STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315276	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Milford Manor LLC	69 Maple Road West Milford, NJ 07480

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Complaint #: NJ187267 Based on observation, interviews, review of medical records, and review of other pertinent facility documents on 6/24/2025, it was determined that the facility failed to ensure that a resident received the treatment and care in accordance with professional standards of practice by failing to follow a Physician's order for a Stat (immediate) x-ray. This deficient practice was identified for 1 of 5 residents reviewed (Resident #2), as evidenced by the following: A review of the medical record according to the admission sheet, Resident #2 was admitted with diagnoses that included but were not limited to: Type 2 Diabetes Mellitus Without Complications. According to the Minimum Data Set (MDS), an assessment tool dated 4/14/25 (Comprehensive), Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3/15 indicating severe cognitive impairment and needed supervision or touching assistance with eating. A review of Resident #2's Order Summary Report (OSR) with a print date of 6/23/25, received from the Licensed Nursing Home administrator (LNHA), revealed a diet order NCS (No Concentrated Sweets) diet Regular texture, Thin Liquids consistency, . with an order date of 3/15/2022. A review of the Order Details for Resident #2 revealed on 6/10/25 at 1923 (7:23 p.m.), a Physician phone order was received for STAT Chest X-ray. A review of Resident #2's Progress Note (PN) dated 6/10/25 at 22:12 (10:12 p.m.) revealed Undersigned nurse alerted to dining room. Resident noted coughing up a lot of phlegm and being suctioned by RN supervisor New order for STAT chest X-ray A review of the Incident Report for Resident #2 received on 6/23/25 from the LNHA, with a date of 6/10/25 at 18:40 (6:40 p.m.) revealed under Incident Description, At approximately 6:30 p.m., staff alerted RN to the dining room where a patient was in distress and choking. Resident stated that did not chew properly. Under Immediate Action Taken revealed, Upon arrival, RN administered multiple backblows initiated. Stat CXR pending. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	During interview with surveyor on 6/23/25 at 10:00 a.m., the LNHA stated that when she came in the following day after Resident #2's choking incident, she had asked the Director of Nursing (DON) if the x-ray was done and if she had a chance to to speak to the 3:00 p.m. - 11:00 p.m. or 11:00 p.m. - 7:00 a.m. nurse about the x-ray that was ordered, and the DON said no. The LNHA further stated, The expectation was for the nurse on the unit to follow up with the x-ray company after the Physician ordered the x-ray, to follow up when the x-ray technician would come. It was important for the nurse to follow up because it was a doctor's order. During interview with the surveyor on 6/23/25 at 11:56 a.m., LPN #2 who was the assigned nurse for Resident #2 on 6/10/25 on the 3:00 p.m. - 11:00 p.m. shift, stated, The x-ray was not done when I left my shift. They were still awaiting the arrival of the x-ray technician. When the surveyor asked LPN #2 the process after an x-ray order was received, LPN #2 stated that the nurse would put the order in, call the x-ray company for a routine follow up, and to get the estimated time of arrival (ETA). During interview with the surveyor on 6/23/25 at 2:26 p.m., LPN #3 stated that she called Resident #2's doctor and reported the incident. The doctor ordered a STAT portable chest x-ray at 6:40 p.m. and LPN #3 stated that she entered the order in the computer system. LPN #3 stated that she printed the order and usually when she refreshed the page, she would see an X which means a technician was not assigned. LPN #3 stated that just as she was about to call the x-ray company, she refreshed the page and noticed that a technician was assigned, so she did not call. During an interview with the surveyor on 6/23/25 at 3:51 p.m., the DON stated, That once a verbal Physician order was received, the expectation was for the nurse to write the physician's order in computer system, call the x-ray company because it was stat order. The DON further stated, when a tech is assigned, it means someone received the requisition, it does not say when the tech was coming. During an interview with surveyor on 6/24/25 at 10:57 a.m., the [NAME] President (VP) stated that the x-ray order for Resident #2 was received. She further stated, the facility can always pick up the phone to get an exact ETA. During interview with surveyor on 6/24/25 at 12:48 p.m., Resident #2's doctor stated that for a stat order, the expectation is for it to get done as soon as possible, call the radiology and if there is a hold up, to notify me of the delay, especially for a stat order I expect the facility to call me back and let me know the status if there was a delay. A review of the Verbal Orders policy with a date Implemented on 9/1/2024, under Policy Explanation and Compliance Guidelines revealed: 5. Follow through with orders by making appropriate contact or notification (e.g., lab or pharmacy). N.J.A.C. : 8:39-27.1 (a)