| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315299 | A. Building<br>B. Wing | 10/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| King Manor Care and Rehabilitation Center | 2303 West Bangs Ave<br>Neptune, NJ 07753 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Complaint #: 407581Based on interviews, review of medical records, and pertinent facility documents, it was determined that the facility failed to notify the resident's physician and responsible party of a change in condition for 1 of 3 residents (Resident #1) reviewed. This deficient practice was evidenced by the following:On 10/27/2025 at 8:30 AM, the surveyor reviewed the closed medical record for Resident #1.A review of the admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; urinary tract infection, congestive heart failure, and chronic respiratory failure with hypoxia (inadequate supply of oxygen to the body's tissues).A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 1/7/2025, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated a severely impaired cognition.A review of the corresponding Medication Administration Record (MAR) revealed that the resident's temperature on 2/24/2025, during an unspecified time on the 11-7 shift was 100.2'F.A review of the progress notes did not reveal any nursing notes related to the temperature recorded in the MAR on 2/24/2025 during the 11-7 shift. There were no follow up temperatures recorded in the MAR during the said shift. There was no documentation that the resident's physician and responsible party were notified of the resident's fever.On 10/27/2025 at 12:47 PM, during an interview with the surveyor, Registered Nurse (RN) #1 stated that if a resident has fever, Tylenol would be administered and that temperatures should be taken every 4 hours to see if the staff need to give Tylenol. RN #1 further stated that the staff documents for any change in condition and call the physician and family.On 10/27/2025 at 12:49 PM, during an interview with the surveyor, the Director of Nursing (DON) stated that if a resident has fever, the staff should be documenting all they do so they would know what to follow through. The DON further stated that staff should continue monitoring, offer fluid, call the physician if they want laboratory work done. The family should be notified. They need to give Tylenol. They need to document everything. A review of the facility-provided policy dated January 2025, titled Change in a Resident's Condition or Status included under Policy Interpretation and Implementation, 1.) The nurse will notify the resident's attending physician or physician on call when there has been a: d.) significant change in the resident's physical/ emotional/ mental condition. 4.) Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b.) there is a significant change in the resident's physical, mental, or psychosocial status.A review of the facility-provided policy dated December 2024, titled Charting and Documentation under Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. N.J.A.C. 8:39 - 13.1 (c) (d) |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>Complaint #: 407581Based on interviews, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, by failing to ensure that medication was administered and documented according to a physician order. This deficient practice was identified for 1 out of 3 residents reviewed for quality of care (Resident #1). 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 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.On 10/27/2025 at 8:30 AM, the surveyor reviewed the closed medical record for Resident #1.A review of the admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; urinary tract infection, congestive heart failure, and chronic respiratory failure with hypoxia (inadequate supply of oxygen to the body's tissues).A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 1/7/2025, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated a severely impaired cognition.A review of the Order Summary Report dated 2/25/2025, included a physician's order (PO) started on 2/9/2025, for acetaminophen tablet 325 milligrams, give 2 tablets by mouth every 4 hours as needed for temperature 100'F and above. Two tablets = 650mg *Do not exceed 3 gram/day.A review of the corresponding Medication Administration Record (MAR) revealed that the resident's temperature on 2/24/2025, during an unspecified time on the 11-7 shift was 100.2'F. The MAR reflected that the resident did not receive a dose of acetaminophen on 2/24/2025 and 2/25/2025 during the 11-7 shift. The nursing administration signatures for those dates and shift were blank. A review of the resident's progress notes did not reveal any nursing notes related to the temperature recorded in the MAR on 2/24/2025 during the 11-7 shift. There were no follow up temperatures, assessments, or monitoring documented in the resident's medical record after the fever was noted.On 10/27/2025 at 12:47 PM, during an interview with the surveyor, Registered Nurse (RN) #1 stated that if a resident has fever, Tylenol would be administered and that temperatures should be taken every 4 hours to see if the staff need to give Tylenol. RN #1 further stated that the staff documents for any change in condition and call the physician and family.On 10/27/2025 at 12:49 PM, during an interview with the surveyor, the Director of Nursing (DON) stated that if a resident has fever, the staff should be documenting all they do so they would know what to follow through. The DON further stated that staff should continue monitoring, offer fluid, call the physician if they want laboratory work done. The family should be notified. They need to give Tylenol. They need to document everything. A review of the facility-provided policy dated July 2025, titled Administering Medications included under Policy Interpretation and Implementation, 22.) If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 23.) The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. A review of the facility-provided policy dated December 2024, titled Charting and Documentation under Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. N.J.A.C. 8:39 - 27.1 (a); 29.2 (d) |