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	12/06/2024

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

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** 37590 Based on record review, interview, and policy review, the facility failed to develop care plans related to use and monitoring of psychoactive medications for one (Resident (R) 49 of five residents reviewed for unnecessary medications out of a sample of 35 residents. Findings include: Review of R49's Admission Record located under the Profile tab of the electronic medical record (EMR) revealed R49 was admitted to the facility on [DATE] with diagnoses that included depression and anxiety, Review of R49's physician orders, located under the Physician Orders tab of the EMR, revealed medication orders for Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 milligram (mg) three times a day for agitation; Mirtazapine Oral Tablet 7.5 mg at bedtime for depression; and Buspirone HCl Oral Tablet 5 mg three times a day for anxiety. Review of R49's care plan located under the Care Plan tab of the EMR, did not include the use of psychoactive medication or interventions for monitoring for side effects or behaviors. Review of the facility's policy Comprehensive Care Plan last reviewed 07/02/24 indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . to meet a resident's medical, nursing, and mental and psychosocial needs that identified in the resident's comprehensive assessment. During an interview with the Director of Nursing (DON) on 12/06/24 at 3:11PM she was asked about R49's care plan. The DON confirmed that any resident receiving psychoactive medication should have a care plan with interventions that describe the monitoring of behaviors and reporting side effects from the use of the medication. NJAC 8:39-11.2(e) thru (i) NJAC 8:39-27.1(a)

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observations, interviews, record review, and policy review, the facility failed to provide two residents (Resident (R) 139 and R108) out of nine residents reviewed for Activities of Daily Living (ADLs) the necessary repositioning and incontinence care to ensure residents dependent on assistance with ADLs received care and services for toileting hygiene and skin protection out of a total sample of 41 residents. Findings include: 1. Review of R139's Face Sheet found in the Resident Report tab of the electronic medical record (EMR) revealed admission on 11/12/22 with diagnoses including sepsis, extended spectrum beta lactamase resistance, muscle weakness, and benign prostatic hyperplasia. Review of R139's quarterly Minimum Data Set (MDS) located in the MDS tab in the EMR with an Assessment Reference Date (ARD) of 08/21/24, revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated moderate cognitive impairment. According to the MDS R139 was always incontinent of urine and bowel, is dependent on toileting hygiene, showering/bathing, toilet transfer, and R139 required substantial/maximal assistance with rolling left and right. The resident is identified as high risk for developing pressure ulcers. During a continuous observation on 12/03/24 from 1:30 PM to 3:30 PM, R139 was seated in the communal area on the 300 unit. The resident was never repositioned or checked for incontinence. During an interview on 12/03/24 at 1:45 PM, R139's resident representative (RR2), she stated that the resident was always brought to the communal area every morning and stayed there until evening, when they were put back into bed. They stated that staff did not reposition, toilet, or provide R139 incontinence care while in the common room. During an observation on 12/03/24 from 4:15 PM until 4:45 PM, R139 was still observed in their chair in the same position, with no staff present. During an additional continuous observation on 12/05/24 from 11:00 AM until 2:50 PM, R139 were observed in their Broda wheelchairs in the communal area. R139 was observed attending the activity and the lunch service in the communal area during this time, without leaving the room being repositioned, nor checked for incontinence care needs. Review of R139's EMR under the Resident Orders tab under the Resident Reports revealed an order, dated 10/09/24, to turn and position every two hours as tolerated to prevent pressure wounds, every shift. Review of R139's EMR under the Resident Orders tab under the Resident Reports revealed an order, dated 10/09/24, for Phyto plex z-guard 57-17% .apply to diaper area topically every shift for skin protectant with each diaper change. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R139's Care Plan in the EMR under the Care Plan tab, initiated 10/16/23 and revised 07/24/24, revealed R139 had the potential for skin integrity impairment of the sacrum related to impaired mobility and incontinence. Interventions included assisting the resident with general hygiene and comfort measures. Review of R139's Care Plan in the EMR under the Care Plan tab, initiated 11/20/23 and revised 08/06/24, revealed R139 had bowel and bladder incontinence related to Alzheimer's, generalized weakness/impaired mobility, benign prostatic hyperplasia, and overactive bladder. Interventions included checking every two hours and as required for incontinence, to wash, rinse and dry perineum. Review of R139's EMR under the Task tab revealed bladder documentation every shift for October 2024. Documentation by Certified Nurse Aides (CNAs) revealed no documentation completed for 42 of 93 opportunities. Review of R139's EMR under the Task tab revealed bladder documentation every shift for November 2024. Documentation by CNAs revealed no documentation completed for 23 of 90 opportunities. Review of R139's EMR under the Task tab revealed turning and repositioning documentation every shift for October 2024. Documentation by CNAs revealed no documentation completed for 42 of 93 opportunities. Review of R139's EMR under the Task tab revealed turning and repositioning documentation every shift for November 2024. Documentation by CNAs revealed no documentation completed for 23 of 90 opportunities. Review of R139's EMR under the Task tab revealed turning and repositioning documentation every shift for December 2024. Documentation by CNAs revealed no documentation completed for three of 18 opportunities. During an interview on 12/06/24 at 4:55 PM, CNA2 stated that the nurse aides should check the residents every 15 minutes, to observe them. She confirmed residents should be checked every two hours for care needs. During a concurrent interview on 12/06/24 at 5:00 PM, Registered Nurse (RN) 1 and RN2 confirmed that it was important to check for incontinence and reposition R139 because he had a history of skin breakdown, fungal infection, and urinary tract infections. RN1 and RN2 said that the resident received his brief change at approximately 8:00 AM and again by 11:00 AM. They both stated that after that R139 was out of bed and in his Broda wheelchair and in the communal area. RN1 and RN2 said that the resident would then be checked for incontinence and changed after 3:00 PM when he went back to his room. They both confirmed the resident was totally incontinent of bowel and bladder. 2. Review of R108's Face sheet located under the Resident Report tab of the EMR revealed R108 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease Review of R108's annual MDS with an ARD of 10/23/24, located under the MDS tab, revealed the resident was severely impaired and unable to complete the interview. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R108's care plan found under the Care Plan tab of the EMR revealed R108 has potential for pressure ulcer development r/t [related to] Immobility, Incontinence. The care plan interventions indicated, assist to shift weight in W/C [wheelchair q [every]15 minutes. and following the facilities policy/protocols for the prevention/treatment of skin breakdown that was initiated 10/27/23. Observation of R108 on 12/05/24 at11:00AM until 4:27PM in the 3rd floor dining room, revealed that R108 was seated in a Broda chair. During the observation, the resident was not approached until 4:27PM, when CNA 2 brought the resident a pillow and placed it behind the resident's head, however, did not check R108 for incontinence. Review of the ADL flow sheet provided by the facility revealed that R108 was toileted/provided incontinence care on 12/03/24 at 12:17AM and 11:59PM; and on 12/04/24 at 6:32AM and 7:38PM. During an interview on 12/06/24 at 5:17 PM, Director of Nursing (DON) stated that if a resident was wet, they needed to be changed right away. She said that every shift the nurse aides were required to check residents' skin and for any incontinence. The CNAs should monitor for incontinence every two hours to prevent any skin breakdown, prevent infection, or any urinary infection. The DON confirmed that nurse aides should remove residents from the day room every two hours to go to the resident room for a side to side or stand check to monitor for incontinence. Review of the facility's policy Activities of Daily Living dated 07/01/24 indicated, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care .transfer and ambulation .toileting .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 37590 Resident #108 Activities of Daily Living Review of MAR revealed meds given as ordered. Shower sheets do not reveal a concern. \ Observation of resident from 3PM to 4:24PM on 12/03/24. No staff observed adjusting resident as she is reclined in Broda chair. Resident was not readjusted, but at 4:27 Review of R108's care plan revealed the resident has potential for pressure ulcer development r/t Immobility, Incontinence initiated 10/27/23. Goal is for resident to have intact skin, free of redness, blisters or discoloration using interventions that included: assist to shift weight in W/C q 15 minutes and following the facilities policy/protocols for the prevention/treatment of skin breakdown (initiated 10/27/23). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/03/24 04:27 PM Staff member came and brought resident a pillow and place behind the resident's head. Observed resident in the main dining 12/04/24 01:32 PM appearing to be asleep. Non-slip socks in place, pillow behind head and back. No odors or obvious signs of distress. Resident does have foot drop 12/04/24 01:35 PM staff member approached to assist with meal. Resident was set up by staff and able to feed self. Food was pureed consistency. Care Plan: [NAME] has potential for pressure ulcer development r/t Immobility, Incontinence -Goal is for resident skin to remain intact, free of redness/blisters/discoloration, with interventions that included assisting resident with shifting her weight every 15 minutes Review of most recent annual MDS revealed although resident is at risk for skin deterioration, she has had none. 12/05/24 02:53 PM Says have been actively hiring and using agency. Have improved but weekends are still a concerns. Offers incentives and use other companies and recruiters to get staffing. Says biggest concern they have been made aware of is call light response time needs to be improved. The DON was also asked about expectations for residents seated in the common area for monitoring over an extended period time, and she stated that she expects staff to follow each residents plan of care. If the resident's plan of states to check for incontinence every 2 hours she expects staff to take the resident to their room, for privacy and check their brief, adding that if resident requires a Hoyer then staff has to find help. NJAC 8:39-4.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on interview, record review, and facility policy review, the facility failed to ensure ongoing communication and collaboration with the dialysis facility and failed to ensure a medication was administered on dialysis days for one of one residents (Resident (R) 61) reviewed for dialysis out of a sample of 41. Findings include: 1. Review of R61's Face Sheet, found in the Resident Report tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnosis including end stage renal disease, kidney transplant failure, congestive heart failure, hypertension, and diabetes mellitus type two. Review of R61's quarterly Minimum Data Set (MDS) located in the MDS tab in the EMR with an Assessment Reference Date (ARD) of 09/10/24 revealed a Brief Interview for Mental Status (BIMS) score of fourteen out of 15, which indicated no cognitive impairment. R61 was documented to receive dialysis while a resident. Review of R61's EMR under the Resident Orders tab under the Resident Reports revealed an order dated 04/20/24, for the resident to attend dialysis on Monday, Wednesday, and Friday at 9:45 AM. Further review revealed an order dated 04/20/24, for furosemide (diuretic medication) oral tablet 40 milligram (mg) .give one tablet by mouth in the afternoon for CHF (congestive heart failure). The medication was scheduled to be administered at 1:00 PM once a day. Review of R61's Medication Administration Record (MAR) of the EMR under the Resident Orders tab for October 2024, revealed furosemide oral tablet 40 mg was not administered on seven of 13 opportunities, (10/07/24, 10/09/24, 10/11/24, 10/14/24, 10/21/24, 10/25/28, and 10/28/24) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's MAR of the EMR under the Resident Orders tab for November 2024, revealed furosemide oral tablet 40 mg was not administered on seven of 13 opportunities, (11/04/24, 11/06/24, 11/15/24, 11/20/24, 11/22/24, 11/25/24, and 11/27/24) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's MAR of the EMR under the Resident Orders tab for December 2024, revealed furosemide oral tablet 40 mg was not administered on two of two opportunities, (12/02/24 and 12/04/24) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's EMR under the Resident Orders tab under the Resident Reports revealed an order, dated 04/20/24, for carvedilol oral tablet 25 mg .give one tablet by mouth two times a day for hypertension give with food. The medication was scheduled to be administered at 12:00 PM and 9:00 PM. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R61's MAR of the EMR under the Resident Orders tab for October 2024, revealed carvedilol oral tablet 25 mg was not administered on eleven of 13 opportunities, (10/07/24, 10/09/24, 10/11/24, 10/14/24, 10/16/24, 10/18/24, 10/21/24, 10/23/24, 10/25/24, 10/28/24, and 10/30/24) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's MAR of the EMR under the Resident Orders tab for November 2024, revealed carvedilol oral tablet 25 mg was not administered on eight of 13 opportunities, (11/04/24, 11/06/24, 11/13/24, 11/15/24, 11/20/24, 11/22/24, 11/25/24, and 11/27/24) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's MAR of the EMR under the Resident Orders tab for December 2024, revealed carvedilol oral tablet 25 mg was not administered on two of two opportunities, (12/02/24 and 12/04/24) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's EMR under the Resident Orders tab under the Resident Reports revealed an order, dated 04/20/24, for Humalog injection solution 100 unit/milliliter (ml) .inject as per sliding scale subcutaneously four times a day every Monday, Wednesday, and Friday for diabetes mellitus. The medication was scheduled to be administered at 7:30 AM, 1:00 PM, 5:00 PM, and 9:00 PM. Review of R61's MAR of the EMR under the Resident Orders tab for October 2024, revealed Humalog injection solution 100 unit/ml was not administered on eight of 52 opportunities, (10/07/24, 10/09/24, 10/11/24, 10/14/24, 10/18/24, 10/21/24, 10/25/24, and 10/28/24 at 1:00 PM) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's MAR of the EMR under the Resident Orders tab for November 2024, revealed Humalog injection solution 100 unit/ml was not administered on seven of 52 opportunities, (11/04/24, 11/06/24, 11/15/24, 11/20/24, 11/22/24, 11/25/24, and 11/27/24 at 1:00 PM) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's MAR of the EMR under the Resident Orders tab for December 2024, revealed Humalog injection solution 100 unit/ml was not administered on two of eight opportunities, (12/02/24 and 12/04/24 at 1:00 PM) and was coded by nursing staff as out of the facility on scheduled dialysis dates. Review of R61's Dialysis Communication documentation from October 2024 to December 2024 revealed that the facility did not send these medications to dialysis for administration, and the dialysis center did not document that these medications were administered while away from the facility. During a concurrent interview on 12/06/24 at 5:00 PM, Registered Nurse (RN)1 and RN2 stated that R61's went to dialysis on Mondays, Wednesdays, and Fridays, usually by 9:45 AM. RN2 said that R61 usually returned around 2:30 PM. They both stated that the resident was checked upon return from dialysis, and that they had good communications with the dialysis center. They stated that if the dialysis center had concerns for R61 they would write the information on the communication forms. RN1 said that the nurses complete their part of the communication form, and then review and complete them upon return. They confirmed R61 was administered medications furosemide, Humalog, and carvedilol while scheduled to be at dialysis and that those medications could not be given if the resident was not present. Once the resident returned from dialysis it was too late to administer the medications. RN1 and RN2 confirmed that the carvedilol, furosemide, and Humalog were important because the resident had congestive heart failure, diabetes, and end stage renal disease. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/24 at 5:17 PM, Director of Nursing (DON) stated that the facility nurses should take resident vitals, check the site, and prepare the dialysis communication binder that the resident would take with them for dialysis. She stated that the dialysis center knew what medications the resident was taking, but that the dialysis center did not administer any of those medications. The [NAME] stated that if the resident had a medication that was ordered to be administered while the resident was scheduled to be at dialysis, the nurse should call the physician to see if the medication could be given before or after they go out for dialysis. The DON stated that if the physician stated that the scheduled medication did not need to be given when the resident was going out to dialysis, the physician would document that. She confirmed that the dialysis center did not administer R61's Humalog or carvedilol while they were out of the facility. She confirmed that the physician should reschedule the medication or withhold it. Review of the facility's policy titled, Hemodialysis dated 07/01/24 documented, The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, .The licensed nurse will communicate to the dialysis facility via telephone communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to .timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility . physician/treatment orders .The facility will communicate with the dialysis facility, attending physician and/or nephrologist medication administration or withholding of certain medications prior to the dialysis treatment and document such orders .The facility will ensure that the physician's orders for dialysis include: .Any medication administration or withholding of specific medications prior to dialysis treatments. NJAC 8:39-2.9

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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** 29015 Based on observations and interview, the facility failed to ensure medication rooms on three (2nd nursing unit (NU), 3rd NU, and 5th NU) of four nursing units, did not have expired medical products or items left open. This has the potential to increase of risk of infections due to expiration. Findings include: During observations conducted with Licensed Practical Nurse (LPN)9, revealed the following expired items located in the resident care supplies: 1. Observation on [DATE] at 9:26 AM on the second-floor nursing unit, revealed the following expired items: (10) Central Line Trays w/chloral prep expired on [DATE]. (2) Huber needles (1) expired on [DATE], and (1) expired on [DATE]. (1) Microbore Extension set expired on [DATE]. (1) IV Securement Kit expired on [DATE]. (1) 30ml sterile water syringe left open. (1) IV (intravenous) administration kit that expired on [DATE]. (12) Replacement caps expired on [DATE]; (29) on [DATE], and (24) on [DATE]. 2. Observation conducted on [DATE] at 10:17 AM on the third-floor nursing, revealed the following expired items: (1) Huber Needle expired on [DATE]. .(2) sterile water vials that expired on [DATE], and [DATE]. (1) specimen transport tube expired on [DATE]. (1) Five-gram lubricating jelly expired on [DATE]. (34) Needleless connector caps expired on [DATE]. 3. Observation conducted on [DATE] at 11:59 AM on the fifth-floor nursing, revealed the following expired items: (2) saline enema laxative expired on ,d+[DATE], and ,d+[DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(10) Micro scaffold collagen expired on [DATE]. (1) Micro-kill one Germicidal alcohol wipes-160 wipes expired on [DATE]. (1) box-quantity of six- Glucose control solutions expired on [DATE]. During an interview on [DATE] at 12:12 PM, the Director of Nursing (DON) stated that the unit managers should be overseeing the medical supplies and expiration dates. NJAC 8:,d+[DATE].4

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 29015 Based on observations, interviews, and policy review, the facility failed to ensure that one of 10 medication carts (fifth floor south) and one of one rolling cart (fifth floor) were not left unsecured and unmonitored when medication cart was unlocked. This the potential for medication diversion and for residents to obtain medications that could affect their health. Findings include: Review of the facility's policy titled Medication Storage dated 07/01/24, revealed, it is the policy of this facility to ensure all medications housed on our premises will be stored in the medication rooms/medication carts according to the manufacturer recommendations .All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls .During a medication pass, medications must be under the observation of the person administering medications or locked in the medication storage area/cart. During observations conducted on the fifth-floor nursing unit on 12/03/24 at 12:07PM, the 5 South medication cart was observed as being unlocked. Licensed Practical Nurse (LPN)1 was observed removing medications and leaving the medication cart unlocked while administrating the medications. The medication cart was observed as being unlocked; out of sight of LPN1, and unattended from 12:07PM to 12:15PM. During an interview on 12/03/24 at 12:15PM, LPN1 confirmed the medication had been left unlocked, and stated the medication cart keys were lost, everyone was aware of it, and they were waiting for pharmacy to come fix it. When questioned how long the cart had been left unlocked, LPN1 responded since 7:15 AM that morning. During an interview on 12/03/24 at 1:31PM with the Administrator, Director of Nursing (DON), the Administrator was questioned if he was aware of the issue with the medication cart. The Administrator responded yes, and they had placed a stat order for pharmacy to supply another lock/key. The Administrator was questioned what the facility's plan was to ensure the security of the medications in the cart, the Administrator responded, the plan is for the nurse to not leave the cart unattended. During an observation on 12/04/24 at 3:36PM to 3:46PM on the Fifth-floor nursing unit, it was observed that there was a plastic rolling cart left unattended with three insulin pens on top of the cart. The medication was observed as unsecured and not within sight of licensed nursing staff. During an interview on 12/04/24 at 3:47 PM, the Unit Manager (UM) confirmed the cart had been left unattended, and the medications were left unsecured on top of the cart. The UM stated the medication should not have be left unattended and proceeded to secure medications. During an interview on 12/05/24 at 3:51PM, the DON stated she expected the nursing staff not to leave medications unattended and to lock the medication cart. (continued on next page)

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	12/06/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-29.4

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on interviews, record review and policy review, the facility failed to maintain an accurate medical record for two (Resident (R) 71 and R22) of six residents reviewed for nursing services. The facility failed to ensure medications administrations were accurately documented administration record. Findings include: 1. During an interview with R71's Resident Representative (RR) on 12/03/24 at 12:20 PM, she stated that R71 has missed medication administrations. Review of R71's Electronic Medical Record (EMR), under the Orders tab revealed Medication Administration Record (MAR) dated November 2024 lacked documentation that the following medications were not administered on 11/14/24 and 11/26/24 for the following medications: Lasix (diuretic) 20 milligram (mg), Sertraline (antidepressant) 100mg, Divalproex (antipsychotic) 125mg, Memantine (miscellaneous central nervous system agent) 10mg (twice daily), and Donepezil (Acetylcholinesterase inhibitor) 10mg. Further review of the Nurse notes in the EMR, under Progress Notes lacked documentation as to why the medications were not administered. During an interview with Licensed Practical Nurse (LPN) 8 on 12/05/24 at 4:42PM, who was the nurse on the PM shift on 11/14/24, LPN8 could not recall the situation but stated that if she did not give the medication, she would have written a nurses note and contacted the physician. During an interview with the Director of Nursing (DON) and the Corporate Nurse (CRN) 1 on 12/06/24 at 3:16PM, the DON was asked about R71's missing medication administrations on 11/1424 and 11/16/24. The DON stated that she was not aware of the missed medications and believed this was just a lack of incomplete documentation. The DON stated that if a medication was not given or given late it should be documented in the medical record on the MAR and should include a corresponding nurses note. 2. Review of R22's undated Admission Record located in the EMR, under the Profile tab, indicated the resident was admitted to the facility on [DATE], and discharged home on 11/17/24, with diagnoses including gout, hypertension, kidney transplant, atrial fibrillation, neuropathy, for gastroesophageal reflux disease(GERD), type 2 diabetes mellitus with hyperglycemia, respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD). Review of R22's MAR dated 10/20/24 located in the EMR under the Orders tab, indicated the following medications were not administered to the resident per the physician orders: Allopurinol daily at 9:00AM for Gout Amlodipine daily at 9:00AM for hypertension (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cyclosporine one time at 9:00AM for kidney transplant Furosemide daily at 9:00AM for atrial fibrillation Gabapentin daily at 9:00AM for nerve pain Metoprolol Succinate daily at 9:00AM for hypertension Prednisone daily at 9:00AM for COPD Protonix daily at 9:00AM for GERD Apixaban two times daily, 9:00AM dose was not given, for atrial fibrillation Albuterol Sulfate every 8 hours, not given at 2:00PM, for COPD Insulin Lispro, inject six (6) units subcutaneously before meals and at bedtime, not administered at 7:30AM, and 11:30AM, for diabetes Insulin Lispro sliding scale, no blood sugar and/or insulin given at 7:30AM, and 11:30AM, for diabetes. Review of R22's Assessments located in the EMR under the Assessment tab and Progress Notes located in the EMR under the Progress Notes tab revealed no documentation related to why the medications were not given for 10/20/24. During an interview with DON on 12/06/24 at 4:32 PM, the DON stated she had spoken to LPN5, who was responsible to administer R22's medications. LPN5 was adamant that he had administered the medications, and just had not documented them as given. During an interview on 12/06/24 at 12:20 PM with the Corporate Registered Nurse (CRN)1, DON, and Administrator, they reviewed the October 2024 MAR and stated the resident's medications for 10/20/23 were not documented as being administered. The DON stated she expected the residents' medications to be administered and if not, it should be documented in the record. Review of the undated facility's policy titled, Accuracy of Medical Records indicated Each resident's medical record shall contain an accurate representation of the actual experience of the actual experiences of the resident and include enough information to provide picture of the resident's progress through complete, accurate, and timely documentation. The policy's Compliance Guidelines included: 1. Licensed staff and interdisciplinary team members shall document . services provided in the resident's medical record 2. Documentation should be completed at the time of service, but no later than the shift in which .care service occurred. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Documentation shall be accurate, relevant, and complete, containing sufficient details about resident's care and/or responses to care. NJAC 8:39-35.2(d)(9)