STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315307	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Harborage LLC	7600 River Rd North Bergen, NJ 07047

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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 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT NJ #2669783 and #2735273 Based on interview, record review, and review of facility documents, it was determined that the facility failed to ensure the resident representative was notified of a significant change in condition, including a fall for 1 of 2 residents (Resident #252) and a resident's death for 1 of 1 resident (Resident #250), and failed to ensure such notification was documented in the medical record for 2 of 2 residents (Resident #250 and Resident #252) reviewed for notification of change. This deficient practice was evidenced by the following: 1.On [DATE] at 11:53 AM, Surveyor #1 (S #1) reviewed the closed records of Resident #250. A review of the admission Record (AR) or face sheet (an admission summary), revealed the resident had diagnoses which included, but were not limited to; acute respiratory failure (inability to maintain adequate oxygenation), pleural effusion (fluid buildup around the lungs), anemia, heart failure, and malignant neoplasm of the bladder. A review of the progress notes (PN) included a nurse's note, dated [DATE] at 1:05 PM, which reflected the resident expired at 12:53 PM. The PN indicated hospice services were notified and that the Unit Manager (UM) and Supervisor were aware. There was no documentation in the medical record indicating that the resident's representative (RR) was notified of the resident's death. On [DATE] at 12:49 PM, S #1 conducted a telephone interview with the Hospice Agency Director (HAD) who stated, Our process is for the person who pronounces the death in the facility to notify the RR. The HAD further stated the hospice agency follows up with the RR for bereavement services. On [DATE] at 8:56 AM, S #1 interviewed the Director of Nursing (DON) who stated the UM reported that the RR was notified of the resident's death; however, the DON was unable to provide documentation to support that notification occurred. On [DATE] at 9:18 AM, S #1 interviewed the Hospice Nurse (HN) who stated, the facility is responsible for notifying the RR when a resident expires in the facility. On [DATE] at 8:21 AM, the DON provided in-service education documentation which identified an area of opportunity for the facility related to timely notification of RR for residents receiving hospice services. The documentation indicated education was provided to nursing staff regarding the importance of notifying RR immediately upon a resident's death and documenting such notification in the medical record. A review of the facility's Notification of Changes Policy, dated [DATE], included, the facility must (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inform the resident, consult with the resident's physician, and/or notify the resident's family member or legal representative when there is a change requiring such notification.The policy further included that death of a resident requires immediate notification and documentation. On [DATE] at 9:00 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, and the survey team, acknowledged that documentation of notification to the RR could not be provided. 2. On [DATE] at 10:31 AM, the Assistant Director of Nursing (ADON) notified Surveyor #2 (S #2) that Resident #252 was no longer in the facility. On [DATE] at 1:50 PM, S #2 reviewed the electronic Medical Records (eMR) of Resident #252, which revealed an AR that included diagnoses but not limited to; fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing, other abnormalities of gait and mobility, muscle weakness (generalized), muscle wasting and atrophy, not elsewhere classified, multiple sites, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, heart failure, unspecified, acute kidney failure, unspecified, and chronic kidney disease, unspecified. A review of the comprehensive Minimum Data Set (MDS) (an assessment tool to facilitate the plan of care), with an assessment reference date (ARD) of [DATE], revealed a Brief Interview Mental Status (BIMS) score of 9 out of 15 indicating moderate cognitive impairment; sit to stand partial/moderate assistance; and walked 10 feet partial/moderate assistance. A review of the Care Plan (CP) revealed: impaired cognitive function/dementia or impaired thought processes related to dementia, date initiated [DATE]; risk for falls related to recent falls at home, pubis fracture, gait imbalance and actual fall dated [DATE], date initiated [DATE]. A review of the nursing PN dated [DATE] at 11:03 PM, electronically signed by the License Practical Nurse (LPN), revealed the resident was found on the floor by a CNA. The LPN documented the resident was confused, denied any discomfort, no visible injuries, vital signs taken, nursing supervisor notified, put back to bed and fall precautions in placed for safety. There was no documentation to indicate the RR was notified of the fall. On [DATE] at 8:45 AM, S #2 received the fall investigation report written by the LPN dated [DATE], which revealed the RR was notified of the fall on [DATE] at 5:15 PM (18 hours and 12 minutes later). On [DATE] at 10:08 AM, S #2 interviewed the DON regarding the facility's process with regard to fall investigations. The DON stated the nurse will come in and assess the resident head to toe, if no visible injury, assisted the resident back to bed, neuro (neurological) checks were done, notify the doctor and RR, administer pain medication if there was complaint of pain, initiate a risk assessment, and would gather statements, timeline would be that shift, and then Interdisciplinary Team (IDT) will review following day for underlying conditions or potential causes. On [DATE] at 11:57 AM, the Staffing Coordinator provided the number for the LPN that was assigned to the resident the night of the fall incident. She also stated the supervisor scheduled at the time of incident was currently on medical leave. On [DATE] at 12:01 PM, S #2 interviewed the LPN regarding the fall investigation, and the LPN (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, the CNA found the resident on the floor during his rounds and told the LPN. The LPN further stated that resident was confused, vitals done, neuro checks done, skin assessed, and there were no bruises. She stated the RR, Nursing Supervisor and doctor were notified before her shift (3:00 PM-11:00 PM) was over. At that same time, S #2 asked the LPN if the RR was notified and what the process was for informing the RR. The LPN stated she would look into resident's profiles and see who was listed. She stated she called the RR first because the RR was very involved, and stated she was unsure if she called the emergency contact person #1. She further stated that the CP should be updated by the UM or supervisor, and notification of the doctor and RR should also be documented in the PN. S #2 asked the LPN as to why the emergency contact person #1 was not called first, and the LPN responded that she was new and just started. S #2 asked about the fall investigation report which was written by the LPN and indicated that the RR was notified of the fall the next day on [DATE] at 5:15 PM, and she said she did not know why. On [DATE] at 12:41 PM, S #2 interviewed the ADON regarding the [DATE] fall incident, and that RR was notified on [DATE] at 5:15 PM. The ADON stated the process was family to be called immediately and doctor when it happened. S #2 and ADON reviewed the incident report and investigation documents, and S #2 asked why the emergency contact person #1 was not called. S #2 asked if there was a period to notify the RR, and the ADON confirmed, I do not know how that happened. We call the first contact unless we can not reach them, then go to next one. It should have been documented in the PN and that RR should be notified immediately when it occurred, and notification should be immediate. On [DATE] at 1:52 PM, the survey team met with the LNHA, [NAME] President of Clinical Services (VPoCS), DON, and Administrator in Training (AIT), and S #2 notified them of concern with not notifying RR timely and emergency contact person of change in condition for an unwitnessed fall on [DATE] timely. S #2 requested the LNHA to provide documentation that primary emergency contact #1 was notified. On [DATE] at 10:59 AM, the survey team met with the LNHA, AIT, and the DON stated We completed in-service yesterday with staff regarding importance of documenting when falls, incidents happened and notifying the primary (emergency #1) contact. There was no additional documentation provided that the primary contact was aware of the fall. A review of the facility's Notification of Changes Policy, revised on [DATE], revealed, the purpose. facility promptly informs.the RR when there is a change requiring notification . Under Additional Considerations #1c. a designated family member should be notified of significant changes.especially in the case of sudden illness or accident . A review of the facility's Fall Prevention Program Policy, revised on [DATE], revealed under Policy Explanation and Compliance Guidelines #6. When a resident experiences a fall, the facility will: d. Notify physician and family. e. Review the resident's CP and update as indicated . NJAC 8:39-13.1(c),13.2(a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. NJ#2643214Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding. This deficient practice was identified for 1 of 32 sampled residents (Resident #221) and 1 of 6 residents (Unsampled Resident) from resident council meeting reviewed.This deficient practice was evidenced by the following: 1. On 4/27/26 at 8:35 AM, Surveyor #1 (S #1) observed Resident #221 lying in bed, the floor mat on the right side of the resident was dirty, stained, and had wet pools on it in multiple places. On 4/27/26 at 10:31 AM, S #1 made a second observation of the floor mat which was still stained and had wet pools on it in multiple places. On 4/28/26 at 12:23 PM, S #1 made a third observation of the floor mat, which was vertical by the window wall, and stained in multiple places with dried colored chunks and pieces. On 4/28/26 at 12:45 PM, S #1 interviewed Certified Nursing Assistant #1 (CNA #1) who stated they saw the floor mat was dirty on 4/27/26 and called housekeeping then. CNA #1 acknowledged the floor mat was still dirty now. On 5/1/26 at 8:50 AM, S #1 interviewed the Director of Housekeeping (DH) who stated that housekeeping cleans the rooms daily and should be wiping down the floor mats daily as part of the routine room cleaning. The DH further stated that they did not keep a log. The DH also stated that the floor mat should have been cleaned when the room was cleaned. A review of the facility's Safe and Homelike Environment Policy, revised 9/1/26, revealed, in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment.Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 2. On 4/27/26 at 8:23 AM, Surveyor #2 (S #2) interviewed the Assistant Director of Nursing (ADON) who stated that fourth floor unit census (total number of residents) was 63. On 4/29/26 at 10:30 AM, during resident council meeting with Surveyor #3 (S #3), an Unsampled Resident (UR) stated there was a shortage of towels in the morning and that they only received one towel which was not enough. The UR stated that it had been an issue for months. On 4/29/26 at 12:35 PM, the DH provided S#2 a par list for each unit. A review reflected that the cart delivered for 7-3 shift (7:00 AM-3:00 PM) had 60 towels. The amount did not provide each resident with one towel for morning (am) care when the unit census was greater than 60 residents. The list also included 15 towels that were delivered to the unit supply closet at 10, 12, and 2. The list reflected that the cart for 3-11 (3:00 PM-11:00 PM) and 11-7 (11:00 PM-7:00 AM) shifts had 60 towels on the cart. On 4/30/26 at 9:26 AM, S #2, in the presence of the Laundry Supervisor (LS) and the Maintenance Director (MD) observed the supply closet which contained the backup laundry for the facility. S #2 observed that there were no towels in the closet. S #2 then observed the laundry room which had (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seven laundry carts that had 15 towels on each cart and that there were approximately 45 towels on the table and an additional pile of laundry that was being folded which had just come out of the dryer. On 4/30/26 at 9:36 AM, the DH stated that 50 dozen towels were ordered this week and that it was approved by the Licensed Nursing Home Administrator (LNHA) on Monday (4/27/26, the same day the recertification survey started at 6:30 AM). The DH stated that the towels should have arrived yesterday, but they did not. On 4/30/26 at 9:47 AM, the DH stated that the expectation was that the staff were preparing the carts for 3-11 and 11-7 shifts now. She added that the expectation at the end of day was if they may still need towels for the 7-3 shift cart for the next day that those towels would be washed on 3-11 shift and then put on the 7-3 shift cart. The DH further stated that there were some days that they did not need them for the cart and that there were some days that the cart was incomplete. She added that it depended on what came back from the floors to wash and that they did purges in the rooms. On 4/30/26 at 9:50 AM, in the presence of the DH, S #2 observed that the fourth floor unit supply closet had no towels. The DH stated that a delivery of 15 towels came to the unit at 10, 12, and 2. The DH further stated that the large cart came up in the am and that the CNAs distributed the towels to the eight small linen carts (1 for each CNA's assignment of residents) and that each cart would have seven or eight towels to start. Fourth floor unit had a resident capacity of 64 which would require eight CNAs. On 4/30/26 at 10:12 AM, S #2 interviewed CNA #2 who stated that sometimes there was not enough towels that came up in the morning and that they would bring more up at 10. On 4/30/26 at 12:44 PM, S #2 notified the LNHA, Director of Nursing (DON), Administrator in Training (AIT) and [NAME] President of Clinical Services (VPoCS) the concern that they were not enough towels and that enough towels were provided for am care. On 5/1/26 at 11:19 AM, in the presence of the LNHA and AIT, the DON stated that towels were delivered yesterday. The LNHA stated that they were making sure residents were getting additional towels if they wanted. The LNHA did not provide any additional information. A review of the facility's Linen Policy with a reviewed/revised date of 9/1/25, included the following, a linen par is the amount of linen needed to satisfy the daily needs of each resident. Established linen pars allow the laundry department to provide nursing with the linens they need in the proper amounts and at the proper time. There must always be agreed-upon par, along with regularly scheduled delivery times. It is best practice that linen inventory should be a minimum of 3 times your par (the amount of linen needed to satisfy the daily needs of each resident). The facility should maintain a par level of all essential linens. Inventory will be monitored to prevent shortages and ensure that any worn, stained or torn linens are removed from circulation and replaced immediately. Bath towels-Par Level 3.0-Calculation (Per Bed) 3 per resident. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-4.1(a)11; 31.3; 31.4(a)(b);

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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 #260384Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to; a.) ensure a timely initial nursing assessment was completed, b.) ensure physician ordered medication was administered, and c.) ensure hospice services were documented, communicated, and coordinated in accordance with the resident's plan of care and standards of clinical practice. This deficient practice was identified for 2 of 2 residents (Resident #11 and Resident #249) reviewed for quality of care, and 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 4/29/26 at 11:05 AM, the surveyor reviewed the closed record of Resident #249. A review of the admission Record (AR) or face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses included, but were not limited to; atrial fibrillation, cerebral infarction (stroke), type 2 diabetes mellitus, hypertension, and dementia. A review of the resident's medical record revealed there was no initial nursing assessment was completed on 8/8/25, not until 8/11/25. A review of the progress notes (PN) revealed no nursing documentation was completed on 8/8/25, 8/9/25, and 8/10/25, to establish the resident's baseline status upon admission. A review of the electronic Medication Administration Record (eMAR) revealed a physician's order (PO) dated 8/17/25, lomotil oral tablet (tab) 2.5-0.025 milligrams (mg), to be given one tab by mouth every 12 hours as needed (PRN) for diarrhea after stool for Clostridium difficile (C-diff) had been collected for one day. Further review of the eMAR revealed no signature indicating that the medication (med) was administered. Further review of the PN revealed no documentation explaining why the med was not administered or omitted. On 4/30/26 at 11:40 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON) and the survey team, was made aware that the initial nursing assessment was not completed timely and that the physician-ordered Lomotil med was not administered as ordered. A review of the facility's Medication Administration Policy, dated 9/1/24, included, medications (meds) are administered. as ordered by the physician and in accordance with professional standards of practice.The policy further included, ensure that the six rights of med administration are followed. including right time and right documentation. 2. On 4/28/26 at 8:30 AM, the surveyor observed Resident #11 lying in bed with the call bell within reach. The surveyor reviewed the medical record for Resident #11. A review of the AR revealed the resident had diagnoses which included, but were not limited to; Alzheimer's disease, chronic kidney disease, peripheral vascular disease, and functional quadriplegia. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 3/12/26, reflected a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident was receiving hospice services. A review of the resident's individual comprehensive care plan (CP), dated 3/18/26, included a focus area that the resident was on hospice care with poor appetite and difficulty chewing and swallowing. Interventions included assisting the resident with meals, encouraging fluids, and providing nutritional (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supplements. A review of the Order Summary Report (OSR), dated as of 4/28/26, included the PO dated 3/3/25, for hospice evaluation and treatment with no directions specified. On 4/28/26 at 11:01 AM, the surveyor interviewed the Registered Nurse (RN) who stated, when the hospice nurse has a recommendation it is verbally communicated to the nurse. The RN further stated hospice documentation was located in the Misc (miscellenous) section; however, she could not locate weekly hospice visit documentation. On that same date and time, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated, the Hospice nurse visits weekly. The RN/UM further stated there was no hospice binder kept at the nursing station, and that all documentation was completed in the electronic medical record (eMR). On 4/28/26 at 12:10 PM, the surveyor reviewed of Misc section in the eMR, revealed hospice nursing notes; however, further review revealed gaps in hospice nursing documentation, including no consistent weekly documentation in the facility's eMR despite the resident receiving ongoing hospice services. On 4/28/26 at 12:16 PM, the surveyor interviewed the DON and [NAME] President of Clinical Services (VPoCS), who provided hospice nurse notes from the hospice agency that were not included in the facility's eMR. They stated that the hospice nurse was having difficulty uploading his notes. The DON further stated, the nurses will communicate verbally when needed regarding communication between hospice and facility staff. On 4/30/26 at 9:00 AM, the surveyor conducted a follow-up interview with the Hospice Nurse who stated he had not consistently provided weekly documentation and was unaware the facility required each weekly visit to be documented in the medical record. On 4/30/26 at 9:30 AM, the surveyor conducted a follow-up interview with the Hospice Agency Administrator who stated hospice documentation was maintained in their own system and that expectations for documentation in the facility's record were unclear. On 4/30/26 at 9:42 AM, the DON, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, acknowledged that hospice documentation was not consistently maintained in the facility's medical record and that communication between hospice and facility staff was not clearly defined. A review of the facility's Coordination of Hospice Services Policy, dated 9/1/24, included, the facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility .The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities . A review of the facility's Conducting an Accurate Resident Assessment Policy, dated 9/1/24, included, qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline.Information provided by the initial comprehensive assessment establishes baseline data for the ongoing assessment of resident progress . A review of the facility's admission of a Resident Policy, dated 2/26/25, included, upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol . On 5/1/26 at 12:10 PM, the DON, in the presence of the LNHA, stated, A binder is to be used going forward for weekly hospice nursing visits to be documented. NJAC 8:39-27.1

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #2643214 Based on observation, interview, and record review, it was determined that the facility failed to ensure consistent a.) accountability, b.) disposition (destruction) of the controlled dangerous substance (narcotic; medications, with high potential for abuse, were tracked with detail) for 2 of 8 medication carts inspected, and c.) properly dispose of non-narcotic medications, identified during the medication pass observation of 4 nurses who administered medications to 5 residents. The deficient practice was evidenced by the following: 1. On [DATE] at 11:53 AM, in the presence of Registered Nurse #1 (RN #1), Surveyor #1 (S #1) began the narcotic medication (med) inspection, which was stored in a mounted, double locked portion of the med cart (narcotic box) located on the South side of the fourth floor. A review of the shift-to-shift accountability log reflected that both nurses had signed, and no discrepancies were noted that morning. At that time, S #1 and RN #1 reviewed the Controlled Drug Administration Record (a declining inventory log (DIL) for Resident #258's Hydromorphone (a narcotic, pain reliver) reflected 18 tablets (tabs) remained and was compared against the corresponding bingo card (a multidose card containing individually packaged medications) that contained 17 pills. RN #1 stated that he had administered the Hydromorphone to Resident #258, and did not sign the DIL when he removed the med from the bingo card and again did not sign after he had administered the Hydromorphone that morning. S #1 and RN #1 reviewed the electronic Administration Record (eMAR) together that reflected an order for Hydromorphone 4 milligram (mg), to be given one tablet (tab) every 8 hours as needed (PRN), started on [DATE], and revealed that it was administered on [DATE] at 8:08 AM. The concern that three hours and 45 minutes had passed from the time of administration and observation was discussed with RN #1. 2. At that time, S #1 observed the DIL for Resident #258's Oxycodone -Acetaminophen 10/325 mg (milligram) (Oxy/APAP; a narcotic pain reliver) reflected 13 tabs remained and was compared against the corresponding bingo card that contained 12 pills. S #2 and RN #1 reviewed the eMAR together that reflected an order for Oxy/APAP 10 /325 mg to be given every 12 hours PRN for breakthrough pain and revealed an administration for that day was not signed as administered on the eMAR. The Oxy/APAP 10/325 mg pill was found in a med cup, in the med cart, was not in the mounted, double locked portion of the med cart and was unlabeled. At that time, RN #1 stated that he had removed one pill from Resident #258's inventory for administration but the resident had refused and requested for the Hydromorphone. When asked why the removal, the refusal was not documented, a response was not provided. When asked why the Oxy/APAP was not disposed, RN #1 stated that he needed two signatures but could not state why he had not asked to speak with another nurse on duty for proper disposal of the med. When asked when the DIL should be signed, RN #1 stated that the DIL should have been signed when he removed the narcotics from Resident #258's inventory. On [DATE] at 12:06 PM, in the presence of S #1, and RN #1, the Assistant Director of Nursing (ADON) confirmed the removal of the med should have signed on the DIL, refusal of the med administration should have been documented on the eMAR, after the refusal of the Oxy/APAP the pill should not have been stored in the med cart, and instead should have been disposed by two nurses then (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recorded. 3. On [DATE] at 8:30 AM, during the med pass observation, in the presence of Surveyor #2 (S #2), S #1 observed RN #2 removed two Lidocaine 4% patches from the med cart and dated a patch. At that time, RN #1 stated that she had the wrong strength and threw both patches into the trash, locked the med cart and left to obtain Lidocaine 5% patches. On [DATE] at 8:56 AM, during an interview with the surveyors, the Unit Manager (UM) could not state where the Lidocaine 4% patches should have been disposed of and stated she would get back to the surveyors with the answer. On [DATE] at 8:57 AM, during an interview with the surveyors, RN #1 was asked by S #2 asked where meds such as Lidocaine 4% be disposed of. At that time, RN #1 stated that it should have been disposed of in the drug disposal solution. On [DATE] at 1:52 PM, in the presence of the survey team, the [NAME] President of Clinical Services (VPoCS), the Administrator in Training (AIT), the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), S #1 discussed the above concerns with narcotic medications (meds) Hydromorphone and Oxy/APAP for Resident #258 that were not logged on the DIL, refusal that was not documented on the eMAR, the one tab of Oxy/APAP in a med cup, unlabeled stored in the med cart, and the failure to dispose of the Oxy/APAP after the resident's refusal and the failure to dispose of the Lidocaine in the drug disposal solution. On [DATE] at 11:00 AM, during a meeting with the survey team, the LNHA, AIT and the MDS Coordinator, the DON stated that the DIL should have been signed immediately after a narcotic med was removed from the resident's inventory and that the nurses were re-educated on the process for documentation on the DIL and the destruction of narcotic meds and non-narcotic meds. A review of the facility's Controlled Substance Administration and Accountability Policy, dated/revised on [DATE], included that The Controlled Drug Record (or other specified forms) serves the dual purpose of recording both narcotic disposition and patient administration. A review of the facility's Destruction of Unused Drugs Policy, dated/revised [DATE], included that all unused, contaminated, or expired prescription shall be disposed of in accordance with state laws and regulations. Our facility utilizes [brand redacted; drug disposal solution] Destroy unused, non-returnable meds. 4. On [DATE] at 10:11 AM, S #2 observed the Licensed Practical Nurse (LPN) remove controlled meds from Resident #116's bingo cards. The meds included the following physician order (PO): -Alprazolam tab 0.5 mg, give 1 tab by mouth one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) for anxiety, giive prior to dialysis. The PO started on [DATE]. -Oxycodone Hydrochloride (HCl) oral tab 5 mg, give 1 tab by mouth every 12 hours PRN for moderate to severe pain (4-10). The PO started on [DATE]. The LPN did not sign the DIL when they removed the meds from the bingo cards. On [DATE] at 10:13 AM, S #2 observed the LPN administer the meds to Resident #116. The LPN still (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had not signed the DIL after administering the meds. On [DATE] at 10:22 AM, S #2 observed the LPN prepare meds for the next resident, Resident #208. The LPN still had not signed the DIL for Resident #116's meds. On [DATE] at 10:28 AM, S #2 interviewed the LPN who stated they should have signed the DIL right away. On [DATE] at 1:56 PM, in the presence of the survey team, S #2 discussed the above concerns with the LNHA, DON, VPoCS, and AIT. On [DATE] at 11:00 AM, during a meeting with the survey team, the LNHA, AIT and the MDS-Coordinator, the DON stated that the DIL should have been signed immediately after a narcotic med was removed from the resident's inventory. A review of the facility's Medication Administration Policy, revised [DATE], revealed, if med is a controlled substance, sign narcotic book upon removal from inventory. 5. On [DATE] at 10:22 AM, S #2 observed the LPN prepare meds for Resident #208. On [DATE] at 11:45 AM, the LPN administered the meds to the resident. Two orders remained on the LPN's computer screen highlighted in red and were overdue. The meds that remained included the following PO: -Novolog Injection Solution 100 Unit/mL (unit/milliliters) inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units call MD (Medical Doctor) if less than 70 or greater than 350, subcutaneously before meals and at bedtime for Diabetes Mellitus (DM) (a disease characterized by high levels of blood sugar). The PO started on [DATE]. -Lantus Subcutaneous Solution 100 Unit/mL Inject 18 unit subcutaneously one time a day for DM. The PO started on [DATE]. On [DATE] at 11:46 AM, S #2 asked the LPN why the meds listed above remained on the screen and were overdue. The LPN stated they already administered the meds earlier that day but did not sign that they administered them in the eMAR. The LPN stated further that they should not be administering meds without signing for them so that the documentation and time will be correct. A review of the Medication Administration Audit Report of [DATE] for Resident #208 revealed the following: -Novolog Injection Solution 100 Unit/mL was scheduled for [DATE] at 7:30 AM, administered on [DATE] at 9:00 AM, and documented on [DATE] at 11:57 AM. -Lantus Subcutaneous Solution 100 Unit/mL was scheduled for [DATE] at 9:00 AM, administered on [DATE] at 8:06 AM, and documented on [DATE] at 11:48 AM. On [DATE] at 1:56 PM, in the presence of the survey team, S #2 discussed the above concerns with the LNHA, DON, VPoCS, and AIT. They did not provide a verbal response at that time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medication Administration Policy, revised [DATE], revealed the following: -Sign MAR after administered. -Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. NJAC 8:39-11.2(b); 27.1(a); 29.2(d); 29.4(a), (b)2

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Complaint #2738075Based 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 administration observation on 4/29/26, the surveyors observed 4 nurses administer medications to 5 residents. There were 30 opportunities, and 4 errors were observed which resulted in a medication error rate of 13.33%. This deficient practice was identified for 2 of 5 residents (Resident #141 and #257), that was administered by 2 of 4 nurses.This deficient practice was evidenced by the following: 1. On 4/29/26 at 8:05 AM, two surveyors observed Registered Nurse #1 (RN #1) prepare medications (meds) for Resident #141. The meds included the following physician's order (PO): - Strovite One (prescription strength vitamin that included folic acid 1.67 milligrams (mg) used for treatment of megaloblastic anemia due to folic acid deficiency and anemia of nutritional deficit); one tablet (tab) by mouth one time a day for supplement. The PO started on 3/18/26. - Lidoderm Patch 5 % (Lidocaine); apply to left leg topically in the morning for pain, do not apply to sx [surgical site]. The PO started on 3/27/26. - Lidoderm Patch 5 % (Lidocaine); apply to left shoulder topically in the morning for pain, do not apply to sx [surgical site]. The PO started on 3/27/26. On 4/29/26 at 8:14 AM, in the presence of Surveyor #1 (S #1), Surveyor #2 (S #2) observed RN #1 removed an opened multivitamin (MVI) bottle from the medication (med) cart, poured one tab into a med cup. RN #1 stated it was stocked in the facility, for multiple residents use who an order, and was not sent from the pharmacy. At that time, the surveyors observed RN #1 removed two Lidocaine 4% patches from a box. RN#1 stated she would administer the oral meds first and place the patches on the resident afterwards. On 4/29/26 at 8:17 AM, RN #1 informed S #1 and S #2 that she was ready to administer the meds. On 4/29/26 at 8:18 AM, S #2 observed RN #1 placed the Lidoderm 4% patches back in the med cart and locked the med cart. On 4/29/26 at 8:19 AM, S #2, in the presence of S #1, observed RN #1 enter Resident #141's threshold for administration. S #2 stopped the med pass and requested to speak with RN #1 outside the resident's room to review the eMAR and the PO. At that time, RN #1 informed the surveyors that the MVI was requested from central supply and was an over the counter (OTC) med. RN #1 also stated that on 3/19/26, the PO did not arrive, she called the pharmacy at that time and further stated that she was instructed to substitute the PO Strovite One with an OTC MVI (contained zero amount of Folic Acid). At that time, RN #1 stated that she did not document the conversation with the pharmacy and did not inform the prescriber that Strovite One had not arrived on 3/19/26. The RN stated she would call the prescriber, call the pharmacy, inform the Unit Manger and the Assistant Director of Nursing (ADON). On 4/29/26 at 8:24 AM, RN #1 informed S #2 that she would dispose of the MVI into the drug disposal solution. At that time, RN #1 was observed removing the MVI from the med cup and disposed of the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MVI inro the drug disposal solution. Refer to F755. 2. On 4/29/26 at 8:30 AM, In the presence of S #1, S #2 observed RN #1 remove the Lidocaine 4% patches from the med cart and dated a patch. At that time, RN #1 stated that she had the wrong strength and threw both patches into the trash, locked the med cart and left to obtain Lidocaine 5% patches. On 4/29/26 at 8:40 AM, RN #1 returned to the med cart and stated that the Lidocaine 5% was not available and that the Unit Manager called the prescriber and the new order would be entered as an alternative. At that time, S #2 observed RN #1 prepare the patches from the new PO that reflected: - Lidocaine Patch 4 % (Lidocaine); apply to left leg topically, one time only, for pain until 4/29/26 at 11:59 PM. The PO started on 4/29/26. -Lidocaine Patch 4 % (Lidocaine); apply to left shoulder topically, one time only, for pain until 4/29/26 at 11:59 PM. The PO started on 4/29/26. On 4/29/26 at 8:47 AM, RN #1 informed S #2 she was ready to administer the patches, turned and entered Resident #141's room for administration. At that time, S #2 asked to speak with RN #1 outside of the resident's room. On 4/29/26 at 8:49 AM, in the presence of S #1, S #2 and RN #1 reviewed the eMAR together. When asked how the RN knew how many patches to administer and where the specified location on the left leg and left shoulder should be placed, RN #1 confirmed and acknowledged that the orders for Lidoderm 5% and Lidocaine 4% were incomplete, should have had a specified quantity and specific location on the leg and on the shoulder. RN #1 also stated that she asked the resident where they wanted the patches applied, the resident had no surgical site and could not say how the pain was managed when the specific location was undefined, for prescriber assessments of muscular, joint or nerve issues and referred pain. On 4/30/26 at 1:52 PM, in the presence of the survey team, the [NAME] President of Clinical Services (VPoCS), the Administrator in Training (AIT), the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), S #2 discussed the above concerns that from 3/29/26, Strovite One was signed administered on the eMAR yet was not received from the pharmacy. At that time, S #2 requested evidence to support that Strovite One was received, the pharmacy and the physician were contacted. S #2 also discussed the concern with the PO for Lidoderm that did not include the quantity of patches to be administered to the leg and shoulder and did not include a specified location on the leg and shoulder for proper pain management. On 5/1/26 at 11:00 AM, during a meeting with the survey team, the LNHA, AIT and the MDS-Coordinator, the DON stated that all nurses who were involved with the med pass errors were re-educated. At that time, the DON also stated that the pharmacy had informed RN #1 that Strovite One and the OTC MVI were interchangeable. At that time, S #2 requested evidence that the pharmacy recommended the interchange and that the prescriber was informed and approved the change. No further information was provided. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medication Administration Policy, dated/revised 9/1/25, included to correct any discrepancies and required reporting to the nurse manager. Additionally, staff were to ensure the six rights of med administration were followed, which involved administration to right resident, right drug, right dosage, right route, right time, and right documentation. A review of the facility's Medication Orders Policy, dated/revised 9/1/25, under Elements of Med Order included that dosage, strength of med is involved right resident, right drug, right dosage, right route, right time, and right documentation. 3. On 4/29/26 at 9:06 AM, two surveyors observed RN #2 prepare meds for Resident #257. The meds included, but were not limited to, the following PO: -Pro-Stat Oral Liquid (Amino Acids-Protein Hydrolysate) give 30 ml (milliliters) by mouth 2 times a day for at risk for malnutrition for 15 Days. The PO started on 4/26/26. On 4/29/26 at 9:08 AM, in the presence of S #2, S #1 observed RN #2 pour Pro-Stat Oral Liquid from the bottle into a med cup while holding the med cup in the air. After RN #2 finished pouring the liquid into the med cup, RN #2 closed the bottle and returned the bottle to the drawer in the med cart. S #1 and S #2 observed the med cup on a flat, level surface and read the meniscus (the curved surface of the liquid) at eye level. S #1 and S #2 saw that the liquid measured below 30 ml. RN #2 confirmed they were ready to administer the med. S #1 asked RN #2 if the liquid measured 30 ml, and RN #2 stated that it did not measure 30 ml. RN #2 acknowledged that they should have poured the liquid into the med cup while the med cup was on a flat surface rather than in the air. RN #2 added more Pro-Stat Oral Liquid to the med cup to reach 30 ml. On 4/29/26 at 9:40 AM, S #1 observed RN #2 administer Pro-Stat Oral Liquid to Resident #257. After RN #2 administered the med, S #1 and S #2 observed that there was still liquid left in the cup. On 4/29/26 at 9:42 AM, RN #2 threw out the cup, containing the remaining liquid, in the garbage. S #1 interviewed RN #2 who acknowledged they did not administer the full dose of the liquid to Resident #257. RN #2 stated they should have given it to the resident with a spoon. On 4/30/26 at 1:56 PM, in the presence of the survey team, S #1 discussed the concern with the LNHA, DON, VPoCS, and AIT. They did not provide a verbal response at that time. A review of the facility's Medication Administration Policy, revised 10/20/25, revealed, the following -Ensure that the six rights of med administration are followed: Right resident, Right drug, Right dosage, Right route, Right time, Right documentation. -Administer meds as ordered in accordance with manufacturer specifications. Provide appropriate amount of food and fluid. NJAC 8:39-11.2(b), 29.2(d)