STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Cedar Grove	536 Ridge Road Cedar Grove, NJ 07009

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 3 of 35 residents reviewed for the accommodation of needs (Resident #108, #128, and #116), and was evidenced by the following: 1. On 11/12/24 at 11:55 AM, the surveyor observed Resident #108 in bed on a specialty mattress with a contracture to their right hand. The surveyor observed the resident's call bell (a bell used to summon staff for assistance) was affixed to the right upper enabler and dangling down towards the floor, not within his/her reach. The surveyor reviewed the medical record for Resident #108. A review of the resident's Admission Record reflected that Resident #108 was admitted to the facility with diagnoses that included but were not limited to hemiplegia (mild or partial weakness or loss of strength on one side of the body) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body), dysphagia and gastrostomy status (surgical procedure creating an opening into the stomach through the abdominal wall to provide nutrition). A review of Resident #108's Annual Minimum Data Set (MDS) an assessment tool dated 9/26/24 revealed Resident #108 had a long- and short-term memory problem and a severe cognitive impairment. The MDS further revealed that the resident was dependent on staff for personal hygiene. A review of Resident 108's Individualized Care Plan (CP) included a focus that indicated the resident had impaired vision r/t cataracts with interventions to tell the resident where items are placed; and to be consistent. 2. On 11/13/24 at 12:00 PM, the surveyor observed Resident #128 in bed on a specialty mattress with the call bell dangling down on the right side of the bed between the upper enabler and the mattress, not within the Resident's reach. A review of Resident #128's Admission Record reflected that the Resident was admitted to the facility with diagnoses that included but were not limited to cerebrovascular disease, aphasia, and hypertension. (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: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Cedar Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 536 Ridge Road Cedar Grove, NJ 07009	

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	A review of Resident #128's quarterly MDS dated [DATE] revealed Resident #128 had highly impaired vision, long- and short-term memory problems, and severe cognitive impairment. The MDS further revealed that the resident was dependent on staff for personal hygiene. A review of Resident 128's CP included a focus that indicated the resident had a cerebral vascular accident (stroke) affecting the right side with interventions to keep the call bell on the left side of the resident where his/her arm is stronger. On 11/13/24 at 12:10 PM, the surveyor and Certified Nursing Assistant (CNA #1) assigned to Resident #128's care, entered the resident's room and observed the call bell dangling down on the right side of the bed between the upper enabler and the mattress, not within the Resident's reach. The CNA stated that she should have placed the call bell within the resident's reach as the resident was unable to speak and the call bell was their only means of summoning staff assistance. 3. On 11/13/24 at 12:05 PM, the surveyor observed Resident #116 in bed on a specialty mattress with the call bell on the floor under the resident's bed. The surveyor interviewed Resident #116 who stated that he/she would usually use their call bell to call for staff assistance, but they were unable to locate it today. Resident #116 further stated, She forgot to give it to me. A review of Resident #116's Admission Record reflected that the Resident was admitted to the facility with diagnoses that included but were not limited to dependence on dialysis, glaucoma, and visual loss in both eyes. A review of Resident #116's quarterly MDS dated [DATE] revealed Resident #116's vision was severely impaired. The MDS further assessed resident #116 had a BIMS score of 15 out of 15 which indicated the resident's cognition was intact. A review of Resident 116's CPs included a focus that indicated the resident was at high risk for falls with interventions to keep the call bell within their reach and a CP which included a focus that indicated Resident #116 had visual function loss with interventions to place the call bell near the resident's hand and to move the resident's hand so that he/she could feel the call bell was within reach. On 11/13/24 at 12:22 PM, the surveyor accompanied by the Licensed Practical Nurse (LPN) entered Resident #116's room. The LPN observed the call bell on the floor and confirmed that the call bell should always be kept within the resident's reach. On 11/13/24 at 12:33 PM, the surveyor interviewed the CNA (CNA #2) assigned to Resident #116's care who confirmed she should have ensured the call bell was placed within the resident's reach. On 11/15/24 at 1:14 PM, the surveyor discussed the above observations and concerns with the Administration. The Director of Nursing (DON) confirmed that the call bells should be placed within the residents' reach. NJAC 8:39- 31.8 (c)(9)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Cedar Grove	536 Ridge Road Cedar Grove, NJ 07009

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 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. 34421 Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice for not following physician orders for medications with parameters for 1 of 1 residents reviewed (Resident # 148). The 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 licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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 surveyor reviewed the medical records for Resident #148 that revealed the following: According to the Order Summary Report Resident # 148 had an order dated 8/16/24 for Entresto (a medication to treat high blood pressure) 24-26 MG, give 1 tablet by mouth two times a day. Hold if SBP (systolic blood pressure) is less than 110. The November 2024 Electronic Medication Administration Records revealed there were several dates that the nurse gave the Entresto 24-26 MG medication when the resident's systolic blood pressure was below 110. Entresto 24-26 was given when the SBP was below 110 by the 3-11 nurse on 11/4, 11/5, 11/8, and 11/9/24. The surveyor interviewed the Licensed Practical Nurse on 11/15/24 at 11:47 AM, who stated that the medication should have been held for the dates of 11/4, 11/5, 11/8 and 11/9/24, when the resident's SBP was lower than 110. She stated that there were no negative outcomes after that medication was administered. At 12:35 PM, the DON stated that the facility did not have a specific policy regarding following a physician's order. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Cedar Grove	536 Ridge Road Cedar Grove, NJ 07009

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36419

Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure respiratory tubing cannula was stored in accordance with infection control measures for 1 of 4 residents, (Resident #55) and b.) administer oxygen therapy according to the physician's order for 3 of 4 residents, Resident #28, #160 and #273).

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 11/12/24 at 12:00 PM, the surveyor observed Resident #55 in bed with a portable oxygen tank at bedside, not in use. The surveyor observed a nasal cannula (NC) tubing dated 9/26/24, wrapped around the tank, suspending down onto the floor. The tubing was not stored in a bag. Resident #55 stated that he/she used the oxygen mostly at night for shortness of breath.

The surveyor reviewed the medical record for Resident #55.

According to the Admission Record, the resident was admitted to the facility with diagnoses that included but were not limited to obstructive sleep apnea and hypertension.

The quarterly Minimum Data Set (MDS), an assessment tool, dated 11/8/24, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #55's cognition was intact.

A review of the resident's Individual Care plan (CP) included a focus area initiated on 4/19/23 that indicated the resident used oxygen therapy as needed for ineffective gas exchange. The interventions included monitoring for signs and symptoms of respiratory distress and reporting to MD.

A review of the November Order Summary Report (OSR) reflected an order for Oxygen at 2 Liters per minute (LPM) via nasal cannula (NC)

as needed (PRN) for shortness of breath.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Complete Care at Cedar Grove		STREET ADDRESS, CITY, STATE, ZIP CODE: 536 Ridge Road, Cedar Grove, NJ 07009	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 11:30 AM, the surveyor observed Resident #55 in his/her room seated in a wheelchair. The surveyor observed the portable oxygen tank not in use with the NC tubing stored in a plastic bag dated 9/26/24. On 11/13/24 at 11:40 AM the surveyor accompanied by the Licensed Practical Nurse (LPN #1) entered the resident's room and observed that the NC tubing stored in a plastic bag was dated 9/26/24. LPN #1 stated that the facility policy was for the NC tubing to be changed every Wednesday by the night nurses. LPN #1 acknowledged that she should have checked it earlier and then discarded the tubing. 2. On 11/12/24 at 12:20 PM, the surveyor observed Resident #28 in bed with their eyes closed. The surveyor observed the NC tubing undated and suspending off the back of the tank not stored in a plastic bag. The surveyor reviewed the medical record for Resident #28. According to the Admission Record, the resident was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure, Parkinson's disease, diabetes mellitus, and gastrostomy status (a tube inserted into the stomach to provide nutrition.) The quarterly MDS dated [DATE] reflected a BIMS score of 9 out of 15 which indicated Resident #55 had a moderate cognitive impairment. A review of the resident's CP included a focus area that indicated the resident used oxygen therapy as needed. The interventions included monitor for signs and symptoms of respiratory distress and report to MD, initiated on 11/13/24. A review of the November OSR reflected an order for Oxygen at 2 LPM via NC as needed (PRN) for shortness of breath. 3. On 11/14/24 at 10:25 AM, the surveyor observed Resident #160 in their room, seated in a wheelchair. The surveyor observed the resident wearing a NC tubing with the oxygen concentrator gauge set at 3.5 LPM. The surveyor reviewed the medical record for Resident #160. According to the Admission Record, the resident was admitted to the facility with diagnoses that included but were not limited to diabetes mellitus, Parkinson's disease, and hypertension. The quarterly MDS dated [DATE] reflected a BIMS score of 15 out of 15 which indicated Resident #55's cognition was intact. A review of the resident's CP included a focus area that indicated the resident was receiving Oxygen therapy for CHF initiated on 8/28/24. The interventions included administering oxygen as ordered, monitoring for signs and symptoms of respiratory distress, and reporting to MD. A review of the November OSR reflected an order for Oxygen at 2 LPM via nasal cannula (NC) every shift for Congestive Heart Failure (CHF) with a start date of 11/1/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Complete Care at Cedar Grove		STREET ADDRESS, CITY, STATE, ZIP CODE: 536 Ridge Road Cedar Grove, NJ 07009	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 10:30 AM, the surveyor accompanied by LPN #2 entered Resident #160's room. LPN #2 confirmed that the oxygen was set at 3.5 LPM. At that time LPN #2 reviewed the PO, which reflected an order for 2 LPM. LPN#2 stated that he usually checked the oxygen gauge for accuracy during his morning rounds, but was so busy that he had neglected to check it this morning. On 11/15/24 at 1:14 PM, the surveyor discussed the above observations and concerns with the Administration. The Director of Nursing (DON) confirmed that the Physician orders should be followed, tubing should be changed and dated weekly, and should be stored in a plastic bag for infection control prevention. 45449 4.) On 11/13/24 at 11:05 AM, the surveyor observed Resident #273 in bed receiving oxygen (O2) via nasal cannula (a tube with 2 prongs at the end that deliver oxygen through the nose) that was connected to an oxygen concentrator that was set to 3 liters per minute (LPM). The resident was awake and conversant. On 11/14/24 at 1:17 PM, the surveyor observed the resident lying in bed awake, and alert. The O2 concentrator was on and set to 3LPM. The surveyor reviewed the medical record for Resident #273. According to the Admission Record (AR; or face sheet, an admission summary), the resident was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease (COPD; restrictive breathing affecting lung capacity), and chronic diastolic congestive heart failure (CHF; a heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). The Comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/10/24, reflected a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS revealed the resident required respiratory treatment and received continuous oxygen. A review of the electronic Medication Administration Record (eMAR) for November 2024 reflected the following orders: - O2 at 2 LPM via nasal cannula every shift O2 at 3LPM via nasal cannula. The order was initiated on 11/9/24 and discontinued on 11/13/24. The eMAR was not signed as checked or administered on the night shift on 11/12/24. -O2 at 2 LPM via nasal cannula every shift for COPD oxygen at 2LPM via nasal cannula. The order was initiated on 11/13/24 and discontinued on 11/14/24 at 2:06 PM. The eMAR was signed checked or administered on all three shifts on 11/13/24 and was not signed checked or administered 11/14/24 on the day shift. A review of the ongoing Care Plan (CP) reflected a focus that included, the resident's required O2 therapy which was initiated on 11/13/24. An intervention dated 11/13/24, included to administer oxygen as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Cedar Grove	536 Ridge Road Cedar Grove, NJ 07009

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 1:20 PM, the surveyor and the Licensed Practical Nurse/ Unit Manager (LPN/UM) entered Resident #273's room to observe the resident's O2 concentrator, greeted the resident and walked out of the resident's room. At that time, the LPN/UM confirmed with the surveyor that the O2 concentrator was set to 3 LPM. The LPN/UM and the surveyor reviewed the eMAR together which reflected an order for O2 at 2 LPM. The LPN/UM stated that the expectation was that the nurse should have checked during the morning visit of each room and ensured the O2 was set according to the physician's order. At 1:23 PM, the surveyor and the LPN/UM walked back into the resident's room. The LPN/UM explained to the resident that she had to titrate the O2 concentrator to 2L as per physician's order, and used a pulse oximeter (SPO2; device used to measure blood oxygen saturation level) which reflected low saturation without a numerical value (normal values are 95% to 100%). An LPN walked in with another SPO2 device that reflected the same result, low saturation without a numerical value. At 1:30 PM, the LPN/UM stated that all nurses on all shifts were responsible to ensure the resident's oxygen orders were followed. The LPN/UM stated that she would inform the physician and the hospice nurse to request for Resident #273 to be evaluated. On 11/14/24 at 1:14 PM, in the presence of the survey team, the Regional Associated Clinical Supervisor (RACS), the Regional Director of Operations (RDO), the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns regarding the failure to follow the physician's order for the O2 and to maintain the respiratory services for Residents #55, #28, #160 and #273. On 11/18/24 at 12:17 PM, in the presence of the survey team, the RACS, the RDO, and the LNHA, the DON stated that the nurse who received the order from the physician should have adjusted the oxygen concentrator for the resident and the nurses should have ensured the physician's orders were followed. A review of the facility provided policy, Administering Medication, updated on 1/2024 included the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 2. medications must be administered in accordance with the orders, including any required time. A review of the provided facility policy Oxygen Administration, dated/revised 11/2018 included the following: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1.Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Cedar Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 536 Ridge Road Cedar Grove, NJ 07009	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review the resident's care plan to assess for any special needs of the resident. NJAC 8:39-11.2(b) 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Cedar Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 536 Ridge Road Cedar Grove, NJ 07009	

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	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45449 Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to assure that a.) intravenous bags were stored in a tamper and contaminant resistant packaging, b) accurate dispensing and administration of pain medication c.) a narcotic medication that was ordered by the physician was available for administration. The deficient practices were identified for one (1) of two (2) medication rooms and two (2) of four (4) medication carts inspected during the medication storage and observation and was evidenced as follows: 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 11/15/22 at 9:27 AM, during the inspection of the medication room located on the East/West, the surveyor with the Licensed Practical Nurse#1 (LPN #1) observed the following parenteral (biological or medications administered via intravenous or injectable route): -one (1) bag of sodium chloride for injection 1000 milliliter (ml) without an outer packaging or seal -one (1) bag of dextrose for injection 250 ml, without an outer packaging or seal. On 11/15/24 at 9:27 AM, during an interview with the surveyor, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated that the parenteral products should have had an outer covering to ensure against tampering and contaminants. 2. On 11/15/24 at 9:36 AM, in the presence of LPN #2, the surveyor began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart B (narcotic box) located on 2-West/North. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Cedar Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 536 Ridge Road Cedar Grove, NJ 07009	

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	At that time, the surveyor and LPN #2 observed Resident #135's Oxycodone Immediate Release 5 mg (milligram; narcotic medication indicated for pain) bingo card (a multidose card containing individually packaged medications) contained 66 tablets. At that time, the surveyor compared the count of the bingo card against the Individual Patient Controlled Substance Administration Record (declining inventory log) for Resident #135's Oxycodone IR 5 mg tablet which reflected a balance of 67 tablets and was last signed by the administering nurse on 11/15/24 at 6:00 AM. At that time, the surveyor and LPN #2 reviewed the electronic Medication Administration Record (eMAR) together which revealed an order for Oxycodone IR 5 mg, give 1 tablet four times a day for left and right hip pain, and was started on 6/25/24. The administration schedule was for 6:00 AM, 11:00 AM, 4:00 PM and 10:00 PM. At that time, the surveyor questioned the one (1) tablet discrepancy of the count. LPN #2 stated that the resident had requested for their Oxycodone earlier than scheduled and it was the resident's right to receive their medication when requested. LPN #2 administered the medication at 9:00 AM (3 hours after the scheduled dose at 6:00 AM) as opposed to the physician's scheduled order of 11:00 AM. LPN #2 also stated that she had not informed the physician. LPN #2 explained that since she administered the Oxycodone at 9:00 AM, which was earlier than the physician's order, the eMAR would not allow her to sign for the administration. At that time, The LPN acknowledged that she should have should have informed the physician prior to the administration of the narcotic medication earlier than scheduled for the resident to be properly assessed for pain and that the declining inventory log should have been signed immediately after she removed the Oxycodone from the narcotic box for dispensing and administration. 3.) On 11/15/24 at 9:56 AM, the surveyor began the in the presence of LPN #3, the surveyor began the narcotic medication inspection, which was stored in the narcotic box located on 2-South/East. At that time, the surveyor and LPN #3 observed Resident #70's declining inventory log for Clonazepam 0.5 mg (a narcotic medication with indications that include anxiety relief). The declining inventory log reflected the following: -on 11/1/24 at 12:59 PM, two (2) tablets were removed. -on 11/2/24 at 9:00 PM, two (2) tablets were removed. -on 11/3/24 at 1:00 PM, two (2) tablets were removed. -on 11/4/24 at 9:00 PM, two (2) tablets were removed. At that time, the surveyor and LPN #3 reviewed the eMAR which revealed the following orders: -Clonazepam 0.5 mg, give 1 tablet by mouth one time a day for anxiety, and was started on 9/26/24. The administration time was for 9:00 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Complete Care at Cedar Grove		STREET ADDRESS, CITY, STATE, ZIP CODE: 536 Ridge Road Cedar Grove, NJ 07009	

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	-Clonazepam 1 mg, give 1 tablet by mouth one time a day for anxiety, and was started on 9/26/24. The administration time was for 1:00 PM. --Clonazepam 1 mg, give 1 tablet by mouth one time a day for anxiety, and was started on 8/15/24. The administration time was for 9:00 PM. At that time, LPN #3 confirmed with the surveyor that she had administered two (2) tablets of the Clonazepam 0.5 mg on 11/1/24 to for the 1 mg order since the pharmacy had not sent the supply. The LPN #3 stated she was unsure if the medication was available as part of the emergency back-up supply. LPN #3 stated she did not call the physician for an order to administer double of the dose of Clonazepam 0.5 mg. On 11/15/24 at 10:27 AM, during an interview with the surveyor, the LPN/Unit Manager (UM) stated that the nurses should not have been administering double the dose against the physician order which caused the inventory for Clonazepam 0.5 mg to be cut shorter, that would result in the resident to not have enough medication before the next refill. The surveyor requested for the receipt of the Clonazepam 1 mg. On 11/14/24 at 1:14 PM, in the presence of the survey team, the Regional Associated Clinical Supervisor (RACS), the Regional Director of Operations (RDO), the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns regarding the storage of the intravenous medications found that was not in a standard packaging that protected against tampering and contamination, the administration of Resident #135's medication ahead of the physician's scheduled order and the facility's failure to ensure that Resident #70's medication ordered by the physician was available for administration. On 11/18/24 at 12:17 PM, in the presence of the survey team, the RACS, the RDO, and the LNHA, the DON stated that the nurse who administered Resident #135's medication was given an education to inform and obtain a physician's order for early administration of the Oxycodone when appropriate. Additionally, the DON stated that regarding Resident #70's Clonazepam, the nurses were educated to call the pharmacy when an order was not available for administration and were instructed to escalate the issue to the supervisors after having to call the pharmacy more than once. No further information was provided. A review of the provided facility policy, Medication Storage dated/reviewed on 1/2024, reflected under policy that the facility shall store all medications and biologicals in a safe, secure and orderly manner and that medications and biologicals shall be stored in the packaging, containers, or other dispensing system in which they are received. A review of the facility provided policy, Administering Medication, updated on 1/2024 included the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 2. medications must be administered in accordance with the orders, including any required time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Cedar Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 536 Ridge Road Cedar Grove, NJ 07009	

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	NJAC 8:39-29.2 (d), 29.4(f)(g) (h)(l) 29.6(a)29.7(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Cedar Grove	536 Ridge Road Cedar Grove, NJ 07009

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 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

45449

Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation conducted on 11/14/24, the surveyor observed four (4) nurses administer medications to four (4) residents. There were 27 opportunities, and two errors were observed which resulted in a medication error rate of 7.41%. This deficient practice was identified for one (1) of three (3) residents, that was administered by one (1) of three (3) nurses.

and was evidenced by the following:

On 11/14/23 at 9:01 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare medications for Resident #64. The medications included the following:

- Metformin 500 milligram (mg), give 1 tablet by mouth two times a day for type 2 diabetes mellitus. Give with food. The order was started on 3/13/23.

-Potassium Chloride Extended Release 20 milliequivalent (mEq), 1 tablet by mouth one time a day for supplement. Give with food.

The order was started on of 1/3/23.

At 9:06 AM, the LPN confirmed she had five (5) medications in the cup and was ready to administer the medications to Resident #64. The LPN was observed with a cup of medications and a cup of water. At that time, the breakfast truck was not in the hallway.

At 9:07 AM, the LPN and the surveyor entered the resident's room. Resident #64 informed the surveyor that they had not eaten breakfast that morning, and the breakfast tray was not in the resident's room. The LPN proceeded towards the resident to administer the medications to the resident. The surveyor stopped the LPN and asked to speak with the LPN outside the resident's room.

At 9:11 AM, the surveyor, and the LPN reviewed the resident's electronic Medication Administration Record (eMAR) and the bingo card (a multidose card containing individually packaged medications) together.

The eMAR revealed that Metformin was scheduled to be administered at 8:30 AM and 5:30 PM and had instructions for administration that included Take with food. The bingo card had an affixed cautionary label that indicated take with food.

The eMAR also revealed that Potassium was scheduled to be administered at 8:30 AM and had instructions for administration that included Take with food .

At that time, after reviewing the eMAR and the bingo cards with the surveyor, the LPN stated that the Metformin and the Potassium should not be administered on an empty stomach because it could have caused stomach irritation, and that the Metformin could have caused low blood sugar.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Cedar Grove	536 Ridge Road Cedar Grove, NJ 07009

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 1:14 PM, in the presence of the survey team, the Regional Associated Clinical Supervisor (RACS), the Regional Director of Operations (RDO), the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns regarding the medication pass errors observed. On 11/18/24 at 12:17 PM, in the presence of the survey team, the RACS, the RDO, and the LNHA, the DON stated that the LPN was educated on proper administration of medications that were required to be administered with food. The DON acknowledged that the medications should have been administered as ordered and the LPN should have followed the cautionary that was part of the physician's order. A review of the facility provided policy, Administering Medication, updated on 1/2024 included the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 2. medications must be administered in accordance with the orders, including any required time. N.J.A.C. 8:39-29.2 (d)