STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315226	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunterdon Care Center LLC	1 Leisure Court Flemington, NJ 08822

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint: 2582599 Based on interview, review of the medical records, and review of other pertinent facility documents, it was determined that the facility failed to ensure a safe discharge for a resident (Resident #3) with severe cognitive impairment, who lived in the community alone, and was denied at home nursing care services upon discharge. This deficient practice was identified for 1 of 4 residents reviewed (Resident #3). Resident #3, who was had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating a severely impaired cognition with an admission diagnosis of cognitive impairment, was discharged from Medicare Part A services with a last date of coverage on [DATE]. Resident #3 lost an appeal and was discharged to the community on [DATE]. Resident #3 was assessed upon discharge to need at home nursing services, physical therapy (PT), and occupational therapy (OT). A review of a denial email from the home care nursing services (HCNS #1) [name redacted] indicated that since the resident was not ambulating without contact guard assist and wheelchair follow, with no caregiver to assist at home, it was not a safe referral for HCNS #1 [name redacted] to take. During an interview on [DATE], with the Director of Nursing (DON), the DON confirmed that Resident #3 would not have been a safe discharge to the community. The facility's failure to ensure Resident #3 was discharged from the facility safely with all the services required to meet the resident's needs placed Resident #3, as well as all residents being discharge from the facility at risk for an unsafe discharge. This posed the likelihood of serious harm, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation. The IJ began [DATE] at 1:33 P.M., when Resident #3 was discharged from the facility. The facility was notified of the IJ on [DATE] at 4:08 P.M. The facility submitted an acceptable Removal Plan (RP) on [DATE] at 4:23 P.M. The surveyor verified the implementation of the RP on-site during the continuation of the survey on [DATE] at 11:00 A.M. The evidence was as follows:A review of the facility's policy titled Transfer/Discharge/Bed Hold Policy and Procedure dated 4/2025, included This facility will ensure that it will not transfer or discharge a resident in an unsafe manner such as location that does not meet the resident's needs, does not provide needed support and resources, or does not meet the resident preferences and therefore should not have occurred. The surveyor reviewed the closed medical record for Resident #3. According to the admission Record (AR) face sheet, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: mild cognitive impairment, enterocolitis due to clostridium difficile (C. diff; a bacteria infection that causes diarrhea and gastrointestinal cramping), hyperlipidemia (high cholesterol), essential hypertension (high blood pressure), unspecified protein-calorie malnutrition, and Parkinson's Disease without dyskinesia (movement disorder). According to the discharge Minimum Data Set (MDS), an assessment tool dated [DATE], Resident #3 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognition was severely impaired. A review of Resident #3's Care Plan (CP) included the following focus areas: A focus area initiated [DATE], for impaired cognition- that the resident triggered for cognitive loss related to diagnosis of cognitive impairment secondary to a history of Parkinson's Disease, stroke and BIMs score of 6 out of 15 (severely impaired). The resident is alert, oriented to themselves, and can follow one step directions. Resident #3 has impaired safety awareness. Interventions included: to provide activities that are not overly demanding; provide simple, structured activities that highlight the resident's capabilities while not drawing attention to deficits; use cueing as a technique to maximize independence, decrease potential frustration, attempt to keep daily routine, and monitor for change in mental status. A focus area initiated [DATE], that the resident is admitted for an anticipated short term sub-acute placement; expected to discharge from skilled nursing facility upon completion of care/services. Interventions included: interview the resident (or representative as appropriate) to understand resident's post-discharge transportation needs to determine/assess potential barriers to care; provide instructions at discharge that include at a minimum current medications, treatments, therapies, and allergies as applicable; refer resident to clinicians that coordinate care with this facility; arrange for post discharge support services; ascertain information about discharge setting to ensure needs can be met upon discharge; and discuss/address limitations, risks verses benefits, and importance/need for maximum independence. Meet with resident/family throughout stay to discuss discharge planning and coordinating needed services after discharge. A review of the Social Service History and admission Assessment (SSHAA) dated effective [DATE] at 11:07 A.M., included the following information: 1.Power of Attorney.1C. Is the resident/patient able to make decisions at this time? Yes. (1D. explain) patient and their significant other (RR

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Complaint # 2582599Based on interview, review of the medical records, and review of other pertinent facility documents, it was determined that the facility failed to ensure a discharge summary was written at the time a resident (Resident #3) was discharged from the facility. This deficient practice was identified for 1 of 4 residents reviewed (Resident #3).The surveyor reviewed the closed medical record for Resident #3. According to the admission Record (AR) face sheet, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: mild cognitive impairment, enterocolitis due to clostridium difficile (C. diff; a bacteria infection that causes diarrhea and gastrointestinal cramping), hyperlipidemia (high cholesterol), essential hypertension (high blood pressure), unspecified protein-calorie malnutrition, and Parkinson's Disease without dyskinesia (movement disorder).According to the discharge Minimum Data Set (MDS), an assessment tool dated 7/25/25, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognition was severely impaired.A review of Resident #3's Care Plan (CP) included the following focus areas:A focus area initiated 7/18/25, for anticipated short term, sub-acute placement; expected to discharge to community from skilled nursing facility (SNF) upon completion of care/services. Interventions included: to arrange for post discharge support services; make necessary referrals for Durable Medical Equipment (DME) & home care services; social services will communicate with nursing and physicians for medical needs; encourage ongoing resident participation in discharge planning; set reasonable goals for reaching safe discharge; communicate with resident/family regarding services, equipment, prescriptions, and follow up recommendations; assess need for education regarding meds, diet, etc., & provide teaching as needed.A review of Resident #3's Progress Notes (PN), did not include a final discharge summary note written by the LPN at the time of the resident's charge.On 8/11/25 at 01:35 P.M the surveyor interviewed the Assistant Director of Nursing (ADON). The ADON stated the facility's policy is to leave a note at the time of discharge and confirmed this was not done for Resident #3.On 8/11/25 at 01:54 P.M the surveyor interviewed the Licensed Practical Nurse (LPN) who was responsible for discharging Resident #3. LPN stated that she could not recall Resident #3 completely, but she confirmed did not complete Resident #3's discharge as per facility's discharge process.A review of the facility's policy titled Transfer/Discharge/Bed Hold Policy and Procedure dated 4/2025, included under Documentation: The facility will ensure that the transfer/discharge is documented in the resident's medical record (when applicable) an appropriate information is communicated to the receiving health care institution or provider.