STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315234	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Ridge Rehabilitation and Healthcare Center	261 Terhune Drive Wayne, NJ 07470

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews and review of facility policy, the facility failed to develop a comprehensive care plan for one resident, Resident (R) 121, when he/she was readmitted to the facility. This failure had the potential to cause R121 to receive a less effective plan of care which could affect the quality of care and services provided.Findings include: Review of R121's record revealed R121 was readmitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction caused by chemical imbalances, systemic illness or organ failure other than direct physical injury), pneumonitis (inflammation of the lungs), chronic kidney disease stage three, catatonia (a complex neuropsychiatric syndrome characterized by profound abnormalities in movement, speech, and responsiveness), acute respiratory failure with hypoxia (low oxygen levels) and a history of traumatic brain injury. Review of the admission Minimum Data Set (MDS) dated [DATE], under the MDS tab in the Electronic Medical Record (EMR), revealed R121 had a Brief Interview for Mental Status (BIMS) of 6 (severe cognitive impairment). Review of the orders under the Orders tab in the EMR, revealed an order dated 12/20/24 indicating, Please change PureWick [external urinary collection device] catheter q [every] shift and prn [as needed] if soiled with feces . AND every shift for incontinence care. Review of the care plan under the Care Plan tab in the EMR revealed multiple problems and interventions on the care plan that were dated 03/03/23, including a problem titled, [R121's name] enjoys painting especially watercolor painting. He/she wants to teach others how to paint watercolor. Date Initiated: 03/04/2023; And I have potential for skin breakdown r/t [related to] dx [diagnosis] of CVA [cerebrovascular accident] with hemiparesis [paralysis on one side of the body], decline in mobility . admitted : bilateral buttock and sacral redness. Date Initiated: 03/07/2023. Review of the progress notes under the Progress Notes tab in the EMR revealed the admission nurse's note dated 12/05/24 at 10:49 PM read, New admission . sacral wound dressing pad observed on mid sacrum, no wounds observed, place [sic] for protection from pressure sores, as per [family members relationship] statement . In an interview with the Maintenance Director on 06/03/26 at 10:15 AM, he/she was unable to confirm if R121 had a low air loss mattress (LALM). On 06/03/26 at 11:35 AM, the Maintenance Director provided an untitled document dated 12/11/24 with R121's name and room number, and a document titled, Work Order . created on Dec. 11, 2024, indicating needs air mattress requested by Unit Manager Registered Nurse (UMRN)1 on 12/11/24 at 3:13 PM and completed on 12/12/24 at 11:11 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM. Review of R121's record was conducted with the Director of Nurses (DON), Assistant DON (ADON), and UMRN1 on 06/04/26 at 5:52 PM. They all reviewed R121's record and confirmed the PureWick catheter and LALM were not included in the plan of care for R121. UMRN1 and the DON reviewed the record and stated R121 did not have any redness to his/her coccyx or skin breakdown during his/her stay. UMRN1 and the DON confirmed the care plan indicated R121 was admitted with redness to his/her sacrum, which was in 2023, not on 12/05/24. UMRN1 and the DON stated the care plan was not accurate because it was from 2023. They stated when R121 was discharged in March of 2023, the care plan was supposed to be closed but it wasn't, so when he/she was readmitted on [DATE] (almost two years after being discharged) the old care plan was in the EMR, and a new care plan was not initiated and developed. NJAC 8:39-11.2(e)1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint Intake ID #408686Based on interviews, record reviews and reviews of pertinent facility documents, it was determined that the facility failed to ensure care and treatment were provided timely to Resident #121, to prevent further change in condition. This failure delayed care for Resident #121 who was admitted to the intensive care unit at an acute care hospital with a diagnosis of septic shock (the most severe, life-threatening stage of sepsis [body's extreme response to an infection], which is a critical medical emergency requiring immediate hospitalization.) This deficient practice was identified for 1 of 3 residents (Resident #121) reviewed for hospitalization.On 12/28/24 at 8:00 PM, Resident #121 had a change in condition with rapid, shallow breathing and difficulty breathing at rest, noisy breathing, restlessness, and cold lower extremities. The physician was notified and ordered to send the resident to the hospital. The nurse called a transport company instead of 911 to transport Resident #121. On 12/28/24 at 11:00 PM, Resident #121's oxygen saturation was 72% on 10 liters of oxygen via non-rebreather mask. Pulse was 43 and respirations were 31. The resident's family was at the bedside and demanded that the nurse call 911. Resident #121 was transported to the hospital on [DATE] at 12:30 AM, four and a half hours later. The resident was admitted to the Intensive Care Unit (ICU) with septic shock. Interviews with the Director of Nursing (DON) confirmed that the nurse should have called 911 instead of the transport company.The facility's failure to ensure Resident #121's change in condition was addressed timely without a delay in treatment placed Resident #121 as well as other residents with a change in condition at risk for a delay in treatment. This posed the likelihood for serious harm, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation.The IJ began on 12/28/24, when Resident #121 had a change in condition. The facility's Administration was notified of the IJ on 6/5/26 at 2:50 PM. The facility submitted an acceptable Removal Plan (RP) on 6/5/26 at 6:25 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 6/5/26, and determined the immediacy was removed as of 6/5/26 at 9:00 PM.The evidence is as follows: A review of the facility policy revised March 2018, titled Acute Condition Changes – Clinical Protocol revealed, Assessment and Recognition . 1. The physician will help identify individuals with a significant risk for having acute changes of condition during their stay; for example . someone with unstable vital signs . Treatment/Management . 3. If it is decided, after sufficient review, that care or observation cannot reasonably be provided in the facility, the physician will authorize transfer to an acute hospital, Emergency Room, or another appropriate setting . A review of Resident #121's admission Record revealed Resident #121 was admitted to the facility on [DATE] with diagnoses which included but were not limited to; metabolic encephalopathy (brain dysfunction caused by chemical imbalances, systemic illness, or organ failure rather than a direct physical injury), pneumonitis (inflammation of the lung tissue), and stage three chronic kidney disease. Resident #121's admission orders included an order for Full code, indicating Resident #121 was to receive all interventions to sustain life. A review of Resident #121's Progress Notes (PN) dated 12/28/24 at 10:12 PM, revealed a note written by the Registered Nurse (RN #2) . at around 7pm [7:00 PM], the BP [blood pressure] was noted to be low 91/62, midodrine [medication that increases blood pressure] was given via G-Tube [gastrostomy tube – a tube in the stomach] that brought the BP to 114/75 but within an Hour the BP went down again, MD [medical doctor] was notified with the order of CXR [chest x-ray] and IV [intravenous] Rocephin [antibiotic] 1g [gram] daily x [times] 2 [two] days, Resident was transferred back to bed at around 8pm [8:00 PM], Resident was noted with change in health (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	conditions, more reapid [sic] and shallow breathing, difficulty breathing even at rest, noisy breathing, restlessness and cold lower extremities. [MD's name] was made aware of the change in conditions, new order received to send the Resident to the hospital, [family member name and relationship] was made aware, She/he consented to send [Resident #121] to the hospital [name of general transport company] made aware, they will pick [Resident #121] up. The PNs did not reveal documentation to support RN #2 calling 911, but called the transportation services instead. A review of a PN written by the Licensed Practical Nurse (LPN #4) dated 12/29/26 at 12:56 AM, revealed 11pm [11:00 PM] received report from the supervisor [RN #2] that resident had low bp for he/she [sic] was treated, suctioned for chest congestion. Was reported ambulance will arrive soon after waiting x3 [three] hours. Upon this writer assessment bp unable to register [sic], but pulse 43, o2sat [oxygen saturation – the amount of oxygen in the blood] 74 [percent] with o2 [oxygen] via n/c [nasal canula – a tube at the nostrils] @ [at] 2L/min [liters per minute], respiration 31. Resident usually is aphasic [unable to speak]. Non rebirthing [sic - rebreathing] mask initiated with O2 @ 10L/min. 10min later 02 [oxygen saturation] went to 93% then going down @ 73, 72 [percent oxygen saturation]. T [temperature] 98.6- continued with non-rebirthing [sic] mask. Unable to restore resident. family at bedside demanded to call 911 after ambulance did not show up. 911 called and transferred resident to [name of hospital] Hospital @ 12:30 PM [sic – AM]. Further review of Resident #121's PN dated 12/29/24 at 6:57 AM revealed, admitted with septic shock – resident in ICU [intensive care unit]. During an interview with RN #2 on 06/04/26 at 4:59 PM, RN #2 confirmed the physician gave him/her an order to send Resident #121 to the hospital on [DATE], at around 8:00 PM. RN #2 stated, We called 911 and 911 said to call the local transport company because they were busy and it would be a while and after they didn't come within 15 minutes, we called 911 again and they came. RN #2 reviewed his/her documentation on 12/28/24 and did not address the discrepancy between his/her interview and his/her documentation. During an interview on 06/04/26 at 5:52 PM, with the RN Unit Manager (RNUM #1) and the Director of Nursing (DON), they both stated RN #2 should have called 911 and not the transport company when Resident #121 had a change in condition at around 8:00 PM on 12/28/24. RNUM #1 stated he/she thinks RN #2 called a transportation company at around 8:00 PM and 911 wasn't called until around 12:00 AM by LPN #4 (three to four hours after the physician's order to send Resident #121 to the hospital). During an interview with RN #2 on 06/04/26 at 7:07 PM, he/she stated he/she reviewed Resident #121's record, including his/her nursing note in the PNs dated 12/28/24 at 10:12 PM. RN #2 confirmed Resident #121 had a decline in condition with decreased blood pressure and respiratory distress at around 8:00 PM and he/she called a transportation company, not 911. RN #2 stated, I should have sent him/her 911. During an interview with the Medical Doctor (MD #1) on 06/05/26 at 9:51 AM, he/she stated on 12/28/24, Resident #121's condition deteriorated and he/she gave RN #2 an order to send him/her to the hospital. MD #1 stated, I didn't know it was going to take three hours. MD #1 stated, I'm not gonna lie, and confirmed 911 should have been called rather than a transportation company. MD #1 confirmed he told RN #2 to send Resident #121 to the hospital because he/she needed urgent care. [Resident #121] was delicate. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LPN #4 on 06/05/26 at 10:25 AM, he/she stated after he/she received report on 12/28/24 at 11:00 PM from RN #1, that Resident #121 had a change of condition . immediately I went to see the patient. I was thinking I needed to call 911. I reassessed the patient and I noticed it was needed to call 911, because of the blood pressure and change in condition. LPN #4 stated if 911 didn't come within 15 minutes, I would call the police if 911 doesn't come. I need rapid 911. During an interview on 06/05/26 at 11:06 AM with the previous DON (DON #2), he/she confirmed he/she was the DON at the facility on 12/28/24. DON #2 stated on 12/28/24, RN #2 notified him/her Resident #121 had a change in condition. DON #2 confirmed 911 should have been called rather than a transportation company at around 8:00 PM on 12/28/24. DON #2 stated, If 911 didn't come within 30 minutes, they would have to call again . second time called 911, you would call the police. DON #2 stated, If progression is going down and down, it's not a [name of transport company], it's an ambulance. An acceptable Removal Plan (RP) was received on 06/05/26 at 6:25 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the immediacy including; All licensed nurses and nursing supervisors were immediately re-educated on the current Acute Condition Changes – Clinical Protocol policy and Change in Condition and Transfer process by Assistant Director of Nursing. Handouts included the Change in Condition and Transfer Process for nursing, which was also posted on all nursing units, and included the following content: Timely activation of EMS/911 for emergent conditions. Escalation procedures when transportation delays occur. Required ongoing nursing assessments and monitoring while awaiting transfer. Physician notification requirements. Documentation requirements related to emergency transfers. DON/Nursing Supervisor oversight responsibilities. The survey team verified the implementation of the Removal Plan on-site and determined the immediacy was removed on 06/05/26 at 9:56 PM. N.J.A.C. 8:39-27.1(a)