP#1 added that the MD#1 signed the physician orders on paper. On 5/2/24 at 12:17 PM the surveyor, in the presence of the survey team, interviewed the MD#1 via a speaker telephone call. The MD#1 stated that he was in the facility once a week and that NP#1 completed the physician notes and that he signed the physician orders physically. On 5/2/24 at 2:09 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator (LNHA), Assistant Administration (AA), Regional Clinical Nurse (RCN) and Assistant Director of Nursing. The RCN stated that the physicians frequently visited and thought there was electronic physician's progress notes signed by the MD and NP and would have to check. On 5/7/24 at 10:10 AM, the survey team met with the LNHA, AA and RCN. The AA stated that the physician visits had not been completed timely or sequenced with the NP and that all the physicians were reeducated. The AA added that he thought the physician orders could be signed every other month by the APN. The AA added that MD#1 physically signs the monthly physician orders and would check for Resident #30. On 5/8/24 at 11:57 AM, the survey team met with the LNHA, RCN, AA and [NAME] President of Clinical Nursing (VPCN). The RCN stated that the facility policy for physician orders being signed was included in the facility policy for Physician Visits that had been provided. The VPCN stated that if an attending physician was physically signing the monthly orders for a resident, then signed PO would be in the resident's chart. There was no further documentation provided by the facility. A review of the undated facility policy for Physician Visits provided by the LNHA reflected that the Attending Physician must make visits in accordance with applicable state and federal requirements. In addition, the policy reflected: 2. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. 3. Non-physician practitioners (Physician Assistants and Nurse Practitioner) may perform required visits (initial and follow-up), sign orders and sign certifications/re-certifications as permitted by state and federal regulations. 4. After the first ninety (90) days, if the Attending Physician determines that a resident need not be seen by him/her every thirty (30) day, an alternate schedule of visits may be established, nut not to exceed every sixty (60) days. A physician Assistant or Nurse Practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation. 39399 9. On 5/1/24 at 10:37 AM, the resident was observed in the room with eyes closed. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed Resident #171's hybrid medical record. Resident #171 was admitted to the facility with diagnoses that included but not limited to Cellulitis of right lower limb, Myiasis, Peripheral Vascular Disease, and Venous Insufficiency. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 3/11/24 reflected that the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating that the resident had intact cognition. A review of the PPN's in the electronic medical record revealed the following had a LATE ENTRY (Any documentation that is recorded in the medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) designation which indicates the notes were not written on the effective date (Date of service): 1. PPN with an effective date of 3/7/24, but with a created date of 3/11/24 2. PPN with an effective date of 2/14/24, but with a created date of 3/4/24. 3. PPN with an effective date of 11/27/23, but with a created date of 12/26/23. 4. PPN with an effective date of 2/13/24, but with a created date of 2/15/24 10. On 4/29/24 at 11:57 AM, the surveyor observed the resident in bed with eyes closed. Review of the Admission Record (a one-page summary of important information about the patient) (AR) reflected Resident #460 was admitted with diagnosis that included but were not limited to Acute Pulmonary Edema, Congestive Heart Failure, Chronic Pulmonary Embolism and Dementia. A review of the Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated 4/29/24 reflected that the resident had a Brief Interview for Mental Status (BIMS) of 09 out of 15 indicating that the resident had moderately impaired cognition. A review of the PPN's in the electronic medical record revealed the following had a LATE ENTRY designation which indicates the notes were not written on the effective date (Date of service): 1. PPN with an effective date of 4/23/2024, but with a created date of 5/2/24. 44605 11a. The surveyor interviewed Resident #92 on 4/29/24 at 11:45 AM in dayroom. Resident stated they did not recall seeing their Medical Doctor (MD) recently. A review of the medical record revealed the following information. The resident was admitted with diagnoses including but not limited to pain in right foot, pain in left foot, and opioid dependence. The 3/1/24 Annual Minimum Data Set (AMDS), the resident scored a 14 out of 15 for the BIMS test indicating the resident had no cognitive deficits. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Complete Care at Orange Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 140 Park Ave East Orange, NJ 07017	

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of monthly physician orders revealed the primary physician had not hand-signed or electronically signed monthly orders for December 2023, February 2024, March 2024, and April 2024. 11b. A review of the PPN's in the electronic medical record revealed the following had a LATE ENTRY (Any documentation that is recorded in the medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) designation which indicates the notes were not written on the effective date (Date of service): 1. PPN with an effective date of 4/5/2024, but with a created date of 4/30/2023. 2. PPN with an effective date of 3/6/2024, but with a created date of 3/25/2024. 3. PPN with an effective date of 12/12/2023, but with a created date of 12/17/2023. 4. PPN with an effective date of 10/11/2023, but with a created date of 11/12/2023. 5. PPN with an effective date of 9/22/2023, but with a created date of 9/26/2023. 6. PPN with an effective date of 7/11/2023, but with a created date of 7/26/2023. 12a. The surveyor interviewed Resident #56 on 4/29/24 at 11:32 AM in dayroom. Resident stated they did not recall seeing their Medical Doctor (MD) in few months. A review of the medical record revealed the following information. The resident was admitted with diagnoses including but not limited to type 2 diabetes, hypertension, and peripheral vascular disease. The 4/3/24 AMDS, the resident scored a 13 out of 15 for the BIMS test indicating the resident had no cognitive deficits. A review of monthly physician orders revealed the primary physician had not hand-signed or electronically signed monthly orders for December 2023, February 2024, March 2024, and April 2024. 12b. A review of the PPN's in the electronic medical record revealed the following had a LATE ENTRY designation which indicates the notes were not written on the effective date (Date of service): 1. PPN with an effective date of 4/5/2024, but with a created date of 4/30/2023. 2. PPN with an effective date of 3/6/2024, but with a created date of 3/25/2024. 3. PPN with an effective date of 2/10/2024, but with a created date of 3/3/2024. 4. PPN with an effective date of 1/10/2024, but with a created date of 2/4/2024. 5. PPN with an effective date of 12/12/2023, but with a created date of 12/17/2023. 6. PPN with an effective date of 10/11/2023, but with a created date of 11/12/2023. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/2/24 at 10:05 AM, the surveyor conducted a phone interview with NP#1. The NP stated they will see all the resident's and type their progress notes but will leave the note in draft and sign off up to 10 days before signing off. The surveyor reviewed the progress notes differences with between the effective and created dates of Resident #92, with some being a difference of 30 days. The NP had no further comments. On 5/2/24 at 2:06 PM, the survey team met with the LNHA, RCN and AA to discuss concerns. All staff stated they were unaware that the NP was backdating PPN and would in-service all NPs immediately. On 5/3/24 at 12:29 PM, the LNHA provided the surveyor with a facility policy titled, Physician Visits. Under the policy interpretation and implementation, it states, 3/ Non-physician practitioners (Physician Assistant, Nurse Practitioner) may perform required visits (initial and follow-up), sign orders and sign certifications as permitted by state and federal regulations. On 5/7/24 at 10:08 PM, the survey team met with facility staff, no further comments made regarding NP backdating. 46889 13. On 05/02/24, at 1:00 PM, the surveyor observed Resident #57 sitting in the wheelchair, alert and oriented, and able to answer the surveyor's inquiry. Resident #57's medical records revealed the following information: According to the Admission Record (an admission summary) (AR), Resident #57 was admitted to the facility with diagnoses that included but were not limited to acute pyelonephritis (kidney infection). The Quarterly Minimum Data Set (QMDS), dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 14 out of 15, which indicates that the resident is cognitively intact. A review of monthly Physician Orders (PO) revealed that the primary physician had not hand-signed or electronically signed the orders for December 2023, January 2024, February 2024, and March 2024. 14. On 04/29/24 at 11:44 AM, the surveyor observed Resident #64 in bed, awake, and unable to answer the surveyor's inquiry. Resident #64's medical records revealed the following information: According to the AR, Resident #64 was admitted to the facility with diagnoses that included but were not limited to dementia (impairment of memory) unspecified severity with agitation. The QMDS, dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 0 out of 15, which indicates that the resident is cognitively severely impaired. A review of the monthly PO revealed that the primary physician had not hand-signed or electronically signed the orders for January 2024 and February 2024. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. On 04/29/24 at 11:09 AM, the surveyor observed Resident #37, who had just come out from the bathroom, sitting in a wheelchair. Resident #37's medical records revealed the following information: According to the AR, Resident #37 was admitted to the facility with diagnoses that included but were not limited to mental disorders not otherwise specified. The Annual MDS (AMDS), dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 15 out of 15, which indicates that the resident is cognitively intact. A review of the monthly PO revealed that the primary physician had not hand-signed or electronically signed the orders for April 2024. 16. On 04/29/24 at 10:21 AM, the surveyor observed Resident #22 lying in bed, awake, alert, and unable to answer the surveyor's inquiry. Resident #22's medical records revealed the following information: According to the AR, Resident #22 was admitted to the facility with diagnoses that included but were not limited to dementia. The QMDS, dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 0 out of 15, which indicates severely impaired cognition. A review of the monthly PO revealed that the primary physician had not hand-signed or electronically signed the orders for February 2024. 17. On 04/29/24 at 10:21 AM, the surveyor observed Resident #18 lying in bed, awake, alert, and able to answer the surveyor's inquiry. Resident #18's medical records revealed the following information: According to the AR, Resident #18 was admitted to the facility with diagnoses that included but were not limited to type 2 diabetes mellitus (too much sugar in the blood) without complication. The QMDS, dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 12 out of 15, which indicates that the resident has moderately impaired cognition. A review of the monthly PO revealed that the primary physician had not hand-signed or electronically signed the orders for February 2024. 49078 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18a. On 4/29/24 at 12:29 PM the surveyor reviewed the Admission Record for Resident #109. The resident was admitted to the facility with diagnoses that included but were not limited to Chronic Atrial Fibrillation and Bipolar Disorder. A review of the MDS dated [DATE], reflected that Resident #109 had a BIMS score of 15 out of 15, indicating the resident has no cognitive impairment. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #109 which revealed that the resident's primary care physician had not signed the resident's monthly orders from the months of December 2023 through March 2024. A review of the electronic Order Review History revealed that the attending physician (MD#1) had reviewed the PO and signed by Wet Ink on the date 4/10/24 only. The Sign Source was reflected as Web Application and Sign Method as Password at Login. 18b. A review of the Physician's Progress Notes (PPN) in the electronic medical record revealed the following had a LATE ENTRY (Any documentation that is recorded in the medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) designation which indicates the notes were not written on the effective date (Date of service): 1. PPN with an effective date of 4/26/2024, 4/22/2024, 4/18/2024, 4/10/2024, 4/6/2024 and 4/2/2024 but with a created date of 5/3/2024. 2. PPN with an effective date of 4/24/2024, but with a created date of 5/6/2024. 3. PPN with an effective date of 3/29/2024, 3/25/2024, 3/20/2024, 3/16/2024, 3/12/2024 and 3/8/2024 but with a created date of 5/3/2024. 4. PPN with an effective date of 3/4/2024, but with a created date of 5/2/2024. 5. PPN with an effective date of 2/27/2024, but with a created date of 5/2/2024. 19a. On 5/6/24 at 11:10 PM, the surveyor observed Resident #144 in a wheelchair. When the surveyor interviewed, Resident #144 was noted alert and responsive. The surveyor reviewed the Admission Record for Resident #144. The resident was admitted to the facility with diagnoses that included but were not limited to Peripheral Vascular Disease and Major Depressive Disorder. A review of the MDS dated [DATE], reflected that Resident #144 had a BIMS score of 15 out of 15, indicating the resident has no cognitive impairment. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #144 which revealed that the resident's primary care physician had not signed the resident's monthly orders from the months of September 2023 and February 2024. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the electronic Order Review History revealed that the attending physician (MD#1) had reviewed the PO and signed by Wet Ink on the following dates: 10/2/23, 11/17/23, 12/1/23, 1/24/24, 3/11/24 and 4/10/24. The Sign Source was reflected as Web Application and Sign Method as Password at Login. 19b. A review of the PPN's in the electronic medical record revealed the following had a LATE ENTRY (Any documentation that is recorded in the medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) designation which indicates the notes were not written on the effective date (Date of service): 1. PPN with an effective date of 4/24/2024, but with a created date of 5/3/2024. 2. PPN with an effective date of 4/17/2024, but with a created date of 5/2/2024. 3. PPN with an effective date of 3/13/2024, but with a created date of 3/25/2024. 4. PPN with an effective date of 2/14/2024, but with a created date of 3/4/2024. 5. PPN with an effective date of 1/10/2024, but with a created date of 3/4/2024. 6. PPN with an effective date of 12/6/2023, but with a created date of 12/26/2023. 7. PPN with an effective date of 11/5/2023, but with a created date of 12/26/2023. The facility provided no further documentation for all the residents reviewed. NJAC 8.39-23.2(b)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19106 Based on interview and record review, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face to face visits and wrote progress notes at least once every sixty days. This deficient practice was identified for 21 of 36 residents (77, 105, 30, 172, 183, 86, 134, 171, 72, 35, 92, 56, 64, 37, 22, 18, 109, 187, 144, 191, 512) reviewed for physician visits and was evidenced by the following: 1. On 4/29/24 at 11:16 AM, the surveyor observed Resident #77 in bed. When interviewed, Resident #77 was noted alert and responsive. The surveyor reviewed the Admission Record (one page summary of important information about a resident) for Resident #77. The resident was admitted to the facility with diagnoses that included but were not limited to right knee contracture and pyogenic arthritis. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/15/24, reflected that Resident #77 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident had no cognitive deficits. A review of the Physician's progress notes reflected the following: 3/13/24 Physician progress notes completed by Advanced Practice Nurse (APN). 2/25/24 Physician progress notes completed by APN. 2/05/24 Physician progress notes completed by APN. 1/23/24 Physician progress notes completed by APN. 1/07/24 Physician progress notes completed by APN. 12/30/23 Physician progress notes completed by APN. 11/28/23 Physician progress notes completed by APN. There was no documented evidence that the physician visited and examined Resident #77 at least every 60 days. 34033 2. On 5/1/24 at 10:12 AM, the surveyor observed Resident #105 self -propelling in a wheelchair. When interviewed, Resident #105 was noted alert and responsive. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the Admission Record (one page summary of important information about a resident) for Resident #105. The resident was admitted to the facility with diagnoses that included but were not limited to anemia, asthma, major depressive disorder, adjustment disorder with anxiety, other psychoactive substance dependence, hypertension (high blood pressure) and low back pain. A review of the Quarterly Minimum Data Set , an assessment tool used to facilitate the management of care, dated 3/28/24, reflected that Resident #105 had a Brief Interview for Mental Status score of 15 out of 15, indicating an intact cognition. A review of the Physician's progress notes reflected the following: 4/4/24 Physician progress notes were completed by Nurse Practitioner (NP#2). 2/15/24 Physician progress notes were completed by NP#2. 12/12/23 Physician progress notes were completed by NP#2. 9/26/23 Physician progress notes were completed by the NP#2 8/26/23 Physician progress notes were completed by NP#2. 8/17/23 Physician progress notes were completed by the attending physician (MD#4). There were no Physician progress notes for March or January 2024 and October or November 2023. There was no documented evidence that the physician visited and examined Resident #105 at least every 60 days. On 5/2/24 at 1:06 PM, the surveyor interviewed the NP#2 who worked in collaboration with the MD#4 via a telephone call. The NP#2 informed the surveyor that she completed an electronic progress note each time she visited which was monthly and as needed. The NP#2 added that she also signs monthly physician's orders but was unsure if there was a timeframe that the physician completed visits and progress notes and signed the monthly orders. The NP#2 further stated that everything was electronic, and that administration would be able to provide the documentation. On 5/2/24 at 2:09 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator (LNHA), Assistant Administration (AA), Regional Clinical Nurse (RCN) and Assistant Director of Nursing. The RCN stated that the physicians frequently visited and thought there was electronic physician's progress notes signed by the MD and NP and would have to check. On 5/7/24 at 10:10 AM, the survey team met with the LNHA, AA and RCN. The AA stated that the physician visits had not been completed timely or sequenced with the APN and that all the physicians were reeducated. The AA added that he thought the physician orders could be signed every other month by the APN. On 5/8/24 at 11:57 AM, the survey team met with the LNHA, RCN, AA and [NAME] President of Clinical Nursing. The RCN stated that the facility policy for physician orders being signed was included in the undated facility policy for Physician Visits that had been provided. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no further documentation provided by the facility. 3. On 5/1/24 at 11:00 AM, the surveyor observed Resident #30 self -propelling in a wheelchair. When interviewed, Resident #30 was noted alert and responsive. The surveyor reviewed the Admission Record (one page summary of important information about a resident) for Resident #30. The resident was admitted to the facility with diagnoses that included but were not limited to pneumonia, malnutrition, cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD), schizophrenia and human immunodeficiency virus (HIV). A review of the Quarterly Minimum Data Set , an assessment tool used to facilitate the management of care, dated 3/31/24, reflected that Resident #30 had a Brief Interview for Mental Status score of 15 out of 15, indicating an intact cognition. A review of the Physician's progress notes reflected the following: 4/10/24 Physician progress notes completed by NP#1. 3/13/24 Physician progress notes completed by NP#1. 3/10/24 Physician progress notes completed by NP#1. 3/5/24 Physician progress notes completed by the NP#1. 2/14/24 Physician progress notes completed by NP#1. 12/26/23 Physician progress notes completed by NP#1. 11/27/23 Physician progress notes completed by NP#1. 10/27/23 Physician progress notes completed by NP#1. 8/18/23 Physician progress notes completed by NP#1. There was no physician progress notes for January 2024 or for September 2023. There was no documented evidence that the physician visited and examined Resident #30 at least every 60 days. On 5/2/24 at 9:48 AM, the surveyor, in the presence of the survey team, interviewed the NP#1 who worked in collaboration with the attending physician (MD#1) via a speaker telephone call. The NP#1 stated that he entered all visits electronically and could not speak to the frequency of physician visits. The NP#1 added that the MD#1 signed the physician orders on paper. On 5/2/24 at 12:17 PM the surveyor, in the presence of the survey team, interviewed the MD#1 via a speaker telephone call. The MD#1 stated that he was in the facility once a week and that NP#1 completed the physician notes and he signed the physician orders physically. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/2/24 at 2:09 PM, the surveyor discussed the above concern with the facility's Licensed Nursing Home Administrator (LNHA), Assistant Administration (AA), Regional Clinical Nurse (RCN) and Assistant Director of Nursing. The RCN stated that the physicians frequently visited and thought there was electronic physician's progress notes signed by the MD and NP and would have to check. On 5/7/24 at 10:10 AM, the survey team met with the LNHA, AA and RCN. The AA stated that the physician visits had not been completed timely or sequenced with the NP and that all the physicians were reeducated. The AA added that he thought the physician orders could be signed every other month by the APN. The AA added that MD#1 physically signs the monthly physician orders and would check for Resident #30. On 5/8/24 at 11:57 AM, the survey team met with the LNHA, RCN, AA and [NAME] President of Clinical Nursing (VPCN). The RCN stated that the facility policy for physician orders being signed was included in the facility policy for Physician Visits that had been provided. The VPCN stated that if an attending physician was physically signing the monthly orders for a resident, then they would be in the resident's chart. There was no further documentation provided by the facility. A review of the undated facility policy for Physician Visits provided by the LNHA reflected that the Attending Physician must make visits in accordance with applicable state and federal requirements. In addition, the policy reflected: 2. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. 3. Non-physician practitioners (Physician Assistants and Nurse Practitioner) may perform required visits (initial and follow-up), sign orders and sign certifications/re-certifications as permitted by state and federal regulations. 4. After the first ninety (90) days, if the Attending Physician determines that a resident need not be seen by him/her every thirty (30) day, an alternate schedule of visits may be established, nut not to exceed every sixty (60) days. A physician Assistant or Nurse Practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation. 34421 4. On 4/29/24 at 11:16 AM, the surveyor observed Resident # 172 in bed in their room with their eyes closed and the resident was unable to be interviewed. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #172 which revealed that the resident's primary care physician had not written a progress note from September 2023 to March 2024. A review of the resident's Face Sheet with diagnoses that included Anoxic Brain Damage, Chronic Respiratory Failure, Cardiac Arrest, Tracheostomy, Gastrostomy, and Dependence on Respirator Ventilator Status. A review of the QMDS, an assessment tool used to facilitate care management dated 4/1/24, indicated that the resident was severely cognitively impaired. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 4/29/24 at 11:06 AM, the surveyor observed Resident # 183 in bed in their room with their eyes closed and the resident was unable to be interviewed. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #183 which revealed that the resident's primary care physician had not written a progress note for the month February 2024. A review of the resident's Face Sheet with diagnoses that included Anoxic Brain Damage, Asthma, Epilepsy, Quadriplegia, Tracheostomy, and Gastrostomy. A review of the QMDS, an assessment tool used to facilitate care management dated 3/31/24, indicated that the resident was severely cognitively impaired. 6. On 4/30/24 at 9:45 AM, the surveyor observed Resident # 86 in bed in their room and was pleasant upon interview. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #86 which revealed that the resident's primary care physician had not written a progress note for the month of January 2024. A review of the resident's Face Sheet with diagnoses that included Heart Failure, Dependence eon renal Dialysis, Peripheral Vascular Disease, Chronic Viral Hepatitis C, and End Stage Renal Disease. A review of the Annual Minimum Data Set (AMDS), an assessment tool used to facilitate care management dated 3/8/24, indicated that the resident was cognitively intact. 7. On 4/29/24 at 10:59 AM, the surveyor observed Resident # 134 in bed in their room and was pleasant upon interview. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #134 which revealed that the resident's primary care physician had not written a progress note from November 2023 to March 2024. A review of the resident's Face Sheet with diagnoses that included Chronic Respiratory Failure, Tracheostomy, Gastrostomy, Dependence on Ventilator, Peripheral Vascular Disease and Hydronephrosis. A review of the QMDS, an assessment tool used to facilitate care management dated 2/12/24, indicated that the resident was severely cognitively impaired. On 5/2/24 at 12:23 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated that the physician's should be writing progress notes in the electronic medical record and could not provide any further information. 39399 8. On 5/1/24 at 10:37 AM, the resident was observed in the room with eyes closed. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed Resident #171's hybrid medical record. Resident #171 was admitted to the facility with diagnoses that included but not limited to Cellulitis of right lower limb, Myiasis, Peripheral Vascular Disease, and Venous Insufficiency. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 3/11/24 reflected that the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating that the resident had intact cognition. A review of the Physician's progress notes reflected that there was no documented evidence that the physician visited and examined Resident #171 at least every 60 days from November 2023 through April 2024. 9. On 04/29/24 11:57 AM, the resident was observed in the room with eyes closed. The surveyor reviewed Resident #72's hybrid medical record. Resident #72 was admitted to the facility with diagnoses that included but not limited to Seizures, Chronic Ischemic Heart Disease, Hypertension, Benign Prostatic Hypertrophy. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 4/28/24 reflected that the resident had a Brief Interview for Mental Status (BIMS) of 06 out of 15 indicating that the resident had intact cognition. A review of the Physician's progress notes reflected that there was no documented evidence that the physician visited and examined Resident #72 at least every 60 days from November 2023 through April 2024. 44605 10. On 4/29/24 at 11:19 AM, the surveyor observed Resident #35 in bed asleep. The surveyor reviewed the Admission Record for Resident #35. The resident was admitted to the facility with diagnoses that included but were not limited to chronic respiratory failure with hypoxia, tracheostomy, and paraplegia. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/25/24, reflected that Resident #35 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating the resident had no cognitive deficits. A review of the Physician's progress notes (PPN) reflected the following: 4/19/2024 PPN completed by Advanced Practice Nurse (APN#1). 3/7/24 PPN completed by APN#1. 2/15/24 PPN completed by APN#1. 1/31/24 PPN completed by APN#1. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/7/24 PPN completed by APN#1. 12/21/23 PPN completed by APN#2. 11/25/23 PPN completed by APN#1. There was no documented evidence that the physician visited and examined Resident #35 at least every 60 days. 11. On 4/29/24 at 11:45 AM, the surveyor interviewed Resident #92 in dayroom. Resident stated they did not recall seeing their Medical Doctor (MD) recently. The surveyor reviewed the Admission Record for Resident #92. The resident was admitted with diagnoses including but not limited to pain in right foot, pain in left foot, and opioid dependence. The 3/1/24 Annual Minimum Data Set (AMDS), the resident scored a 14 out of 15 for the BIMS test indicating the resident had no cognitive deficits. A review of the PPN reflected the following: 4/5/24 PPN completed by Nurse Practitioner (NP#1) 3/6/24 PPN completed by NP#1 12/12/23 PPN completed by NP#1 10/11/23 PPN completed by NP#1 9/22/23 PPN completed by NP#1 There was no documented evidence that the physician visited and examined Resident #92 at least every 60 days. 12. On 4/29/24 at 11:32 AM, the surveyor interviewed Resident #56 in dayroom. Resident stated they did not recall seeing their Medical Doctor (MD) in few months. The surveyor reviewed the Admission Record for Resident #56. The resident was admitted with diagnoses including but not limited to type 2 diabetes, hypertension, and peripheral vascular disease. The 4/3/24 AMDS, the resident scored a 13 out of 15 for the BIMS test indicating the resident had no cognitive deficits. A review of the PPN reflected the following: 3/6/24 PPN completed by NP#1 2/10/24 PPN completed by NP#1 (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/10/24 PPN completed by NP#1 12/12/23 PPN completed by NP#1 There was no documented evidence that the physician visited and examined Resident #56 at least every 60 days. 46889 13. On 4/29/24 at 11:44 AM, the surveyor observed Resident #64 in bed, awake, and unable to answer the surveyor's inquiry. Resident #64's medical records revealed the following information: According to the Admission Record (an admission summary) (AR), Resident #64 was admitted to the facility with diagnoses that included but were not limited to dementia (impairment of memory) unspecified severity with agitation. The QMDS dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 0 out of 15, which indicates that the resident is cognitively severely impaired. A review of the Physician's Progress Notes (PPN) reflected that APN #1 completed the following notes on the following dates: 4/10/24, 3/6/24, 2/14/24, 1/21/24, 1/17/24, 1/13/24, 1/8/24, 1/3/24, 12/26/23, and 11/27/23. 14. On 4/29/24 at 11:09 AM, the surveyor observed Resident #37, who had just come out from the bathroom, sitting in a wheelchair. Resident #37's medical records revealed the following information: According to the AR, Resident #37 was admitted to the facility with diagnoses that included but were not limited to mental disorders not otherwise specified. The AMDS, dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 15 out of 15, which indicates that the resident is cognitively intact. A review of the PPN reflected that the APN had completed the following notes on the following dates: 5/6/24 and 4/26/24. 15. On 4/29/24 at 10:21 AM, the surveyor observed Resident #22 lying in bed, awake, alert, and unable to answer the surveyor's inquiry. Resident #22's medical records revealed the following information: According to the AR, Resident #22 was admitted to the facility with diagnoses that included but were not limited to dementia. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The QMDS, dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 0 out of 15, which indicates that the resident is cognitively severely impaired. A review of the PPN reflected the APN #1 completed the following notes on the following dates: 4/10/24, 3/13/24, 2/14/24, 1/10/24, 12/26/23, and 11/27/23. 16. On 4/29/24 at 10:21 AM, the surveyor observed Resident #18 lying in bed, awake, alert, and able to answer the surveyor's inquiry. Resident #18's medical records revealed the following information: According to the AR, Resident #18 was admitted to the facility with diagnoses that included but were not limited to type 2 diabetes mellitus (too much sugar in the blood) without complication. The QMDS, dated [DATE], indicated that the facility assessed the resident's cognitive status using BIMS. The resident scored 12 out of 15, which indicates that the resident has moderately impaired cognition. A review of the PPN reflected that APN #1 completed the following notes on the following dates: 4/17/24, 3/6/24, 2/14/24, 1/10/24, 12/26/23, and 11/27/23. 49078 17. On 4/29/24 at 12:49 PM, the surveyor observed Resident #109 in bed. When the surveyor interviewed, Resident #109 was noted alert and responsive. The surveyor reviewed the Admission Record for Resident #109. The resident was admitted to the facility with diagnoses that included but were not limited to Chronic Atrial Fibrillation and Bipolar Disorder. A review of the MDS dated [DATE], reflected that Resident #109 had a BIMS score of 15 out of 15, indicating the resident has no cognitive impairment. A review of the Physician's progress notes reflected the following: Physician progress notes, reflecting the words LATE ENTRY, dated 4/26/24, 4/22/24, 4/18/24, 4/10/24, 4/6/24 and 4/2/24 with a created date of 5/3/24 completed by the NP #1 A Physician progress note reflecting the words LATE ENTRY, dated 4/24/24 with a created date of 5/6/24 completed by the physician MD #1. Physician progress notes, reflecting the words LATE ENTRY, dated 3/29/24, 3/25/24, 3/20/24, 3/16/24, 3/12/24 and 3/8/24 with a created date of 5/3/24 completed by NP #1. Physician progress notes, reflecting the words LATE ENTRY, dated 3/4/24 with a created date of 5/2/24 completed by NP #1. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician progress notes, reflecting the words LATE ENTRY, dated 2/27/24 with a created date of 5/2/24 completed by NP #1. Further review of the resident's electronic medical record (EMR) did not reflect any further Physician progress notes completed by the physician. There was no documented evidence that the physician visited and examined Resident #109 at least every 60 days. 18. On 4/30/24 at 10:07 AM, the surveyor observed Resident #187 in bed. When interviewed, Resident #187 was noted alert and responsive. The surveyor reviewed the Admission Record for Resident #187. The resident was admitted to the facility with diagnoses that included but were not limited to Essential Hypertension, fracture of left tibia and Major Depressive Disorder. A review of the Admission MDS dated [DATE], reflected that Resident #187 had a BIMS score of 15 out of 15, indicating the resident had no cognitive deficits. A review of the Physician's progress notes reflected the following: A Physician progress note, dated 4/10/24,reflecting the words LATE ENTRY with a created date of 4/21/24 completed by the physician (MD #5). Physician progress notes, dated 4/30/24, 4/24/24, 4/22/24, 4/20/24, 4/17/24, 4/15/24 and 4/12/24 completed by APN #1. Physician progress notes, dated 3/20/24, 3/18/24, 3/14/24, 3/12/24, 3/8/24, 3/6/24 and 3/4/24 completed by APN #1. Physician progress notes, dated 2/28/24, 2/26/24, 2/23/24, 2/20/24, 2/19/24, 2/16/24, 2/14/24, 2/12/24, 2/8/24 and 2/7/24 completed by APN #1. A Physician progress note / History and Physical (a note made when a resident is first seen in the facility) dated 2/5/24 completed by APN #1. Further review of the resident's electronic medical record (EMR) did not reflect any further Physician progress notes completed by the physician. The EMR reflected a note with a discharge date of [DATE]. There was no documented evidence that the physician visited and examined Resident #187 at least every 60 days. 19. On 4/29/24 at 12:49 PM, the surveyor observed Resident #144 in a wheelchair. When the surveyor interviewed, Resident #144 was noted alert and responsive. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the Admission Record for Resident #144. The resident was admitted to the facility with diagnoses that included but were not limited to Peripheral Vascular Disease and Major Depressive Disorder. A review of the MDS dated [DATE], reflected that Resident #144 had a BIMS score of 15 out of 15, indicating the resident has no cognitive impairment. A review of the Physician's progress notes reflected the following: A Physician progress note, reflecting the words LATE ENTRY, dated 4/24/24, with a created date of 5/3/24 completed by the physician MD #1. A Physician progress note reflecting the words LATE ENTRY, dated 4/17/24 with a created date of 5/2/24 completed by the physician NP #1. Physician progress notes, reflecting the words LATE ENTRY, dated 3/13/24, with a created date of 3/25/24 completed by NP #1. A Physician progress note, reflecting the words LATE ENTRY, dated 2/14/24 with a created date of 3/4/24 completed by NP #1. A Physician progress note, reflecting the words LATE ENTRY, dated 1/10/24 with a created date of 3/4/24 completed by NP #1. A Physician progress note, reflecting the words LATE ENTRY, dated 12/6/23 with a created date of 12/26/23 completed by NP #1. A Physician progress note, reflecting the words LATE ENTRY, dated 11/5/23 with a created date of 12/26/23 completed by NP #1. Further review of the resident's electronic medical record (EMR) did not reflect any further Physician progress notes completed by the physician. There was no documented evidence that the physician visited and examined Resident #144 at least every 60 days. 20. On 4/29/24 at 11:39 AM, the surveyor observed Resident #191 in bed. When the surveyor interviewed, Resident #191 was noted alert and partially responsive. The resident was able to respond to surveyor basic questions with yes, no, gestures and facial expressions. The surveyor reviewed the Admission Record for Resident #191. The resident was admitted to the facility with diagnoses that included but were not limited to Degenerative Disease of Nervous System and Sickle Cell Disease. A review of the Admission MDS dated [DATE], reflected that Resident #191 had a BIMS score of 9 out of 15, indicating the resident has moderate cognitive impairment. A review of the Physician's progress notes reflected the following: (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician progress note, dated 4/10/24 , reflecting the words LATE ENTRY with a created date of 4/22/24 completed by the physician (MD #5). Physician progress notes, dated 4/18/24 and 4/3/24 completed by APN #1. Physician progress notes, dated 3/21/24, 3/18/24, 3/15/24, 3/13/24, 3/11/24, 3/8/24, 3/6/24, 3/5/24, 3/4/24 and 3/1/24 completed by APN #1. Physician progress notes, dated 2/27/24, 2/26/24 and 2/25/24,completed by APN#1. A Physician progress note / History and Physical (a note made when a resident is first seen in the facility) dated 2/21/24 completed by APN #1. Further review of the resident's electronic medical record (EMR) did not reflect any further Physician progress notes completed by the physician. There was no documented evidence that the physician visited and examined Resident #191 at least every 60 days. 21. Complaint NJ00163003 On 5/7/24 at 12:02 PM, the surveyor reviewed the electronic medical record for Resident #512. The record reflected the resident was discharged from the facility on 8/4/23. The surveyor reviewed the Admission Record for Resident #512. The resident was admitted to the facility with diagnoses that included but were not limited to Type 2 Diabetes and Peripheral Vascular Disease. A review of the Quarterly MDS dated [DATE], reflected that Resident #512 had a BIMS score of 12 out of 15, indicating the resident has moderate cognitive impairment. A review of the Physician's progress notes reflected the following: A Physician progress note reflecting the words LATE ENTRY, dated 7/11/23 with a created date of 7/26/23 completed by nurse Practioner (NP) NP #1. A Physician progress note, reflecting the words LATE ENTRY, dated 6/6/23, with a created date of 6/15/23 completed by NP #1. A Physician progress note, reflecting the words LATE ENTRY, dated 5/9/23 with a created date of 5/9/23 completed by NP #1. A Care Coordination note, dated 4/10/23 with a created date of 4/10/23 completed by NP #3. A Care Coordination note, dated 3/10/23 with a created date of 3/11/23 completed by APN #2. A Care Coordination note dated 1/27/23 with a created date of 1/27/23 completed by APN # 2. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the resident's electronic medical record (EMR) did not reflect any further Physician progress notes completed by the physician. There was no documented evidence that the attending physician, MD #1 visited and examined Resident #512 at least every 60 days. On 5/3/24 at 12:29 PM, the Administrator provided the facility policy titled Physician Visits to the survey team. The surveyor reviewed the facility policy which reflected on the first line, The Attending Physician must make visits in accordance with applicable state and federal regulations. It also reflected: 1. The attending Physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. 2. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. 4. After the first ninety (90) days, if the Attending Physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established, but not to exceed every sixty (60) days. A Physician Assistant or Nurse Practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation. N.J.A.C. 8:39-23.2(c)

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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. 34033 COMPLAINT #NJ0016817 Based on interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by ensuring a.) accurate administration of a medication, (Midodrine)(a medication used to increase the blood pressure), according to the physician's order and b.) the availability of medications ordered by the physician for medication administration. The deficient practice was identified for one (1) of 11 residents, (Resident #513), reviewed for medication management. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and 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 prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient practice was evidenced by the following: The surveyor reviewed the closed medical record for Resident #513. A review of the comprehensive Minimum Data Sheet (MDS) (an assessment tool used to facilitate the management of care) dated 2/17/23, reflected the resident had a brief interview for mental status (BIMS) score of 14 out of 15, indicating the resident had an intact cognition. A review of the resident's Order Summary Report reflected a physician's order (PO) dated 2/10/23 for Midodrine oral tablet 10 milligram (MG), give 1 tablet by mouth every 8 hours for low blood pressure (BP), hold if systolic BP greater than 130. A review of the February 2023 electronic medication administration record (EMAR) revealed the above PO for Midodrine was not administered and had an entry of seven (7) documented on 2/10/23 for the administration time of 2 PM and an entry of three (3) documented on 2/20/23 for the administration time of 6 AM. According to the EMAR chart codes an entry of seven (7) corresponds to Other/See Nurses Notes and three (3) corresponds to Hold/See Nurses Notes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the corresponding electronic nursing progress notes (ENPN) revealed that on 2/10/23 at 2:27 PM the Licensed Practical Nurse (LPN#2) had not administered the Midodrine because awaiting delivery and on 2/20/23 at 6:43 AM the LPN #6 had not administered the Midodrine because the BP 98/57. Additional review of the resident's Order Summary Report reflected a PO dated 2/10/23 for Pantoprazole oral tablet delayed release, 40 MG, give 1 tablet by mouth two times a day for stomach ulcer. A review of the February EMAR revealed the above corresponding PO dated for Pantoprazole (Protonix) (a medication used to reduce acid in the stomach) was not administered and had an entry of seven (7) on 2/10/23 for the administration time of 9 AM. A review of the corresponding ENPN revealed that on 2/10/23 at 9:10 AM the LPN#2 had not administered the Protonix because awaiting delivery. Further review of the resident's Order Summary Report reflected a PO dated 2/10/23 for Psyllium oral packet 58.12%, give 1 packet by mouth two times a day for constipation, hold for loose stools. A review of the February EMAR revealed the above corresponding PO for Psyllium (Metamucil) was not administered at the administration time of 9 AM and had an entry of seven (7) for the following dates: 2/10, 2/11, 2/13, 2/14, 2/15, 2/21, 2/22, 2/23, 2/24, 2/25 and 2/27/23. A review of the ENPN for Metamucil administration revealed that on 2/10, 2/11, 2/13, 2/14, 2/15, 2/21, 2/22, 2/23, 2/24, 2/25 and 2/27/23 the LPN#2 had not administered the Metamucil because awaiting delivery. On 5/2/24 at 11:32 AM, the surveyor, with LPN#2, reviewed the resident's EMAR and ENPN and the LPN#2 verified that she had documented that the Midodrine, Protonix and Metamucil were not administered and indicated that she was awaiting delivery because the medications were not in the cart. LPN#2 stated that she was unsure if she called the physician. LPN#2 also stated that she knew the process when a medication was not available that the physician was to be called for follow up and the pharmacy was to be called. LPN#2 added that there should be a progress note when the physician was called. LPN#2 could not explain to why the process had not been done. Further review of the ENPN revealed no documentation of the physician being called or follow up regarding the medications not being available at the time indicated for administration. On 5/2/24 at 2:09 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), Regional Clinical Nurse (RCN) and Assistant Director of Nursing. The surveyor reviewed the medications that had an entry of seven (7). The RCN stated that Metamucil was a house stock medication and should have been available. The RCN added that she would have to check. A review of the facility over the counter house stock medication list indicated that Metamucil was on the list and that the facility had those listed medications readily available at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER: Complete Care at Orange Park		STREET ADDRESS, CITY, STATE, ZIP CODE: 140 Park Ave East Orange, NJ 07017	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 10:10 AM, the survey team met with the LNHA, AA and RCN. The RCN acknowledged that the medications were not administered and documented as awaiting delivery. The RCN added that the Metamucil was an OTC medication and could not explain why the LPN had not administered the Metamucil. In addition, the RCN stated that the nurses should know the procedure to follow when medications were not available and could not explain why the procedure was not followed. The RCN stated that the nurses were to call the provider pharmacy to find out why a medication was not delivered, and the physician was to be called to see if there were new orders to be followed, or to give another medication. On 5/7/24 at 11:00 AM, the surveyor, with the RCN, reviewed an ENPN completed by LPN#6 indicating that the Midodrine was not administered because the BP was 98/57. The RCN stated that the Midodrine should have been administered. At that time, the AA stated that LPN#6 no longer worked for the facility. On 5/8/24 at 11:48 AM, the surveyor interviewed the RCN who acknowledged that the Midodrine should have been administered for a BP of 98/57. In addition, the RCN acknowledged that the medications that were noted as awaiting delivery were not administered and the procedure if a medication was not available was not accurately documented or followed up on. The RCN stated that the nurses should know the proper procedure and could not speak to why it was not followed. On 5/8/24 at 3:53 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone. The CP stated that she had done medication administration in services frequently with individual nurses at the facility. The CP acknowledged that when a medication was not available there should be follow up. The CP added that the physician should be called and possibly change the medication to a medication that was in the facility back up supply. The CP also stated that Midodrine was a medication that could be confusing but that the nurses needed to read the physician's orders. The CP added that she would email the facility the Administration of Medication Inservice information papers that she used. A review of the Administration of Medication Inservice information papers provided by the CP included Please READ ALL YOUR ORDERS. In addition, Please follow up with the pharmacy if medications are not available. A review of the facility policy for Administering Medications updated 10/2023 provided by the RCN reflected that Medications shall be administered in a safe and timely manner, and as prescribed. In addition, Medications must be administered in accordance with the orders, including any required time frame. A review of the facility policy for Unavailable Medications dated 1/1/2024 provided by the RCN reflected that The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. In addition, Staff shall take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold. NJAC 8:39-11.2(b), 29.2 (a)(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Orange Park	140 Park Ave East Orange, NJ 07017

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44605 Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 4/29/24 at 09:25 AM, the surveyor in the presence of the Certified Dietary Manager (CDM) and Regional CDM (RCDM) observed the following during the kitchen tour: 1. Upon entering the kitchen the surveyor observed the CDM and Chef both wearing earrings that hung more than one inch (in) from their earlobes. The RCDM acknowledged both the CDM and Chef were wearing jewelry that is prohibited in the kitchen area, both staff members removed their earrings. 2 During the kitchen inspection, the surveyor observed inside the walk-in freezer, frost build up on one of two fans as well as multiple boxed items stacked above 18 inches from ceiling. The CDM stated they have the fan cleaned and have the frost removed, the CDM further stated they will rearrange the boxes, so they are stored below the 18 inches from the ceiling. 3. The surveyor observed inside the walk-in refrigerator, a blackish colored debris build up on two of two fans. The CDM stated, the maintenance department oversees cleaning the fans and they would be alerted immediately. On 5/1/24 at 12:54 PM, the CDM provided the surveyor with multiple facility policies including Uniform Policy, Receivable and Storage Policy, and Reporting Equipment/Maintenance Needs Policy. The Uniform Policy with a revised date of 5/8/17 states under the procedure section, Jewelry should be limited to a wedding band. The Receivable and Storage Policy with a revised date of 9/2023 states under the procedure section, Store all items at least 6 inches off the floor, 18 inches from the ceiling and away from the refrigerator, freezer, and dry storage area walls. The Reporting Equipment/Maintenance Needs Policy with a revised date of 11/2023 states under the procedure section, Food Service Director or Designee will identify equipment or maintenance needs as needed. On 5/2/24 at 2:06 PM, the survey team met with Licensed Nursing Home Administrator (LNHA), Regional Clinical Nurse (RCN), Assistant LNHA (ALNHA) to discuss concerns. The RCN stated they will investigate the kitchen concerns and get back to the surveyor. On 5/7/24 at 10:08 LNHA, RCN and ALNHA met with the survey team for follow up to previous concerns. The LHNA stated they in-serviced the staff for jewelry, no further comment. NJAC 8:39-17.2(g)