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

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| Complete Care at Harborage LLC | 7600 River Rd<br>North Bergen, NJ 07047 |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure licensed staff credentials were verified upon hire; a.) by not completing a prior to hiring employees for 37 of 112 employees, b.) not documenting verification of the licenses of 5 of 52 nurses hired since 12/6/24, and c.) not documenting verification of the certification of 3 of 45 Certified Nursing Assistants (CNAs), in accordance with facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy.The deficient practice was evidenced by the following:<br><br>On 4/28/26, 4/29/26, and 4/30/26, Surveyor #1 reviewed the Human Resource Records (HRR) including the Criminal Background Investigations (CBI) for 87 employees hired since last recertification survey, 12/6/24. The following concerns were revealed:<br><br>Employee #4 (E #74), a Registered Nurse (RN) began employment on 7/1/25, The CBI was reported 7/2/25.<br><br>E #10, a Licensed practical Nurse (LPN), began employment on 9/5/25. The CBI was reported on 9/12/25.<br><br>E #11, an RN, began employment on 3/12/25. The CBI was reported on 3/13/25.<br><br>E # 13, an RN, began employment on 12/17/24. The CBI was reported on 12/18/24.<br><br>E # 18, an RN, began employment on 12/23/24. The CBI was reported on 12/31/24.<br><br>E # 21, an LPN, began employment on 9/9/25. The CBI was reported on 9/12/25.<br><br>E # 24, a CNA, began employment on 3/25/25. The CBI was reported on 3/26/25.<br><br>E #27, a CNA, began employment on 9/16/25. The CBI was reported on 9/18/25.<br><br>E # 28, a CNA, began employment on 7/1/25. The CBI was reported on 7/2/25.<br><br>E # 32, an RN, began employment on 5/28/25. The CBI was reported on 5/30/25.<br><br>E #33, an LPN, began employment on 2/4/25. The CBI was reported on 2/6/25.<br><br>E #35, a CNA, began employment on 9/9/25. The CBI was reported on 9/12/25.<br><br>E #41, a CNA, began employment on 5/28/25. The CBI was reported on 6/4/25.<br>(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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | E #43, an RN, began employment on 8/19/25. The CBI was reported on 8/20/25.<br><br>E #47, a Housekeeper, began employment on 7/24/25. The CBI was reported on 7/26/25.<br><br>E #52, an LPN, began employment on 7/1/25. The CBI was reported on 7/2/25.<br><br>E #53, an RN, began employment on 8/5/25. The CBI was reported on 6/11/25.<br><br>E #56, an RN, began employment on 5/8/25. The CBI was reported on .<br><br>E #58, an LPN, began employment on 6/10/25. The CBI was reported on 6/19/25.<br><br>E #59, a CNA, began employment on 9/16/25. The CBI was reported on 9/18/25.<br><br>E #61, a CNA, began employment on 4/30/25. The CBI was reported on 5/5/25.<br><br>E #63, an RN, began employment on 3/12/25. The CBI was reported on 3/14/25.<br><br>E #66, a CNA, began employment on 5/28/25. The CBI was reported on 5/30/25.<br><br>E #70, an RN, began employment on 5/14/25. The CBI was reported on 5/16/25.<br><br>E #107, an RN, began employment on 7/22/25. The CBI was reported on 7/24/25.<br><br>E #108, a Housekeeper (HK), began employment on 7/24/25. The CBI was reported on 7/28/25.<br><br>E #110, a CNA, began employment on 10/7/25. The CBI was reported on 10/8/25.<br><br>On 4/28/26, 4/29/26, and 4/30/26, S #1 reviewed the HRR for 52 nurses hired since the previous Department of Health Recertification Inspection on 12/6/24. The following concerns were revealed:<br><br>E #3, an LPN, began employment on 8/19/25. No documentation for nursing license verification was present in the employee's file.<br><br>E 11, an RN, began employment on 3/12/25. No documentation for nursing license verification was present in the employee's file.<br><br>E #18, an RN, began employment on 12/23/24. No documentation for nursing license verification was present in the employee's file.<br><br>E #70, an RN, began employment on 5/14/25. No documentation for nursing license verification was present in the employee's file.<br><br>E #103, an LPN, began employment on 11/25/25. No documentation for nursing license verification was present in the employee's file.<br><br>On 4/28/26, 4/29/26, and 4/30/26, S #1 reviewed the HRR for 45 CNAs hired since the previous Department of Health Recertification Inspection on 12/6/24. The following concerns were revealed:<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | E #35, a CNA, began employment on 9/9/25. No documentation of Nursing assistant certification verification was present in the employee's file.<br><br>E #68, a CNA, began employment on 3/2/25. No documentation for Nursing Assistant Certification verification was present in the employee's file.<br><br>E #110, a CNA, began employment on 10/7/25. No documentation of Nursing assistant certification verification was present in the employee's file.<br><br>On 4/30/26 at 11:15 AM, S #1 met with the Licensed Nursing Home Administrator (LNHA) and the Director of Human Resources (DHR), who both acknowledged that a number of background checks in the employee files were reported and documented after the employee's date of hire. They both acknowledged they had presented all documentation for the 112 employee files under review.<br><br>On 4/30/26 at 12:38 PM, the survey team met with the LNHA and Director of Nursing (DON), and S #1 presented the above concerns with 70 employee files concerning missing and late CBI and missing licenses and certification concerns.<br><br>On 5/1/26 at 11:01 AM, the survey team met with the LNHA, Administrator in Training (AIT), and the DON regarding concerns with employee files. No further information provided by the LNHA.<br><br>2. On 4/30/26 and 5/1/26, Surveyor #2 (S #2) reviewed the HRR including CBI for 25 employees who were hired since the previous Department of Health Recertification Inspection. The following concerns were revealed.<br><br>E #74, a CNA, began employment on 5/28/25. The CBI was ordered on 5/30/25.<br><br>E #76, a CNA, began employment on 11/4/25. The CBI was ordered on 11/4/25.<br><br>E #80, a nurse, began employment on 4/2/25. The CBI was ordered on 4/4/25.<br><br>E #82, a nurse, began employment on 9/30/25. The CBI was ordered on 10/1/25.6<br><br>E #86, a nurse, began employment on 2/25/26. The CBI was ordered on 2/26/25.<br><br>E #89, a CNA, began employment on 6/11/24. The CBI was ordered on 6/19/24.<br><br>E #91, a CNA, began employment on 7/22/25. The CBI was ordered on 7/23/25.<br><br>E #92, a nurse, began employment on 1/23/25. The CBI was ordered on 1/31/25.<br><br>E #95, a CNA, began employment on 9/9/25. The CBI was ordered on 9/11/25.<br><br>E #96, a CNA, began employment on 9/16/25. The CBI was ordered on 9/17/25.<br><br>A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy, updated 1/2023, indicated in Step #4 that the facility should conduct employee background checks and not knowingly employ an individual found guilty in a court of law or entered into the State Nurse Aide Registry for abuse, neglect, exploitation, misappropriation of property, or mistreatment.<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | NJAC 8:39-4.1(a)5; 43.15 |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on interviews of facility staff and a review of facility provided documentation, it was determined that the facility failed to ensure the nursing staff possessed and maintained the appropriate competencies and skills to provide nursing care to the facilities residents for 5 of 5 nursing employees reviewed. The deficient practice was evidenced by the following: On 4/29/26 at 12:30 PM, the surveyor requested documentation of nursing competencies and annual performance evaluations for five nurses selected from the facility provided active employee roster. On 5/1/26 at 9:45 AM, the Assistant Director of Nursing (ADON) provided 94 Inservice sign in sheets conducted since 1/1/25. The in-service sheets reflected a topic, 0 of 94 sheets reflected nursing competencies performed, a syllabus of information or skills presented, skill assessments or minutes from the in-service. 0 of 94 in-service sheets included a time of the in-service or hours credited to the attendees of the in-service. On 5/1/26 at 10:45AM, the Director of Nursing (DON) in the presence of the ADON acknowledged no other in-servicing or competencies were available for the five selected nurses and no annual performance evaluations were available for the five nurses. The DON acknowledged 0 of 94 Inservice attendance sheets reflected nursing competencies performed, a syllabus of information or skills presented, skill assessments or minutes from the in-service. The DON acknowledged the facility policy to evaluate nursing employees and that nurses should have an evaluation performed at least annually and competencies for job skills as needed. The DON and ADON confirmed the following: Employee #1 (E#1), a Registered Nurse (RN), hired on 1/30/24 had no competencies or evaluations on file.E #2, a Licensed Practical Nurse (LPN), hired on 11/29/21 had no competencies or evaluations on file.E #3, an LPN, hired on 8/10/20 had no competencies or evaluations on file.E #4, an LPN, hired on 6/15/92, had no competencies or evaluations on file.E #5, an RN, hired on 5/30/23, had no competencies or evaluations on file. On 5/1/26 at 11:15 AM, the survey team met with Licensed Nursing Home Administrator (LNHA), Administrator in Training, and the DON to discuss the concerns with nursing competencies. The LNHA did not provide additional information. A review of the facility's Evaluation Process Policy, dated 9/1/25, reflected, it is the policy of the facility to review the work performance of employees with a formal written evaluation . NJAC 8:39-25.1; 25.2(a), (b); 26.1 |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>Based on interviews of facility staff and a review of facility provided documentation, it was determined that the facility failed to ensure the Certified Nursing Assistants employed by the facility received an annual evaluation of their work performance facilities residents for 4 of 5 employees reviewed. The deficient practice was evidenced by the following: On 4/29/26 at 12:30 PM, the surveyor requested from the Director of Nursing (DON) the annual performance evaluations for five Certified Nursing Assistants (CNA) selected from a roster of active employees provided by facility. On 5/1/26 at 10:45AM, the DON confirmed the performance evaluations for 4 of the 5 selected employees did not have written annual evaluations: Employee #1 (E1), CNA hired on 2/24/14. No performance evaluation on file.E #2, CNA hired on 1/11/23. No performance evaluation on file.E #3, CNA hired on 12/17/24. No performance evaluation on file.E #4, CNA hired 6/19/24. No performance evaluation on file. A review of the facility's Evaluation Process Policy, dated 9/1/25, reflected, it is the policy of the facility to review the work performance of employees with a formal written evaluation . On 5/1/26 at 12:05 PM, the surveyor met with Licensed Nursing Home Administrator and the DON to discuss concerns with performance evaluations for CNAs. The DON confirmed 4 of the 5 CNAs employee files requested did not have documentation of evaluations and were required to have an annual evaluation on file every year. NJAC 8:39 13.4; 25.4(b); 43.17 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**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:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | recorded.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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):<br><br>-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].<br><br>-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].<br><br>The LPN did not sign the DIL when they removed the meds from the bingo cards.<br><br>On [DATE] at 10:13 AM, S #2 observed the LPN administer the meds to Resident #116. The LPN still<br>(continued on next page) |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | had not signed the DIL after administering the meds.<br><br>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.<br><br>On [DATE] at 10:28 AM, S #2 interviewed the LPN who stated they should have signed the DIL right away.<br><br>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.<br><br>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.<br><br>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.<br><br>5. On [DATE] at 10:22 AM, S #2 observed the LPN prepare meds for Resident #208.<br><br>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:<br><br>-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].<br><br>-Lantus Subcutaneous Solution 100 Unit/mL Inject 18 unit subcutaneously one time a day for DM. The PO started on [DATE].<br><br>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.<br><br>A review of the Medication Administration Audit Report of [DATE] for Resident #208 revealed the following:<br><br>-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.<br><br>-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.<br><br>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.<br>(continued on next page) |

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| Complete Care at Harborage LLC | 7600 River Rd<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's Medication Administration Policy, revised [DATE], revealed the following:<br><br>-Sign MAR after administered.<br><br>-Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.<br><br>NJAC 8:39-11.2(b); 27.1(a); 29.2(d); 29.4(a), (b)2 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>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:<br><br>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):<br><br>- 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.<br><br>- 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.<br><br>- 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.<br><br>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.<br><br>On 4/29/26 at 8:17 AM, RN #1 informed S #1 and S #2 that she was ready to administer the meds.<br><br>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.<br><br>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).<br><br>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).<br><br>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<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | MVI inro the drug disposal solution.<br><br>Refer to F755.<br><br>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.<br><br>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:<br><br>- 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.<br><br>-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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>No further information was provided.<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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:<br><br>-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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>A review of the facility's Medication Administration Policy, revised 10/20/25, revealed, the following<br><br>-Ensure that the six rights of med administration are followed: Right resident, Right drug, Right dosage, Right route, Right time, Right documentation.<br><br>-Administer meds as ordered in accordance with manufacturer specifications. Provide appropriate amount of food and fluid.<br><br>NJAC 8:39-11.2(b), 29.2(d) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to; a.) properly label an opened blood glucose test strips, b) identify and dispose of expired biological supply, and c) properly store insulin pens, in accordance with currently accepted professional principles and facility's policy. This deficient practice was identified for 4 of 8 medication carts and 1 of 2 medication rooms inspected 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.<br><br>1. On 4/30/26 at 10:19 AM, Surveyor #1 (S #1) inspected the south/center cart on the fifth (5th) floor, in the presence of Registered Nurse #1 (RN#1) and Surveyor #2 (S #2). During the inspection, S #2 observed loose disinfecting caps for needless connectors (used to decrease the central venous catheter (hollow tube inserted into the vein) associated blood stream infection on intravenous needleless connectors). Three of the disinfecting caps had an expiration date of 4/25/26, and the original container was not found on the cart. At that time, S #1 discussed the concern with the expired disinfecting caps with RN#1.<br><br>At 10:37 AM, S #1 observed an opened bottle of blood glucose (bg) test strips that did not have a written opened date. During an interview with the surveyors, RN #1 stated she was not sure when the bg test strips were opened. RN #1 also stated that it was important to know the opened date, since that was used as the reference for the expiration date.<br><br>At that time, RN#1 stated she would dispose of both the disinfecting caps and the bg test strips, confirmed that the expired items should have been removed and would inform the Unit Manager (UM).<br><br>A review of the manufacturer's specifications for the [brand redacted] bg test strips, under storage and handling reflected: Use within six months of first opening or the expiration date on the label, whichever comes first.<br><br>2. On 4/30/26 at 10:29 AM, S #1 inspected the medication (med) room on the 5th floor, in the presence of RN #1 and S #2. During the inspection, S #1 found an opened, half full box of the disinfecting caps with an expiration date of 4/25/26. RN #1 stated she would inform the UM of the concern and acknowledged and confirmed expired supplies should have been removed from active inventory.<br><br>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 #1 discussed the above concerns.<br><br>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 a facility wide audit for undated glucose test strips, expired medications (meds) and supply was conducted, to ensure all meds and supplies provided to the<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | residents were in date.<br><br>The LNHA did not provided further information.<br><br>A review of the facility's Medication Storage Policy, dated/revised 4/2/26, reflected that all meds housed in the facility would be stored in the pharmacy and/or med rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.<br><br>3. On 4/30/26 at 10:51 AM, S #2 inspected the cart on the 5th floor ventilation unit in the presence of the Respiratory Therapist (RT). Upon opening a drawer of the cart, S #2 observed an opened foil package containing three vials of Ipratropium Bromide 0.5 mg (milligram) and Albuterol Sulfate 3 mg Inhalation Solution. It was written on the front of the package that there were originally five vials. The opened foil package had no date of opening written on it. Upon opening another drawer of the cart, S #2 observed that the nonconductive connecting tubing had expired on 10/1/25.<br><br>On 4/30/26 at 11:05 AM, S #2 interviewed the RT who stated the expectation was that the date should have been written on the opened foil package containing the three vials of Ipratropium Bromide 0.5 mg and Albuterol Sulfate 3 mg Inhalation Solution when it was opened. The RT acknowledged it did not have a date of opening written on it. Moreover, the RT observed and acknowledged that the nonconductive connecting tubing was expired.<br><br>4. On 4/30/26 at 12:44 PM, S #2 inspected the north cart on the third floor in the presence of RN #2. Upon opening a drawer of the cart, S #2 observed an opened box containing more than 100 disinfecting caps for needleless connectors. All the disinfecting caps had an expiration date of 2/6/25.<br><br>5. On 4/30/26 at 1:18 PM, S #2 inspected the south cart on the second floor in the presence of RN #3 and S #1. During the inspection, S #2 observed that Resident #76's Insulin Lispro Injection Solution 100 Unit/milliliter (mL) pen and Resident #5's Lantus Solostar Injection Solution 100 Unit/mL pen were in the same bag labeled with Resident #5's name and med label. There was no bag labeled with Resident #76's name and med label.<br><br>On 4/30/26 at 1:20 PM, S #2 interviewed RN #3 in the presence of S #1. RN #3 stated they did not know where the Resident #76's bag with the resident's name and med label was located. RN #3 stated they thought Resident #76 was discharged . RN #3 acknowledged that the insulin pens belonging to two different residents should not be kept together in one resident's bag.<br><br>On 4/27/26 at 1:30 PM, S #2 reviewed the electronic medical record of Resident #76, which revealed the resident was still in the facility.<br><br>A review of the April 2026 electronic Medication Administration Record (eMAR) for Resident #76 revealed the following:<br><br>-On 4/30/26 at 7:30 AM, Insulin Lispro Injection Solution 100 Unit/mL Inject as per sliding scale subcutaneously (subq) before meals for type 2 diabetes, had a check mark with the nurse's initials and 2 units documented.<br><br>-On 4/30/26 at 12:30 PM, Insulin Lispro Injection Solution 100 Unit/mL Inject as per sliding scale<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | subq before meals for type 2 diabetes, had a check mark with the nurse's initials and 8 units documented.<br><br>A review of the April 2026 eMAR for Resident #5 revealed the following:<br><br>-Insulin Glargine subq Solution 100 Unit/mL Inject 20 unit subcutaneously at bedtime for diabetes mellitus had a check mark with the nurses' initials at 9:00 PM on 4/27/26, 4/28/26, 4/29/26, and 4/30/26.<br><br>On 4/30/26 at 1:56 PM, in the presence of the survey team, S #2 discussed the concern with the LNHA, DON, VPoCS, and AIT.<br><br>A review of the facility's Medication Administration Policy, revised 10/20/25, revealed, Identify expiration date. If expired, notify nurse manager.<br><br>NJAC 8:39-29.4 (g) (h) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>Based on interviews of facility staff and review of facility provided documentation, it was determined the facility failed to ensure and document that all Certified Nursing Assistants (CNAs) completed 12 hours of in-service training including the topics of preventing resident abuse, dementia management, and areas of weakness identified in the individual CNA's annual review for 4 of 5 CNA employees reviewed. The deficient practice was evidenced by the following: The surveyor reviewed the training records provided by the facility for five selected CNAs and revealed: -A review of the facility provided 94 attendance sheets for in-services provided to all staff members since 1/1/25, 0 of 94 attendance sheets provided included a number of credited hours or minutes assigned to the given topic. -Zero of 94 attendance sheets included a syllabus for information included or minutes from the in-service. -Zero of 94 attendance sheets indicated the in-service was for training in dementia management. On 5/1/26 at 10:55AM, the surveyor with Director of Nursing (DON) and Assistant Director of Nursing (ADON), and the ADON acknowledged that the facility did not have a register or tracking record of which CNAs completed trainings, which topics each CNA received training in and the facility had not tracked individual CNA training hours. The ADON further stated that she was aware every CNA was required to complete of 12 hours of in-service training annually, and that the subjects of dementia management and abuse prevention were to be included in that training. On that same date and time, the DON acknowledged the facility did not have written annual evaluations for 4 of the 5 CNAs to identify potential areas of weakness to include in the CNA's annual in-servicing. The DON and the ADON acknowledged that the attendance sheets for in-servicing had not included credited time for the in-service, minutes of each in-service or a syllabus of covered information and no dementia training in-services were included in the 94 attendance sheets provided to the surveyor. A review of the facility's Continuing Education Policy, dated 9/1/25, reflected, all levels of employees are expected to complete required trainings within designated time frames. It is the responsibility of each employee, volunteer, or contract staff to complete required training . On 5/1/26 at 11:15 AM the survey team met with the Licensed Nursing Home Administrator, Assistant Administrator in Training, and the DON to discuss the above concerns with documentation of CNA annual training. No new information provided by the LNHA. NJAC 8:39-43.17 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, interview, and record review, it was determined that the facility failed to ensure the urinary catheter bag was covered. This deficient practice was identified for 1 of 3 residents who had urinary catheters (Resident #122), and was evidenced by the following:On 4/27/26 at 8:42 AM, the surveyor observed that Resident #122 had a urinary catheter bag that was uncovered. On 4/27/26 at 9:30 AM, the surveyor reviewed the electronic medical record of Resident #122. The admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included, but were not limited to, other neuromuscular dysfunction of the bladder (dysfunction of the urinary bladder caused by damage to the nerves that control bladder function). A review of the Order Summary Report revealed an order dated 2/25/26, Patient has indwelling Suprapubic catheter. Size: 20 Fr (french (or French Gauge/Scale), which represents the outer diameter of a catheter or medical tube) balloon size: 10 cc (cubic centimeter) every shift for diagnosis of neurogenic bladder. Check for placement and patency every shift. On 4/28/26 at 12:55 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that a privacy bag for the urinary catheter bag was always required. They also noticed on 4/27/26 that there was no privacy bag. The LPN acknowledged that the urinary catheter bag had been left uncovered. On 4/30/26 at 1:48 PM, the surveyor discussed the above concern with the Licensed Nursing Home Administrator (LNHA), Director of Nursing, and [NAME] President of Clinical Services. The LNHA did not provide a verbal response at that time. A review of the facility's Appropriate Use of Indwelling Catheters Policy, revised 1/15/26, did not address the covering of urinary catheter bags. NJAC 8:39-4.1(a)12 |

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| | 315307 | A. Building<br>B. Wing | 05/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Complete Care at Harborage LLC | 7600 River Rd<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 2 of 32 residents (Resident #122 and Resident #221) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: 1. On 4/27/26 at 8:42 AM, the surveyor observed Resident #122 lying in bed, the resident's call device was wrapped around itself and dangled over the outlet on the wall, and out of reach of the resident. On 4/28/26 at 11:27 AM, the surveyor made a second observation of Resident #122 lying in bed. The call device was in the same position as the previous observation, out of reach of the resident. On 4/28/26 at 12:35 PM, the surveyor interviewed Certified Nursing Assistant #1 (CNA #1) and Certified Nursing Assistant #2 (CNA #2) who both observed and acknowledged the call device was out of reach of the resident. 2. On 4/27/26 at 8:34 AM, the surveyor observed Resident #221 lying in bed, the resident's call device extended across the top of the heating and air conditioning unit that was against the window wall. The call device dangled over the side of the unit, out of reach of the resident. On 4/28/26 at 12:45 PM, the surveyor interviewed CNA #1 who acknowledged the call bell was out of reach of the resident on 4/27/26. A review of the care plan report initiated on 1/28/24, revealed that Resident #221 was high risk for falls. Interventions included, but were not limited to, Be sure Resident #221's call light is within reach and encourage Resident #221 to use it for assistance as needed. Resident #221 needs prompt response to all requests for assistance. On 4/30/26 at 1:48 PM, the surveyor discussed the above concern with the Licensed Nursing Home Administrator (LNHA), Director of Nursing, and [NAME] President of Clinical Services. The LNHA did not provide a verbal response at that time. A review of the facility's Call Lights: Accessibility and Timely Response Policy, revised 1/15/26, revealed the following:-Staff will ensure the call light is within reach of the resident and secured, as needed.-The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. NJAC 8:39-31.8(c)9 |

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| 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>**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:<br><br>1.On [DATE] at 11:53 AM, Surveyor #1 (S #1) reviewed the closed records of Resident #250.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>A review of the facility's Notification of Changes Policy, dated [DATE], included, the facility must 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.<br><br>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.<br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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.<br><br>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].<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>On [DATE] at 12:01 PM, S #2 interviewed the LPN regarding the fall investigation, and the LPN 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.<br><br>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<br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 .<br><br>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 .<br><br>NJAC 8:39-13.1(c),13.2(a) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>The LNHA did not provide any additional information.<br><br>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.<br><br>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).<br><br>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.<br><br>Bath towels-Par Level 3.0-Calculation (Per Bed) 3 per resident.<br>(continued on next page) |

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

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure grievances were documented on the facility grievance form and responses were documented according to facility policy. This deficient practice was identified for 1 of 38 residents (Resident #9) reviewed. This deficient practice was evidenced by the following: On 4/27/26 at 9:16 AM, the surveyor observed Resident #9 who was seated up in bed and stated that they had been in the facility for two years. A review of Resident #9's admission Record (AR) or face sheet (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to heart failure (chronic, progressive condition where the heart muscle cannot pump blood efficiently, often caused by coronary artery disease, high blood pressure, or heart attacks) and hypertension (high blood pressure). A review of Resident #9's most recent comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 3/3/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated that the resident's cognitive status was intact. A review of Resident #9's Progress Notes (PN) included the following note dated 2/19/26: observed in bedroom yelling and expressing dissatisfaction with the facility and staff assignments. I am going to continue to call the state. Resident was asked to clarify specific care issues and did not identify unmet clinical care needs but reiterated demand to have the same CNA (certified nursing assistant) assigned daily. The resident was informed that all CNAs were trained and competent to meet their needs and that while consistent assignment will be accommodated when feasible, it cannot be guaranteed due to staffing requirements. Resident was educated on their right to voice grievances and contact outside agencies. On 4/29/26 at 9:45 AM, the surveyor reviewed the facility provided grievance binder for 2025 and 2026. There was no grievance listed for Resident #9. On 4/29/26 at 11:02 AM, the surveyor interviewed the CNA about complaints. The CNA stated that most residents do not complain but that Resident #9 did complain and that she reported it to the nurse. On 4/29/26 at 11:08 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding complaints. The ADON stated that they had a customer relation staff that went to the residents and they gave their complaints to her and she would write them and give to the department. The ADON added that they had to put what they did to resolve issue, makes rounds. The ADON stated that if someone complained to a CNA that they would tell her, the unit manager or Director of Nursing (DON) and would write a grievance. On 4/29/26 at 11:52 AM, the surveyor asked the ADON if they kept a log of grievances. The ADON stated the Licensed Nursing Home Administrator (LNHA) kept it. On 4/29/26 at 12:13 PM, the surveyor interviewed the patient relations who stated that she went around daily and ask residents if they had any concerns. She stated that she brought the grievance to the Social Worker (SW) and the SW followed up. She added that the Social Services Director (SSD) filled out the grievance form. On 4/29/26 at 12:17 PM, the surveyor interviewed the SSD who stated that when there was a concern or grievance that they would interview the resident and if a grievance or concern, then they would write it up and forward to appropriate department. The SSD stated that nursing may document the issue in the PN but that she did not and that there was a log kept. She added that the LNHA signed off on all grievances. On 4/30/26 at 10:47 AM, the surveyor showed the SSD Resident #9's PN dated 2/19/26. The SSD stated that she was not aware of that situation or directly involved. The surveyor asked the SSD if a grievance should have been filled out. The SSD stated that usually if something goes above in house, that they did not usually do a separate grievance. On 4/30/26 at 11:01 AM, the surveyor interviewed the ADON regarding Resident #9's PN dated 2/19/26. The ADON stated that the DON and herself went in the room and addressed the concern and that she thought the DON notified the Ombudsman. The surveyor asked if the expectation was for the resident's concern to be written as a grievance. The SSD stated that she did not write a<br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | grievance but that she notified the DON and that she was not sure if it was written and put in the book. The ADON stated that Resident #9 often complained about the CNA and the facility. The ADON stated that they try to give the resident a consistent CNA if they could. The surveyor asked the ADON if Resident #9's complaints would be considered grievances. The ADON stated that the problem was that it was almost every day. On 4/30/26 at 11:13 AM, the surveyor interviewed the DON regarding the grievance process. The DON stated that if a resident had a concern/grievance voiced then someone would write up a grievance form. He added that anyone could write it. The DON stated that generally it was given to Social Services (SS) and they brought it to the team. When it was resolved it went back to SS and the resident or resident representative (RR) notified and placed in the grievance binder. The surveyor asked if all complaints were put in the grievance binder. The SSD stated that it depended and that if it was a concern or if it was a want was possible it was a grievance. The surveyor asked the DON about Resident #9, and that there were no grievances in the log for Resident #9. The DON stated that they had called the Ombudsman and that they had made a folder for him to review. On 4/30/26 at 11:23 AM, in the presence of the DON, the SSD stated that Resident #9 did not contact her and that the resident went higher and notified the ombudsman. The SSD stated that she never wrote a grievance. On 4/30/26 at 12:44 PM the surveyor notified the LNHA, DON, Administrator in Training (AIT) and [NAME] President of Clinical Services (VPoCS) the concern that Resident #9's grievance documented in the PN was not documented as a grievance in the facility binder and that there were no documented grievances for Resident #9 in the 2025 and 2026 binders. On 5/1/26 at 11:26 AM, in the presence of the LNHA and AIT, the DON stated that Resident #9 bypassed facility staff for a lot of things and called the ombudsman. The surveyor asked if the resident had concerns were they not to be documented as a grievance. The DON stated that it was different with Resident #9. The surveyor asked how the facility determined what a grievance was. The LNHA stated that a complaint was generally given to the SW and written as a grievance. The DON stated that they had an ambassador that made rounds daily and tried to resolve any issues immediately. The LNHA did not provide any additional information. A review of the facility's Resident and Family Grievances Policy with a reviewed/revised date of 2/10/26, included the following:Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal.Policy Explanation and Compliance Guidelines:2. The Grievance Official is responsible for overseeing the grievance process' receiving and tracking grievances through to their conclusion; leading any necessary investigation by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations.10. Procedure:b. The staff member receiving the grievance will record the nature and specifics.on the designated grievance form, or assist.to complete the form.c. Forward the grievance form to the Grievance Official as soon as practicable.d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form.e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances.g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation.11. Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision. N.J.A.C. 8:39-4.1(a)(35);13.2(c) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on interviews and record review, it was determined that the facility failed to complete and transmit the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within 14 days as required, for 2 of 38 residents, (Resident #14 and Resident #229), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following:According to the Resident Assessment (RAI) Manual, dated October 2025, RAI-required Assessment Summary:-The admission (Comprehensive) assessment, the MDS completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The CAA(s) (Care Area Assessment) Completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The Care Plan Completion date is no later than CAA(s) Completion date + 7 calendar days. The Transmission date is no later than Care Plan Completion date + 14 calendar days.-The Quarterly (non-comprehensive) assessment, the MDS completion date ARD (assessment reference date) + 14 calendar days. The transmission date MDS Completion Date + 14 calendar days.-The Discharge MDS assessment return not anticipated, the MDS completion date is the discharge date + 14 calendar Days. The Transmission date is MDS Completion date + 14calendar days. 1.On 4/27/26 at 6:58 AM, the surveyor observed the Certified Nursing Aide (CNA) inside Resident #14's room to respond to the call bell, the resident was observed in a low bed, and no adaptive device noted to the extremities. The surveyor reviewed the medical record of Resident #14, and revealed:A review of Resident #14's admission Record (AR) or face sheet (the admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction (a type of ischemic stroke caused by a blockage in blood vessels supplying the brain, resulting in tissue death (necrosis) due to lack of oxygen) unspecified, cognitive communication deficit, hemiplegia and hemiparesis (hemiparesis is partial weakness, allowing some movement, while hemiplegia is severe or complete paralysis on one side) following cerebral infarction affecting left non-dominant side, wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing, and unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing. Resident #14's comprehensive MDS assessment with an ARD of 1/2/26, admission date of 12/26/25, Care Areas Completion date was 1/9/26 (was in red), completion date was on 1/9/26 (was in red) and was accepted (or transmitted) on 4/22/26. The comprehensive MDS was completed late, after 14 days, which should have been completed no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The CAA(s) Completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). Resident #14's quarterly MDS assessment with an ARD of 4/2/26, was completed on 4/17/26 (in red) and accepted on 4/22/26. The quarterly MDS was completed a day late, after 14 days, which should have been completed within ARD + 14 calendar days. 2.The surveyor reviewed the medical record of Resident #229, and revealed: A review of Resident #229's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; Parkinson's disease without dyskinesia, without mention of fluctuations, unilateral primary osteoarthritis (the most common chronic joint disease, characterized by the breakdown of cartilage-the protective tissue cushioning the ends of bones) right knee, and chronic pulmonary disease (COPD, a progressive, long-term lung disease that causes obstructed airflow, making it difficult to breathe). Resident #229's comprehensive MDS assessment with an ARD of 1/9/26, admission date of 12/24/25, Care Areas Completion date was 1/9/26 (was in red), completion date was on 1/9/26 (was in red) and was transmitted on 1/12/26. The comprehensive MDS was completed late, after 16 days, which should have been completed no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The CAA(s) Completion date no later than 14th calendar day of the resident's<br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | admission (admission date + 13 calendar days). Resident #229's Discharge MDS assessment return not anticipated (DRNA) with an ARD of 2/5/26, was completed on 3/6/26 (in red) and was not transmitted. The discharge (d/c) MDS was completed late, after 14 days. The d/c MDS was not transmitted, which should have been transmitted MDS Completion date + 14 calendar days. On 4/29/26 at 8:18 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC) who informed the surveyor in the presence of the Licensed Practical Nurse/MDS Staff (LPN/MDSS) that she was new to her RN/MDSC position. The RN/MDSC further stated that she was still learning the MDS. The LPN/MDSS informed the surveyor that he was in the MDS position full time for eight years, the facility followed the RAI manual when doing MDS that included accuracy, completion, and submitting or transmitting MDS. On that same date and time, the LPN/MDSS stated that he was aware that there were MDSs that were late and the reason for late MDSs was because some department were not able to complete their sections timely and also due to high volume of discharges at the facility. He further stated that the sections D and Q in the MDS were the responsibility of the Social Worker, Section K was for the Dietician, and the rest of the sections in MDS were the responsibility of nursing, except for Section GG which was the collaboration between nursing and rehab department. He also added that for admission MDS, you have up to 14 days to complete the MDS and another 14 days to submit, and I think it was the same way with d/c MDS. The surveyor then notified both the RN/MDSC and the LPN/MDSS about the above findings and concerns with regards to late completion and not able to transmit due MDSs. The LPN/MDSS confirmed that if the dates were in red, it meant it was late. On 4/30/26 at 12:38 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Administrator in Training (AIT), and [NAME] President of Clinical Services (VPoCS), and the surveyor notified them of the above findings and concerns with late MDSs. On 5/1/26 at 10:59 AM, the survey team met with the LNHA, DON, AIT, and LPN/MDSS stated that all department heads were educated about late MDSs. A review of the facility's MDS 3.0 Completion Policy that was provided by the LNHA, with date implemented 9/1/25, revealed, residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.Policy Explanation and Compliance Guidelines .1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. 2. Types of OBRA (Omnibus Budget Reconciliation Act of 1987, in MDS refers to federal nursing home regulations establishing mandatory, standardized assessment schedules for all residents in certified facilities, regardless of payer type) Assessments.b. admission Assessment-completed within 14 days of admission counting the day of admission as day #1 .f. D/c Assessment-completed using the d/c date as the ARD, must be completed within 14 days of the d/c date/ARD On 5/1/26 at 12:29 PM, the survey team met with the LNHA, DON, AIT, and VPoCS for an exit conference, and the LNHA did not provide additional information. NJAC 8:39 - 11.1 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on interviews and record review, it was determined that the facility failed to accurately reflect the resident status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care in accordance with the federal guidelines for 3 of 38 residents (Residents #10, #14, and #85) reviewed for the accuracy of MDS coding. This deficient practice was evidenced by the following:<br><br>1. On 4/27/26 at 10:00 AM, Surveyor #1 (S #1) observed Resident #10 awake, sitting in the wheelchair (w/c), alert and oriented, able to verbalize needs to staff.<br><br>On 4/28/26 at 10:07 AM, S #1 reviewed the electronic medical record (eMR) of Resident #10, which revealed the following:<br><br>A review of the admission Record (AR) or face sheet (an admission summary) reflected that Resident #10 was admitted with diagnoses that included, but were not limited to, other specified depressive (feeling of sadness) episodes.<br><br>A review of the recent quarterly Minimum Data Set (qMDS), with an assessment reference date (ARD) of 3/17/26, reflected a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the residents had intact cognition. Further review of the qMDS on 9/18/25 and 3/17/26, as reflected in section N – High Risk Drug Classes: Use and Indication, revealed that both qMDS did not code for the use of antidepressant medications (meds).<br><br>A review of the Order Summary Report (OSR) with the start date of 11/15/22, venlafaxine capsule 75 mg (milligram) orally one time a day for depression.<br><br>A review of the care plan (CP) report initiated on 9/19/23, a focused that Resident #10 had an antidepressant medication (med).<br><br>On 4/29/26 at 10:50 AM, S #1 interviewed the Registered Nurse/MDS Coordinator #1 (RN/MDSC #1), who stated that venlafaxine was an antidepressant, and it should be coded as an antidepressant to both qMDS on 3/17/26 and 9/18/25. RN/MDSC#1 acknowledged that she should code the med as an antidepressant.<br><br>2. On 4/27/26 at 9:35 AM, S #1 observed Resident #85 lying in bed awake, able to answer S #1's inquiry.<br><br>On 4/27/26 at 10:34 AM, S #1 reviewed the eMR of Resident #85, which revealed the following:<br><br>A review of the AR reflected that Resident #85 was admitted with diagnoses that included, but were not limited to, obstructive and reflux uropathy (blockage in the urinary tract).<br><br>A review of the recent qMDS with an ARD of 3/19/26, reflected a BIMS score of 3 out of 15, which indicated that the residents had severe cognitive impairment. Further review of the qMDS, as reflected in Section H – Appliances, revealed that Resident #85 has an Ostomy (including urostomy, ileostomy, and colostomy) (an opening in the abdomen that allows stool or urine to exit the body).<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the OSR with the start date of 11/12/25, foley catheter care, and drainage.<br><br>A review of the CP report initiated on 4/27/26, focused on Resident #85, who requires enhanced barrier precautions (EBP) related to an indwelling medical device.<br><br>On 4/29/26 at 10:55 AM, S #1 interviewed RN/MDSC #2, who stated that she miscoded the Resident #85's urostomy in Section H of the qMDS on 3/19/26.<br><br>On 5/1/26 11:35 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Administrator in Training AIT), the Director of Nursing (DON), and the Licensed Practical Nurse/MDS Staff (LPN/MDSS) regarding the above concern, and the LNHA did not provide further information.<br><br>3. On 4/27/26 at 6:58 AM, Surveyor #2 (S #2) observed the Certified Nursing Aide (CNA) inside Resident #14's room responded to the call bell, the resident was in a low bed, and no adaptive device noted to the extremities.<br><br>S #2 reviewed the medical record of Resident #14, and revealed:<br><br>A review of Resident #14's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction unspecified, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing, and unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing.<br><br>A review of the qMDS with an ARD of 4/2/26, revealed in Section C-Cognitive Patterns a BIMS score of 6 out of 15, which reflected that the resident had severely impaired cognition. Section J-Health Conditions, the resident for shortness of breath (SOB) when lying flat was coded yes.<br><br>Further review of the medical records did not reflect that there were documented evidence that the resident had SOB when lying flat to indicate that the resident's coding in Section J was an accurate assessment.<br><br>On 4/29/26 at 8:18 AM, S #2 interviewed RN/MDSC #3, who informed S #2 in the presence of the LPN/MDSS that she was new to her MDSC position. RN/MDSC #3 further stated that she was still learning the MDS. The LPN/MDSS informed S #2 that he was in the MDS position full time for eight years, the facility followed the RAI manual when doing MDS that included accuracy, completion, and submitting or transmitting MDS.<br><br>On that same date and time, S #2 notified RN/MDSC #3 and the LPN/MDSS of the above concern that Resident #14's was coded with SOB when lying flat when there were no documented evidence to show that the resident had SOB when lying flat.<br><br>On 4/30/26 at 12:38 PM, the survey team met with the LNHA, DON, AIT, and [NAME] President of Clinical Services (VPoCS), and S #2 notified them of the above findings and concerns with Resident's 14's inaccurate MDS.<br><br>On 5/1/26 at 10:59 AM, the survey team met with the LNHA, DON, AIT, and LPN/MDSS stated that Resident #14's coding of SOB when lying flat was wrong, the MDS was modified to reflect an<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | accurate MDS, and all department heads were educated about MDS accuracy.<br><br>On 5/1/26 at 12:29 PM, the survey team met with the LNHA, DON, AIT, and VPoCS for an exit conference, and the LNHA did not provide additional information.<br><br>NJAC 8:39-33.2(a,d) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>REPEAT DEFICIENCYBased on observations, interviews, and review of medical records and facility documents, it was determined that the facility failed to develop and implement a comprehensive plan of care to meet residents' goals, medical, and psychosocial needs. This deficient practice was identified for 3 of 38 residents (Residents #5, #14, and #85) reviewed for care plan. This deficient practice was evidenced by the following:<br><br>1. On 4/28/26 at 11:46 AM, Surveyor #1 (S #1) observed Resident #5 lying in bed awake and able to answer S #1's inquiry.<br><br>On 4/28/26 at 1:09 PM, S #1 reviewed the electronic medical record (eMR) of Resident #5, which revealed the following:<br><br>A review of the admission Record (AR) or face sheet (an admission summary) reflected that Resident #5 was admitted with diagnoses that included but were not limited to peripheral vascular disease (PVD, disorder of the circulatory system).<br><br>A review of the most recent quarterly Minimum Data Set (qMDS) (an assessment tool used to facilitate the management of care), with an assessment reference date (ARD) of 3/20/26, reflected a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident had intact cognition. Further review of the qMDS, as reflected in section N – High Risk Drug Classes: Use and Indication, revealed that Resident #5 received an anticoagulant medication (med).<br><br>A review of the Order Summary Report (OSR) revealed an order of apixaban 2.5 mg (milligram) by mouth every 12 hours for DVT (Deep Vein Thrombosis, formation of blood clot) with a start order date of 1/28/26.<br><br>A review of Resident #5's comprehensive Care Plan (CP) report revealed no CP for the use of anticoagulant med.<br><br>On 4/29/26 at 11:28 AM, S #1 interviewed Licensed Practical Nurse #1 (LPN #1), who stated that the anticoagulant should be in the CP to monitor for the effectiveness of the med, the side effects (s/e), such as bleeding.<br><br>On 4/29/26 at 11:35 AM, S #1 interviewed the LPN/Unit Manager (LPN/UM), who stated that the anticoagulant should be in the CP to monitor bleeding and the effectiveness of the med.<br><br>2. On 4/27/26 at 9:35 AM, S #1 observed Resident #85 lying in bed awake, able to answer S #1's inquiry. S #1 observed that there was an indwelling catheter (a flexible tube attached to the bladder through the urethra) hung on the side of the bed inside the privacy bag.<br><br>On 4/27/26 at 10:34 AM, S #1 reviewed the eMR of Resident #85, which revealed the following:<br><br>A review of the AR reflected that Resident #85 was admitted with diagnoses that included, but were not limited to, obstructive and reflux uropathy (blockage in the urinary tract).<br><br>A review of the most recent qMDS with an ARD of 3/19/26, reflected a BIMS score of 3 out of 15,<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | which indicated that the residents had severe cognitive impairment. Further review of the qMDS, as reflected in Section H – Appliances, revealed that Resident #85 had an indwelling catheter.<br><br>A review of the OSR with the start date of 11/12/25, foley catheter care, and drainage.<br><br>A review of Resident #5's CP report revealed no CP for the use of an indwelling catheter.<br><br>On 4/29/26 at 11:55 AM, S #1 interviewed LPN #2, who stated that the indwelling catheter should be part of the CP, and it should be added in the CP.<br><br>On 4/29/26 at 12:00 PM, S #1 interviewed the LPN/UM, who stated that if the resident has an indwelling catheter, it should be in the CP.<br><br>On 5/1/26 11:35 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Administrator in Training (AIT), the Director of Nursing (DON), and the Licensed Practical Nurse/MDS Staff (LPN/MDSS) regarding the above concern, the LNHA did not provide further information.<br><br>2. On 4/27/26 at 6:58 AM, Surveyor #2 (S #2) observed the Certified Nursing Aide (CNA) inside Resident #14's room responded to the call bell, the resident was observed in a low bed.<br><br>S #2 reviewed the medical record of Resident #14, and revealed:<br><br>A review of Resident #14's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction unspecified, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing, and unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing.<br><br>A review of the qMDS with an ARD of 4/2/26, revealed in Section C-Cognitive Patterns a BIMS score of 6 out of 15, which reflected that the resident had severely impaired cognition. Section I-Active Diagnosis did not reflect that depression was included as resident's diagnosis. Section N-Medications (meds) revealed that the resident received antidepressant during the seven days lookback period (this period is used for most clinical items, including functional status, behaviors, and treatments).<br><br>Further review of the medical records did not reflect that there were documented evidence that the resident had a CP that focused on antidepressant med or any psychoactive meds.<br><br>A review of the current OSR revealed an order date on 3/11/26, Lexapro oral tablet (tab) 5 mg, give 1 tab by mouth one time a day for depression/anxiety.<br><br>The above order for Lexapro was transcribed to the electronic Medication Administration record in March and April 2026, signed by nurses daily as administered at 9:00 AM.<br><br>On 4/29/26 at 8:18 AM, S #2 interviewed the LPN/MDSS who informed S #2 in the presence of the Registered Nurse/MDS Coordinator (RN/MDSC), the CP initiation with regard to psychoactive meds were responsibility of nursing. S #2 then notified the LPN/MDSS and the RN/MDSC of the above findings and concerns that the resident's CP did not include information about use of antidepressant med Lexapro for the indication of depression/anxiety.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/29/26 at 8:35 AM, S #2 asked the DON who was responsible for initiating CP for psychoactive meds of the resident and if s/e should also be monitored. The DON responded that it was nursing who was responsible for CP and the s/e should be monitored. S #2 then notified the DON of the above concerns with Resident #14, the resident was on Lexapro with no CP and no monitoring of s/e.<br><br>On 4/30/26 at 12:38 PM, the survey team met with the LNHA, DON, AIT, and [NAME] President of Clinical Services (VPoCS), and S #2 notified them of the above findings and concerns with Resident's 14's CP.<br><br>On 5/1/26 at 10:59 AM, the survey team met with the LNHA, AIT, VPoCS, LPN/MDSS, and the DON stated the antidepressant CP was addressed after surveyor's inquiry.<br><br>A review of the facility's Comprehensive Care Plans Policy that was provided by the AIT, with a reviewed/revised date of 3/1/25, reflected, it is the policy of the facility to develop and implement a comprehensive person-centered CP for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Policy Explanation and Compliance Guidelines.5. The comprehensive CP will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6.The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.<br><br>On 5/1/26 at 12:29 PM, the survey team met with the LNHA, DON, AIT, and VPoCS for an exit conference, and the LNHA did not provide additional information.<br><br>NJAC 8:39-11.2 (e) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure services provided met professional standards of practice by failing to follow the physicians orders for 3 of 38 residents (Residents #9, # 35, and #213) reviewed. This deficient practice was evidenced by the following:<br><br>Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or 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.<br><br>Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, 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.<br><br>1. On 4/27/26 at 9:16 AM, Surveyor #1 (S #1) observed Resident #9 seated up in bed and stated that they had been in the facility for two years.<br><br>A review of Resident #9's admission Record (AR) or face sheet (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to heart failure (chronic, progressive condition where the heart muscle cannot pump blood efficiently, often caused by coronary artery disease, high blood pressure, or heart attacks) and hypertension (high blood pressure).<br><br>A review of Resident #9's most recent comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 3/3/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated that the resident's cognitive status was intact.<br><br>A review of Resident #9's April 2026 electronic Medication Administration Record (eMAR) reflected the following physician order (PO):<br><br>-Measure blood pressure (BP) supine (lying horizontally, with the face and torso facing up) and sitting upright every shift with an order date of 4/23/25.<br><br>Further review of the above PO reflected that there were two rows labeled BP for each shift but there was no indication which row was for the supine BP and which row was for the sitting BP. In addition, the top row of BP's for day shift did not have a BP result recorded, there were NA and one number (not a 2 number BP result); for the evening shift there was 1 BP on 4/23/26, and the rest were NA or one number; for the night shift there were no BP results recorded, there were NA or one number. A review of the chart codes did not indicate what NA stood for.<br><br>A review of Resident #9's May 2025 eMAR reflected the same BP order with a discontinued (dc'd)<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | date of 5/23/25. Further review reflected the two rows labeled with BP with no indication which row was for supine and which row for sitting. In addition, the top row of BP's for the day shift included 1 BP result on 5/8/25, and the rest were either NA or one number; for the evening shift there were 2 BP results and the rest were wither NA, one number or letters; for the night shift there were 7 BP results and the rest were either NA, one number or letters. A review of the chart codes did not indicate what NA stood for.<br><br>On 4/30/26 at 11:24 AM, S #1 interviewed the Director of Nursing (DON) regarding the order for BP. S #1 asked if the expectation was to follow the PO. S #1 showed the DON Resident #9's April and May 2025 eMAR. S #1 asked how it was determined which row was for which BP, and the DON stated that the top would be supine and bottom would be sitting. S #1 asked about the documented NA for most of the top row and what the NA meant and if there should have been documentation why there was not a BP result. The DON stated that he would have to ask the nurse and get back to S #1.<br><br>On 4/30/26 at 12:44 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA), DON, Administrator in Training (AIT), and [NAME] President of Clinical Services (VPoCS) the concern that Resident #9's PO for BP measurement while supine and sitting was not followed in April and May 2025.<br><br>On 5/1/26 at 11:29 AM, in the presence of the LNHA and AIT, S #1 asked the DON if there was additional information regarding Resident #9's PO The DON stated that he was going to check on the NA.<br><br>The LNHA and DON did not provide any additional information.<br><br>2. On 4/30/26 at 9:33 AM, Surveyor #2 (S #2) reviewed the electronic medical record (eMR) of Resident #35.<br><br>The AR revealed Resident #35 had diagnoses that included, but were not limited to, end stage renal disease and type 2 diabetes mellitus.<br><br>A review of the quarterly MDS with an ARD of 4/1/26, reflected a BIMS score of 15 out of 15, which indicated the resident was cognitive intact.<br><br>A review of the PO dated 10/25/25, indicated midodrine 5 milligram (mg) tablet (tab), give 1 tab by mouth every 12 hours as needed (PRN) for hypotension (low BP) if SBP (Systolic blood pressure; the top number in a BP reading which measures the maximum pressure in your arteries when the heart beats] was less than 85. The order was dc'd on 4/18/26.<br><br>A PO dated 4/18/26 indicated midodrine 10 mg tab, give 1 tab by mouth every 12 hours PRN for hypotension. The order did not include BP parameters to indicate when the medication (med) should be administered to the resident.<br><br>A review of the April 2026 eMAR revealed the PRN midodrine 10 mg order entry did not include BP parameters.<br><br>A review of the Nurse Practitioner progress note (PN) dated 4/18/26 at 2:55 PM, revealed Resident #31 's midodrine order was increased to 10 mg with parameters to hold midodrine if BP was greater than or equal to 110/60.<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the nurse PN dated 4/18/26 at 3:28 PM, revealed new orders were received and transcribed to discontinue previous order for Midodrine 5 mg and a new order for midodrine 10 mg tab was initiated with parameters holding the med if SBP is less than or equal to 110 and/or [diastolic BP; the bottom number in a BP reading which measures the pressure in your arteries when the heart rests between beats] is less than or equal to 60.<br><br>The midodrine order transcribed did not include any parameters.<br><br>On 4/30/26 at 10:33 AM, S #2 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated midodrine orders should have parameters included for the nurses to know when to give the med. S #2 notified the LPN/UM about the concern for Resident #35's midodrine order having no parameters, and the LPN/UM acknowledged the PRN midodrine order should have parameters and would clarify the order with the physician.<br><br>On 4/30/26 at 12:38 PM, S #2 notified the LNHA, the DON, the VPoCS, and the AIT of the concern for Resident #35's midodrine order having no parameters. There was no verbal response by the facility at this time.<br><br>On 4/30/26 at 12:42 PM, S #2 interviewed the Registered Nurse (RN) who was assigned to care for Resident #35 about midodrine med orders. The RN stated that midodrine orders should have parameters. The RN further explained the PO indicated when a med should be held as per order parameters.<br><br>At that same time, S #2 with the RN reviewed Resident #35's PRN midodrine order. The RN acknowledged the order did not have parameters and could not speak to why there were none included.<br><br>On 5/1/26 at 10:59 AM, the LNHA, the DON, and the AIT, met with the survey team. The DON stated that in-service education and auditing was ongoing regarding midodrine med administration. There was no additional information provided by the LNHA.<br><br>A review of the facility's Med Administration Policy, with a last revised date of 9/1/25, which revealed under policy, medications (meds) are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .<br><br>3. On 4/28/26 at 9:00 AM, Surveyor #3 (S #3) observed Resident #213 was receiving oxygen via nasal cannula through a concentrator.<br><br>S #3 reviewed the medical record for Resident #213.<br><br>A review of the AR revealed the resident had diagnoses which included, but were not limited to; pleural effusion (fluid buildup around the lungs), heart failure, chronic respiratory failure with hypoxia, and end-stage renal disease requiring dialysis.<br><br>A review of the resident's cMDS with an ARD of 4/14/26, reflected a BIMS score of 4 out of 15, which indicated the resident's cognition was severely impaired.<br><br>A review of the resident's individual comprehensive care plan, dated 4/28/26, included a focus area<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | for meal management related to end-stage renal disease, moderate malnutrition, and chewing difficulties. Interventions included nutritional supplements, including Pro-Stat 30 milliliters two times daily, monitoring intake, and one-to-one meal assistance.<br><br>A review of the Order Summary Report (OSR), dated as of 4/28/26, included the PO dated 4/10/26, for Pro-Stat oral liquid (amino acid-protein hydrolysate) 30 milliliters by mouth two times daily for malnutrition.<br><br>A review of the eMAR revealed the Pro-Stat order dated 4/10/26 was not initiated until 4/13/26. The resident did not receive Pro-Stat from 4/10/26 in the morning through 4/13/26 in the morning, resulting in five missed doses. Further review of the PN revealed no documentation explaining the delay in initiating the PO or the missed doses.<br><br>A review of the facility's Med Administration Policy, dated 9/1/24, included, meds are administered by licensed nurses, or other staff who are legally authorized to do so in this state, 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: right resident, right drug, right dosage, right route, right time, and right documentation.<br><br>On 4/30/26 at 11:45 AM, S #3 notified the LNHA, in the presence of the DON that the PO for Pro-Stat was not followed as written and that doses were missed without documentation for resident #213.<br><br>On 5/1/26 at 11:00 AM, the LNHA and DON provided no additional information regarding the PO for Prostat not administered for 2 1/2 days.<br><br>NJAC 8:39-27.1(a) |

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| 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 #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<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>Based on observation, interview, record review, and review of pertinent documents it was determined that the facility failed to, a.) follow the physician order and ensure assistive device was consistently applied for 1 of 2 residents (Residents #14) and b.) a physician order was obtained with regard to use of an assistive device for 1 of 2 residents (Resident #253), in accordance with facility policy and standard of practice.This deficient practice was evidenced by the following:<br><br>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.<br><br>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.<br><br>1.On 4/27/26 at 6:58 AM, Surveyor #1 (S #1) observed Certified Nursing Aide #1 (CNA #1) inside Resident #14's room responded to the call bell, the resident was in a low bed, and no adaptive devices noted to the extremities.<br><br>On 4/28/26 at 8:08 AM, S #1 interviewed the Unit Clerk (UC) in the 3rd floor nursing station in the presence of the Registered Nurse/Unit Manager (RN/UM) about medical records. The UC informed S #1 that there were no paper chart in the 3rd floor nursing station, the RN/UM also confirmed that all residents' medical records should be in the electronic medical record (eMR).<br><br>At that same time, S #1 asked the RN/UM what the process with regard to ADL (activity of daily living) or range of motion (ROM) and use of sling or other adaptive devices was. The RN/UM stated that it was Certified Nursing Aide #2 (CNA #2) who was responsible for the entire facility's FMP (functional maintenance program). The RN/UM further stated that she was unsure and would get back to S #1 to check where it was being documented. The RN/UM also stated that the process was, when the resident completed or evaluated by the therapist and if the resident was not appropriate for skilled rehab, the resident will transition to FMP and CNA #2 would be responsible for it.<br><br>S #1 reviewed the medical record of Resident #14, and revealed:<br><br>A review of Resident #14's admission Record (AR) or face sheet (the admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction (a type of ischemic stroke caused by a blockage in blood vessels supplying the brain, resulting in tissue death (necrosis) due to lack of oxygen) unspecified, cognitive communication deficit, hemiplegia and hemiparesis (hemiparesis is partial weakness, allowing some movement, while hemiplegia is severe or complete paralysis on one side) following cerebral infarction affecting left non-dominant side, wedge<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing, and unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing.<br><br>A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 4/2/26, revealed in Section C-Cognitive Patterns a brief interview for mental status (BIMS) score of 6 out of 15, which reflected that the resident had severely impaired cognition.<br><br>A review of the current April 2026 Order Summary Report revealed the following physician orders (PO):<br><br>-Maintain left upper arm sling. Skin checks every shift every shift, order date 4/6/26.<br><br>-NWB (no weight bearing) to LUE (left upper extremity), order date 4/6/26.<br><br>The above order to maintain left upper arm sling was transcribed to the electronic Treatment Administration Record (eTAR) in April 2026, signed by nurses every shift (day, evening, and night shifts) with a check mark and nurses' initials as administered (or provided) from 4/6/26 at night shift through 4/28/26.<br><br>Further review of the eMR revealed that there was no documented evidence that the CNAs were documenting about the application of the left arm sling. There was no documented evidence in the eMR that the left arm sling was declined or refused by the resident.<br><br>On 4/29/26 at 8:00 AM, S #1 interviewed the RN/UM who informed S #1 that Resident #14 was cognitively impaired, required total care, had a fall incident in the other unit, no fall incident on the 3rd floor, the fall from other unit the resident sustained a left humerus fracture that was resolved already, and nothing to be done. The RN/UM stated that no adaptive device needed like splint or sling. The surveyor asked the RN/UM to accompany S #1 in the resident's room. Inside the resident room, both S #1 and the RN/UM observed the resident was lying on low bed and the resident did not have a left arm sling.<br><br>Afterward, in the 3rd floor nursing station, S #1 notified the RN/UM of the above findings and concern that S #1 did not observe the resident with sling from day one of survey (4/27/26), yesterday (4/28/26), and today (4/29/26). The RN/UM stated that the resident probably refused the sling, but there should be documentation that the resident refused the sling. S #1 also notified the RN/UM that S #1 reviewed the resident's medical records and there was no documentation in the tasks of the CNA to put on sling, it was with the nurses in their eTAR, and the nurses had been signing it even if it was not applied, as it was observed by S #1. The RN/UM confirmed that there was no sling at that time. She also stated that the resident had history of stroke and that the sling was being used because of that.<br><br>On 4/29/26 at 8:05 AM, S #1 observed the RN/UM entered Resident #14's room and checked the resident's 2nd drawer and found the black sling. At that same time, S #1 asked the RN/UM what it meant to maintain left sling. check skin every shift. The RN/UM stated, as long as the sling was tolerated. S #1 asked if that should be in order as the as tolerated, and she did not respond.<br><br>On 4/29/26 at 8:06 AM, S #1 attempted and unable to interview assigned CNA #3 due to the aide was<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | providing care to another resident.<br><br>At that same time, S #1 interviewed the Registered Nurse (RN) assigned to Resident #14, who informed S #1 that the resident's fractured arm was consolidated already and healed. The RN stated that Resident #14 used to have a sling to left arm, the last time it was seen being used was two weeks ago, and I think the resident had been refusing it on and off. S #1 then notified the concern about last three days of observation with no left arm sling, the nurses were signing the eTAR that the sling was provided, and the RN responded, it was a mistake. The RN confirmed that the checkmark in the eMAR or eTAR meant it was provided or administered.<br><br>On 4/29/26 at 8:35 AM, S #1 notified the Director of Nursing (DON) of the above findings and concern that nurses signed for sling even if it was not applied.<br><br>On 4/30/26 at 12:38 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Administrator in Training (AIT), and [NAME] President of Clinical Services (VPoCS), and S #1 notified them of the above findings and concerns with Resident's 14's left arm sling order was not followed and did not observe it was in use during observations of S #1.<br><br>On 5/1/26 at 10:59 AM, the survey team met with the LNHA, AIT, VPoCS, and the DON stated the physiatrist notified the facility that the discontinuation of the sling will be decided by the ortho (orthopedist) and follow up with ortho was set for 5/4/26 at 11:30 AM.<br><br>On 5/1/26 at 12:29 PM, the survey team met with the LNHA, DON, AIT, and VPoCS for an exit conference, and the LNHA did not provide additional information.<br><br>2.On 4/27/26 at 11:30 AM, Surveyor #2 (S #2) observed Resident #253 in a chair in their room and S #2 observed a black colored arm sling on their left arm. The resident stated, the rehab staff is good.<br><br>On 4/28/26 at 11:08 AM, Surveyor #3 (S #3) observed Resident #253 in a chair in their room. S #2 observed a black colored sling on resident's left arm. The resident stated I had this arm sling on since I was admitted here. The resident further stated that they had a fracture to their left arm.<br><br>A review of Residents #253's medical records revealed the following:<br><br>A review of the resident's nurse progress notes dated 4/16/26, revealed that the resident was alert and oriented.<br><br>A review of the resident's AR revealed that the resident had diagnoses which included but were not limited to left radial fracture and two rib fractures.<br><br>A review of the residents' care plans revealed that there was a care plan (CP) in place for an arm fracture, dated 4/16/26. The CP interventions in place which included use of an arm sling for the resident's left arm.<br><br>There was no PO in place for the use of the resident's left arm sling.<br><br>On 4/29/26 at 9:57 AM, S #3 interviewed the Licensed Practical Nurse (LPN), who care for the resident. The LPN stated that the resident did have a left arm sling and she was unsure as to why there was no PO for the left arm sling, and stated that there should be an order.<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's Use of Assistive Devices Policy that was provided by the LNHA, with date implemented 9/1/25, revealed, the purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function, dignity and quality of life.<br><br>Policy Explanation and Compliance Guidelines:<br><br>1.Assistive devices are tools.types of equipment.that help individuals perform tasks and activities.Assistive devices include.f. Orthotic or prosthetic equipment.<br><br>3. The facility will provide assistive devices, as indicated, for residents who need them.<br><br>5. Facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices safely.<br><br>7. A nurse with responsibility for the resident will monitor the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the care plan will be made as needed.<br><br>8. Storage and maintenance of equipment is based on the determination of the department with responsibility for oversight.<br><br>On 5/1/26 at 9:30 AM, S #3 discussed the above concerns with the LNHA and the DON stated that there should have been an order in place for the left arm sling that the resident has been using. No further information was provided.<br><br>NJAC 8:39-11.2 (e); 27.1(a); 27.2(m) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent documents, it was determined that the facility failed to: a.) to ensure fall interventions were consistently implemented for residents identified as being high risk for falls who sustained injuries from fall and b.) ensure a resident with severe cognitive impairment, who was at risk for elopement and had a known history of wandering was appropriately supervised and monitored to ensure safety, prevent elopement, and/or exiting of the building. This deficient practice was identified for 1 of 2 residents reviewed for accidents (Resident #14) and for 1 of 1 resident reviewed for elopement (Resident #209), in accordance with standards of clinical practice and facility's policies and procedure. This deficient practice was evidenced by the following:<br><br>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.<br><br>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.<br><br>1.On [DATE] at 6:58 AM, Surveyor #1 (S #1) observed Certified Nursing Aide #1 (CNA #1) inside Resident #14's room responded to the call bell, the resident was observed in a low bed, and no adaptive device noted to the extremities.<br><br>On [DATE] at 8:05 AM, S #1 observed Resident #14 lying on low bed covered with blanket, with call bell within reach, add there was no floor mat.<br><br>On [DATE] at 8:08 AM, S #1 interviewed the Unit Clerk (UC) in the 3rd floor nursing station in the presence of the Registered Nurse/Unit Manager (RN/UM) about medical records. The UC informed S #1 that there were no paper chart in the 3rd floor nursing station, the RN/UM also confirmed that all residents' medical records should be in the electronic medical record (eMR).<br><br>S #1 reviewed the medical record of Resident #14, and revealed:<br><br>A review of Resident #14's admission Record (AR) or face sheet (the admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; type 2 diabetes mellitus with diabetic polyneuropathy, cerebral infarction (a type of ischemic stroke caused by a blockage in blood vessels supplying the brain, resulting in tissue death (necrosis) due to lack of oxygen) unspecified, cognitive communication deficit, hemiplegia and hemiparesis (Hemiparesis is partial weakness, allowing some movement, while hemiplegia is severe or complete paralysis on one side) following cerebral infarction affecting left non-dominant side, wedge<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing, and unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing.<br><br>A review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of [DATE], revealed in Section C-Cognitive Patterns a brief interview for mental status (BIMS) score of 6 out of 15, which reflected that the resident had severely impaired cognition.<br><br>A review of the provided fall investigation dated [DATE], revealed, Resident #14 fell from bed and had complained of pain. The fall investigation also included an attached Investigation Summary, which included a documentation that the diagnostic results showed mildly displaced left humeral fracture, the resident was admitted to the hospital for treatment, and the care plan (CP) was updated.<br><br>A review of the individualized CP revealed a focus that Resident #14 was at risk for falls r/t (related to) recent fall at home and experienced an actual fall at the facility on [DATE]. The CP for actual fall had active interventions that included but was not limited to fall mats to bedside that was initiated on [DATE].<br><br>On [DATE] at 8:00 AM, S #1 interviewed the RN/UM who informed S #1 that Resident #14 was cognitively impaired, required total care, had a fall incident in the other unit, no fall incident on the 3rd floor, the fall from other unit sustained a left humerus fracture that was resolved already, and nothing to be done. The RN/UM stated that the resident should have a floormat for safety.<br><br>On that same date and time, S #1 asked the RN/UM to accompany S #1 in the resident's room. Inside the resident room, both S #1 and the RN/UM observed the resident was lying on low bed, there was no floormats on the floor.<br><br>Afterward, in the 3rd floor nursing station, S #1 notified the RN/UM of the above findings and concerned that S #1 did not see the resident with a floor mats. The RN/UM stated that probably the floor mat was dirty and had to be cleaned. S #1 then asked the RN/UM should the resident had no floor mats, and the RN/UM did not respond. The RN/UM confirmed that there was no floor mats at that time.<br><br>On [DATE] at 8:05 AM, S #1 observed the RN/UM entered Resident #14's room and checked the resident's 2nd drawer and found the black sling. At that same time, S #1 still did not observe floor mats, and the resident was lying on bed.<br><br>On [DATE] at 8:06 AM, S #1 interviewed the Registered Nurse (RN) assigned to Resident #14, who informed S #1 that the resident's fracture arm was consolidated already and healed. The RN was unable to state when the last time she saw the resident's floor mat because I was not paying attention. S #1 then notified the concern about the floor mats and asked the RN why there were none observed in resident's room, and the RN stated, details that escaped to me.<br><br>On [DATE] at 8:28 AM, S #1 observed the RN inside the resident's room, the resident was in the low bed, and no floor mats.<br><br>On [DATE] at 8:35 AM, S #1 notified the Director of Nursing (DON) of the above findings and concern about floor mats of Resident #14.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 12:38 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Administrator in Training (AIT), and [NAME] President of Clinical Services (VPoCS), and S #1 notified them of the above findings and concerns with Resident's 14's floor mats.<br><br>On [DATE] at 8:00 AM, S #1 observed Resident #14 lying on bed with no floor mats.<br><br>On [DATE] at 8:02 AM, S #1 interviewed CNA #2, who informed S #1 that she was the assigned aide today of Resident #14. Both S #1 and CNA #2 went in front of resident's room, and CNA #2 confirmed that there were no floor mats, and when asked why the resident did not have one, she stated to ask the assigned RN.<br><br>On [DATE] at 8:05 AM, S #1 interviewed the RN in the nursing station and S #1 asked the RN as why the resident did not have floor mats. The RN stated that the resident was fine, no behavior of getting out of bed (OOB), and did not need it and that S #1 could ask the Unit Manager about it.<br><br>On [DATE] at 8:10 AM, S #1 notified the RN/UM about the observation that the resident did not have floor mats while the resident was lying on bed. The RN/UM informed S #1 that the resident's floor mat was not needed because both residents in the room needed to use a Hoyer lift for transfer, and it was on the way the floor mats. She further stated that Resident #14 had no further fall incidents and was not trying to get OOB.<br><br>At the same time, S #1 asked who decided that the resident did not need the floor mats, and she responded that it was the interdisciplinary team. S #1 then asked was it reflected in the CP because the current CP included fall floor mat at bedside, and if the decision of the team was documented. The RN/UM stated that she thinks that it was not discontinued in the CP and there was no documentation about it.<br><br>On [DATE] at 8:18 AM, S #1 notified the DON of S #1's observation today that Resident #14 had no floor mats.<br><br>On [DATE] at 10:59 AM, the survey team met with the LNHA, AIT, VPoCS, and the DON stated no floor mats required at this time, as the facility team decided today.<br><br>A review of the facility's Incidents and Accidents Policy that was provided by the LNHA, with implemented date [DATE], revealed, it is the policy of the facility for staff to utilize the risk management system to report, investigate, and review any accidents or incidents that occur.<br><br>Policy Explanation: the purpose of the incident reporting can include: assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care.<br><br>Compliance Guidelines.13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions.<br><br>A review of the facility's Fall Risk Assessment Policy that was provided by the LNHA, with reviewed/revised date of [DATE], revealed, it is the policy of the facility to provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Policy Explanation and Compliance Guidelines.5. Monitor the effectiveness of the CP interventions, and modify the interventions as necessary, in accordance with current standards of practice.<br><br>On [DATE] at 12:29 PM, the survey team met with the LNHA, DON, AIT, and VPoCS for an exit conference, and the LNHA did not provide additional information.<br><br>2. On [DATE] at 8:49 AM, S #2 observed Resident #209 sitting in bed in a room that was close to the nurse's station. The Assistant Director of Nursing (ADON) stated that Resident #209 wandered.<br><br>A review of Resident #209's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to dementia and Alzheimer's Disease.<br><br>A review of Resident #209's most recent quarterly MDS, with an ARD of [DATE], had a BIMS score of 5 out of 15, which reflected that the resident's cognition was severely impaired. Further review indicated under section P for Restraints and Alarms, Wander/elopement alarm was used daily.<br><br>A review of Resident #209's Elopement Risk Evaluation dated [DATE], indicated that the resident was a moderate risk for elopement.<br><br>A review of Resident #209's [DATE] electronic Treatment Administration Record (eTAR) included the following orders:<br><br>Wander Guard/Wander Elopement Device #584DD1 due to poor safety awareness Expiration date: [DATE] L wrist. every night shift check function with an order date of [DATE]. The nurse did not sign as administered (box was blank) on [DATE] and [DATE]. The expiration date listed of the wander guard (not guaranteed to function properly after the expiration date) was [DATE] which was 12 days ago.<br><br>Wander Guard/Wander Elopement Device #584DD1 due to poor safety awareness Expiration date: [DATE] Left wrist. every shift check placement with an order date of [DATE]. The nurse did not sign as administered (box was blank) on [DATE] and [DATE] on the night shift and on [DATE] on the day shift. The expiration date listed of the wander guard was [DATE] which was 12 days ago.<br><br>A review of Resident #209's Progress Notes (PN) included the following eMAR (electronic Medication Administration) Note dated [DATE]:<br><br>Wander Guard/Wander Elopement Device #584DD1 due to poor safety awareness Expiration date: [DATE] Left wrist. every shift check placement not in patient wrist. notified to Unit manager.<br><br>There was no additional note to indicate that the same wander guard or a new wander guard was placed on the resident.<br><br>A review of Resident #209's individualized CP included the following: Risk for elopement due to confusion and poor safety awareness. Wander Guard/Wander Elopement Device #584DD1 date: [DATE] Left wrist. Date Initiated: [DATE] Revision on: [DATE].<br><br>On [DATE] at 10:25 AM, S #2 interviewed CNA #3 who stated that she checked Resident #209's wander guard to make sure it was on and that if it was not on she would report to the nurse immediately. CNA #3 stated that the walked around the unit but did not really exit seek and that the (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident took it off.<br><br>On [DATE] at 10:46 AM, S #2 interviewed the Licensed Practical Nurse (LPN) who stated that the wander guard was checked for placement every shift and that they were changed periodically and it should be documented. S #2 asked if the CP should be updated if changed, and the LPN stated that it should be updated and that the supervisor updated the CP. S #2 asked about the blanks on Resident 209's eTAR. The LPN was unsure but stated that she would like to say there should not be blanks. She added that it should be marked as administered or have a reason if not. The LPN further stated that Resident #209 wandered but that did not exit seek.<br><br>On [DATE] at 10:57 AM, S #2 interviewed the Assistant DON (ADON) who stated that wander guard had an order for the placement to be checked every shift and the function checked with a device once a day. The ADON stated that she did not expect to see blanks on the eTAR and that they tried to make sure the nurses did not leave blanks. The ADON stated that the unit managers (UM) or the ADON's updated the CP. S #2 asked about Resident #209's expiration date listed on the order. The ADON stated that Resident #209's wander guard was frequently changed since the resident kept pulling it off and that most of the time a new one was placed because they could not find the one that was removed by the resident. S #2 asked if the order and the CP should be updated with the new expiration date. The ADON stated that they always updated the CP. S #2 showed the ADON the eTAR and CP. The ADON confirmed the blanks and the expiration date of [DATE]. The ADON stated that she would have to make sure the UM updated it. The ADON stated that she was just covering the UM while they were out. The ADON stated that she would have to get Resident #209 a new wander guard if it had an expiration date.<br><br>On [DATE] at 11:07 AM, S #2 and the ADON entered Resident #209's room and observed the resident had a wander guard on their left wrist. The ADON was unable to see if the wander guard had an expiration date. The ADON stated that she would get a new one to view where the expiration date was located.<br><br>On [DATE] at 11:33 AM, the ADON stated that the wander guard expired one year after placement. The ADON stated that she was not sure why that date was on the CP. The ADON stated that they recently placed a new wander guard on Resident #209 on [DATE] and that it would expire one year later. S #2 requested the manufacturer instructions.<br><br>On [DATE] at 12:06 PM, the DON brought the manufacturer instruction sheet. The DON stated that the wander guard would need to be activated by the date listed on the device and that it had a it had one year battery life from that date it was activated. The DON stated that the staff should have put the activation date.<br><br>On [DATE] at 12:46 PM, S #2 asked the ADON where it would be documented that a new wander guard was placed. The ADON stated that it would be in a PN. S #2 showed the ADON Resident #209's PN. The ADON confirmed that there was not a PN for when the wander guard was placed after the PN that indicated that the resident did not have one on their wrist. The ADON stated that the nurse should have written a PN when it was placed.<br><br>On [DATE] at 12:28 PM, S #2 interviewed the DON who stated that if a resident had a wander guard, it would be in the CP and an order for placement checked every shift and function checked daily. The DON stated that the wander guard had to be activated by a certain date and once activated it lasted one year. The DON stated that the activation date should be on the order. S #2 notified the DON that<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #209's wander guard order had listed an expiration date that was expired several days prior to surveyors observation and the several blanks that indicated the order was not followed; the CP had a date but did not indicate what the date referenced; and there was no PN to indicate that the wander guard was placed after the nurse found it was not on the resident.<br><br>On [DATE] at 12:37 PM, the DON stated that Resident #209 took off and put on the wander guard and that he was sure that the UM went and put it back on and secured it. S #2 asked if the expectation was to write a PN. The DON did not answer. S #2 asked if there should be blanks on the eTAR. The DON stated that there should not be blanks.<br><br>On [DATE] at 1:25 PM, the DON stated that there was not a specific policy for the wander guard.<br><br>On [DATE] at 12:40 PM, S #2 notified the LNHA, DON, AIT and VPoCS the concern that Resident #209's wander guard order had listed an expiration date that was expired several days prior to S #2's observation and the several blanks that indicated the order was not followed; the CP had a date but did not indicate what the date referenced; and there was no PN to indicate that the wander guard was placed after the nurse found it was not on the resident.<br><br>The LNHA did not provide any additional information.<br><br>A review of the facility's provided wanderguard user sheet included the following:<br><br>The bracelet signals the controller when it is in field. The controller issues an alarm and can lock a monitored door so that an at-risk resident wearing the bracelet cannot leave through the door.<br><br>Activate By xx/xx/20xx<br><br>Bracelet Activation: The bracelet must be activated before applying it to a resident's wrist or ankle.<br><br>Warranty: The bracelet warranty is binding only if the bracelet was activated before the Activate By date printed on the Bracelet back label. The warranty starts when the bracelet is activated.<br><br>A review of the facility's Elopements and Wandering Residents Policy with a reviewed/revised date of [DATE], included the following:<br><br>Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.<br><br>Policy Explanation and Compliance Guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements .<br><br>3. The facilty shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.<br><br>4. Monitoring and Managing Residents at Risk.<br>(continued on next page) |

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| | 315307 | A. Building<br>B. Wing | 05/01/2026 |

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| Complete Care at Harborage LLC | 7600 River Rd<br>North Bergen, NJ 07047 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. Interventions to increase staff awareness of the resident's risk, modify the residnet's behavior, or to minimize risks associated with hazards will be added to the resident's CP and communicated to appropriate staff.<br><br>d. Adequate supervision will be provided to help prevent accidents or elopements.<br><br>e. Charge nurses and UMs will monitor the implementation of interventions, response to interventions, and document accordingly.<br><br>The policy did not have information regarding the process for the wander guard bracelet.<br><br>N.J.A.C. 8:39-11.2 (e); 27.1(a); 27.2(m) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate treatment and services for a resident receiving enteral feeding. This deficient practice was identified for 1 of 3 residents (Residents #73), reviewed for enteral (tube) feeding.This deficient practice was evidenced by the following: On 4/29/26 at 9:34 AM, the surveyor reviewed the electronic medical record (eMR) of Resident #73. A review of the admission Record or face sheet (an admission summary) documented the resident had diagnoses that included but were not limited to, Alzheimer's disease and unspecified severe protein-calorie malnutrition. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 3/3/26, reflected that resident was rarely/never understood. In Section K (Swallowing/Nutritional Status), Resident #73 was coded as receiving nutrition through a feeding tube while a resident. A review of the physician's order (PO) dated 4/21/26, included, three times a day for hydration support, flush tube with 200 ml (milliliters) of water every 8 hours. The order was scheduled for 9 AM, 1 PM, and 5 PM. A review of the April 2026 electronic Medication Administration Record (eMAR) for the above order entry revealed the water flushes were being administered at 9 AM, 1 PM, and 5 PM; and not every 8 hours as indicated by the PO. On 4/29/26 at 12:19 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for Resident #73. The LPN stated a resident's enteral feeding and water flushes were administered according to the PO. The LPN with the surveyor reviewed Resident #73's water flush order. The surveyor asked if the scheduled time of the water flushes were according to the PO. The LPN replied that the order entry indicated three times a day. The surveyor reviewed with the LPN that the order also indicated every 8 hours. The LPN provided no additional verbal response regarding the frequency of the water flushes. On 4/29/26 at 12:32 PM, the surveyor notified the LPN/Unit Manager (LPN/UM) about the concern for Resident #73's scheduled water flushes not following the PO of every 8 hours. The LPN/UM acknowledged the order needed to be clarified and she would contact the RD (Registered Dietician) to confirm water flush recommendations. On 4/29/26 at 12:48 PM, the surveyor interviewed the RD who stated that the RDs made recommendations for a resident's enteral feeding and water flushes. The RD explained the recommendations were entered in the eMR, under Orders, and then the nurses would call the physician to obtain PO and carry out the order. At that same time, the surveyor asked the RD about the frequency of Resident #73's water flushes. The RD replied, the water flushes for Resident #73 were to be administered every 8 hours. The surveyor notified the RD that the order entry in the eMR indicated Resident #73's water flushes were scheduled to be administered 9 AM, 1 PM, and 5 PM. The RD acknowledged that the frequency was not every 8 hours as recommended. The RD stated when recommendations were entered in the eMR, the system automatically entered a scheduled frequency. The RD was not aware that when the order was entered as three times a day, it would not be programmed for an every 8 hours frequency. On 4/29/26 at 1:12 PM, the surveyor notified the Director of Nursing (DON) of the concern regarding Resident #73's water flush order. The DON stated that the resident still received the total amount for the day. The surveyor discussed with the DON that the order indicated every 8 hours, and the order was not scheduled according to the PO. On 4/30/26 at 12:38 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the DON, the Administrator in Training (AIT), and the [NAME] President of Clinical Services (VPoCS) of the concern Resident #73's water flushes were scheduled according to the PO, and the order was not clarified. There was no verbal response by the facility's management at this time. On 5/1/26 at 10:59 AM, the LNHA, the DON, and the AIT met with the survey team. The DON stated in-service education was provided to the nurses and the RD about water flushes, including order input in the eMR; Additionally, an audit was initiated. A review of the facility's Care and Treatment of Feeding Tubes Policy, with a reviewed date of 1/15/26. Under Policy revealed, it is a<br>(continued on next page) |

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| Complete Care at Harborage LLC | 7600 River Rd<br>North Bergen, NJ 07047 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . NJAC 8:39-27.1 (a) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure that residents received the necessary respiratory care and services, according to the standard of clinical practice, specifically that respiratory equipment were labeled and stored in accordance with infection control measures and cautionary signage for oxygen services for 2 of 7 residents reviewed for respiratory care (Resident #227 and #234).This deficient practice was evidenced by the following:<br><br>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.<br><br>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.<br><br>1. On 4/27/26 at 8:37 AM, Surveyor #1 (S #1) observed Resident #227's nebulizer (neb) treatment mask still attached to the machine laid on top of the dresser. The neb treatment mask was not stored in a bag. Resident #227 was observed seated in a wheelchair in the dayroom.<br><br>On 4/28/26 at 11:17 AM, S #1 interviewed the Licensed Practical Nurse (LPN) who stated that neb treatments were ordered as scheduled or sometimes PRN (as needed). She added that after the treatment was administered, it was wiped down and placed in a bag. S #1 showed the LPN the picture of the observed mask. The LPN stated that it should not be that way. She added that the resident did not get a treatment on her shift and that maybe the resident received the treatment on the night shift.<br><br>On 4/28/26 at 11:26 AM, S #1 reviewed Resident #227's electronic medical record (eMR).<br><br>A review of Resident #227's admission Record (AR) or face sheet (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to type 2 diabetes mellitus (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) and heart failure (chronic, progressive condition where the heart muscle cannot pump blood efficiently, often caused by coronary artery disease, high blood pressure, or heart attacks).<br><br>A review of Resident #227's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 3/18/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated that the resident's cognitive status was intact.<br><br>A review of Resident #227's April 2026 electronic Medication Administration Record (eMAR) which included the following physician orders (PO):<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (milligrams/milliliters), 3 ml inhale orally every 6 hours PRN for wheezing with an order date of 1/24/26 1145, which the order was administered on 4/22/26 at 305, and was effective. The order was discontinued on 4/27/26, and changed to the following order:<br><br>Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally via neb every 6 hours PRN for wheezing **Before treatment obtain LS (lung sound), O2 (oxygen), Respiration **After treatment Obtain LS, O2, Respiration, number of minutes spent completing treatment LS 1=clear 2=diminished 3=crackles 4=wheezes 5=bronchospasms **Rise and spit after each use** with an order date of 4/27/26. This order had not been administered.<br><br>On 4/30/26 at 11:31 AM, S #1 interviewed the Director of Nursing (DON) regarding the storage of the neb mask. The DON stated the neb treatment equipment should be in a bag.<br><br>On 4/30/26 at 12:40 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA), DON, Administrator in Training (AIT) and [NAME] President of Clinical Services (VPoCS) the concern that #227's neb mask was observed on 4/27/26 laid out on the dresser and not in the bag and that on the eMAR the treatment was last administered on 4/23/26.<br><br>On 5/1/26 at 11:22 AM, in the presence of the LNHA and AIT, the DON stated that staff were inserviced on placing neb masks in bags and for nurses to be aware when in the room to see the resident took it off.<br><br>The LNHA did not provide any additional information.<br><br>A review of the facility's Nebulizer Therapy Policy with a reviewed/revised date of 9/1/25, included the following:<br><br>Care of the equipment .<br><br>3. Disassemble parts after every treatment.<br><br>4. Rinse the neb cup and mouthpiece with sterile or distilled water.<br><br>5. Shake off excess water.<br><br>6. Air dry on an absorbent towel.<br><br>7. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag.<br><br>2. On 4/27/26 at 9:03 AM, Surveyor #2 (S #2) observed that there was no posting of cautionary or safety signs indicating the use of O2 while Resident #234 was actively receiving O2. Moreover, the nasal cannula (NC) was not labeled with a date or initials.<br><br>On 4/27/26 at 9:30 AM, S #2 reviewed the eMR of Resident #234.<br><br>A review of the AR reflected that the resident was admitted to the facility with diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) with (Acute) Exacerbation (an acute worsening of respiratory symptoms).<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the Order Summary Report revealed the following PO dated 3/20/26, including but not limited to:<br><br>Oxygen tubing change weekly label each component with date and initials. every night shift every Wed (Wednesday) label each component with date and initials.<br><br>Oxygen at 3 liters/min via NC, continuous every shift for COPD.<br><br>On 4/28/26 at 11:41 AM, S #2 observed that Resident #234 was receiving O2, and the NC was still not labeled with a date or initials.<br><br>On 4/28/26 at 12:16 PM, S #2 interviewed the Registered Nurse (RN). The RN stated the expectation was for the NC to be labeled with a date and initials. The RN observed and acknowledged that the NC was not labeled. The RN also stated they do not know when O2 signage was supposed to be displayed.<br><br>On 4/30/26 at 1:48 PM, S #2 discussed the concerns with the LNHA, DON, and VPoCS. The LNHA did not provide a verbal response at that time.<br><br>A review of the facility's Oxygen Administration Policy, revised 1/7/26, revealed the following:<br><br>-Change O2 tubing and mask/cannula weekly and PRN if it becomes soiled or contaminated.<br><br>-O2 warning signs must be placed on the door of the resident's room where O2 is in use.<br><br>N.J.A.C. 8:39-27.1(a) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily for 1 of 5 days. This failure could affect the knowledge of the availability of staff to care for the residents, resident representative, and visitors.This deficient practice was evidenced by the following: On 4/27/26 at 6:18 AM, upon entry into the facility, the surveyor observed a posted Nursing Home Staffing Report (NHSR) in the reception area of the lobby, dated 4/25/26 Day Shift, 7:00 AM-3:00 PM (7-3 shift), Evening Shift 3:00 PM-11:00 PM (3-11 shift), and Night Shift 11:00 PM-7:00 AM (11-7 shift). The NHSR reflected current census (total number of residents) of 230 for all shifts. On 4/30/26 at 8:00 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for copies of midnight census for dates of 4/25/26 and 4/26/26, list of admissions on 4/25/26 and 4/26/26, and the census for every shift on 4/25/26 and 4/26/26. On 4/30/26 at 9:00 AM, the surveyor interviewed the Staffing Coordinator (SC) who informed the surveyor that she was responsible for posting the staffing report in the lobby. The SC stated that she had a remote access to check census, and she send the staffing report to nursing supervisors to post the correct and updated staffing report every shift as a requirement. She further stated when she was at the facility Monday through Friday, she posted the staffing report for 3-11 shift, and the nursing supervisors would post the 7-3 shift and the 11-7 shift NHSR. She also stated I update it when there was a new admission. At that same time, the surveyor notified the SC of the above concerns that on 1st day of survey on 4/27/26, the surveyor observed the posted NHSR in the lobby was dated for 4/25/26. The SC confirmed that in the beginning of each shift, the posted NHSR should have an accurate date, census and staffing information. On 4/30/26 at 9:26 AM, the LNHA informed the surveyor that there were no new admissions on 4/25/26 and 4/26/26. A review of the documents provided for midnight census report by the LNHA revealed that on both days, 4/25/26 and 4/26/26, the census was 227. Further review of the documents provided of the LNHA revealed that the census of 230 in the posted 4/25/26 NHSR observed by the surveyor on 4/27/26 did not match with the census of 227 provided by the LNHA. The date and the census were inaccurate on 4/27/26 when the surveyor observed the NHSR on the 1st of survey. On 4/30/26 at 10:35 AM, the Registered Nurse Supervisor (RNS) confirmed via a phone interview that she was the RNS that worked on 11-7 shift on the day the survey team entered the facility on 4/27/26 at around 6:30 AM. She informed the surveyor that it was the SC who provided the posted staffing, the SC also changes the census if needed to be changed, then she would print it, and post it in the lobby. On that same date and time, the surveyor notified the RNS of the above concerns that on 4/27/26, when surveyor entered the facility, the posted NHSR in the lobby was for date 4/25/26, with a census of 230. The RNS stated that when you flip the poster the other dates will be there. She further stated that she did not know why the census was 230. On 4/30/26 at 12:38 PM, the survey team met with the LNHA, Director of Nursing (DON), Administrator in Training (AIT), and [NAME] President of Clinical Services (VPoCS), and the surveyor notified them of the above findings and concerns with regard to inaccurate date and census of the posted NHSR on 4/27/26. A review of the facility's Nurse Staffing Posting Information Policy that was provided by the DON, with a reviewed/revised date of 12/14/25, revealed, it is the policy of the facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time.Policy Explanation and Compliance Guidelines:The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information b. the current datec. Facility's current resident census. 2. The facility will post the Nurse Staffing Sheet at the beginning of each shift. On 5/1/26 at 10:59 AM, the survey team met with the LNHA, AIT, VPoCS, and the DON stated we also in service SC with regard to posting of staffing, and as well as the 7-3 shift to ensure accurate posting of NHSR. N.J.A.C. 8:39-41.2 (a)(b)(c) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>Based on observation, interview, and record review, it was determined that the facility failed to ensure the Consultant Pharmacist (CP) identified an irregularity during the drug regimen review (DRR) of a resident with chronic kidney disease. The deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #7) and was evidenced by the following:Reference:According to the manufacturer's boxed warnings (the highest safety- related warnings that medication can have, assigned by the Food and Drug Administration.) for Epogen (epoetin alfa): In controlled trials, patients with chronic kidney disease (CKD) experienced greater risks for death, serious adverse cardiovascular reactions, and stroke when administered erythropoiesis-stimulating agents (ESAs) to target a hemoglobin level of greater than 11grams /deciliter (g/dl). On 4/27/26 at 6:59 AM, the surveyor observed Resident #7 in a low positioned bed, was receiving oxygen (O2) via nasal cannula (a tube with 2 prongs at the end that deliver O2 through the nose), the O2 concentrator was on and set at 2.0 liters per minute (LPM). The surveyor reviewed the medical record for Resident #7. A review of the admission Record or face sheet, (an admission summary), Resident #7 was admitted to the facility with diagnoses which included but were not limited to; chronic kidney disease (gradual loss of kidney function), chronic obstructive pulmonary disease (progressive condition that prevents airflow to the lungs), and anemia (low red blood cells or hemoglobin to carry oxygen to the body's tissues). A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 3/26/26, reflected a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated Resident #7 was cognitively intact. Section N - Medications (meds) reflected that Resident #7 received two injectable meds. A review of the individualized comprehensive care plan for Resident #7 did not reveal the resident's injectables were care planned. A review of April 2026, electronic Medication Administration Record (eMAR) included a physician's order (PO) dated 3/19/26 for Epoetin Alpha injection; inject 10,000 units subcutaneously one time a day every Monday, Wednesday, and Friday for anemia. The order also reflected a monitoring for hematocrit. A hold parameter for administration was not reflected in the order. A review of the 4/8/26, CP medication regimen review (MRR; drug regimen review) did not reveal irregularities (to minimize adverse consequences, adequate duration and potential risks associated with the medication) was identified, and the physician was informed of the boxed warning of the resident's Epogen. On 4/29/26 at 11:10 AM, during an interview with the surveyor, the MDS-Coordinator (MDSC) stated that Section N did not have a section for other high risks meds that required monitoring such as Epogen or cancer target therapies that were not antineoplastic. The MDSC stated that for Resident #7 who had CKD, the Epogen was not highlighted on the assessment because of the form's limitations, however Epogen should still be care planned, since it should be monitored. All staff are responsible to ensure that this is care planned. 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), the surveyor discussed the above concerns. On 5//1/26 at 9:28 AM, during a telephonic interview with the surveyor, the CP stated that he performed MRR for the facility. He was familiar with the medication (med) Epogen, that it required blood laboratory testing, monitoring, particularly the hemoglobin. At that time, the CP acknowledged that monitoring the hematocrit as reflected on the eMAR was unnecessary, not required and does not prohibit administration. The CP stated that he was not aware of the black box warning, and did not make recommendations to prohibit unwanted administration based on the hemoglobin result and did not inform the prescriber of the boxed warning. 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 the expectation was that the CP review the meds and provide recommendations thereafter. A review of the facility's Medication Regimen Review Policy, reflected<br>(continued on next page) |

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| | 315307 | A. Building<br>B. Wing | 05/01/2026 |

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| Complete Care at Harborage LLC | 7600 River Rd<br>North Bergen, NJ 07047 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that the Medication Regimen Review or the Drug Regimen Review, a thorough evaluation of the med regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with med. NJAC 8:39-29.3 |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>Based on observation, interview, and review of facility documentation, it was determined that the facility failed to dispose of garbage and refuse properly in a manner to maintain a sanitary environment and prevent potential pests.This deficient practice was evidenced by the following: On 4/27/26 at 10:02 AM, a tour of the refuse area revealed, one covered compactor with six used gloves around the perimeter, a used mask, debris, and garbage on the front of the compactor on the ground. The surveyor asked who was responsible for keeping the area clean and the Director of Plant Operations (DPO) stated that the hospital housekeeping staff were responsible for cleaning the area, once a week. The DPO confirmed the refuse area should not have garbage and gloves around the perimeter. On 4/28/26 at 11:25 AM, on second day of tour, the surveyor observed the refuse area still with garbage in front and used gloves and mask. The DPO stated the company picks up the compactor every Friday and that the hospital uses it too. The surveyor requested from the FSD policies for the refuse area.On 4/28/26 at 1:30 PM, the surveyor notified the License Nursing Home Administrator (LNHA) and Administrator in Training (AIT) of the above findings and concerns. The LNHA stated, usually they do not check the area. On 4/30/26 at 12:57 PM, the surveyor interviewed the Director of Environmental Services (DES) regarding the refuse area. The DES stated the kitchen had separate refuse, and did not check that, they use a separate company. She further stated We have our own refuse-closed compactor and open dumpster-more for broken furniture. She added that her process was to clean the refuse area, which was to sweep the dock daily and clear the area. 0n 4/30/26 at 1:12 PM, the survey team met with the LNHA, AIT, DON, [NAME] President of Clinical Services, and the surveyor notified them of the concerns with the refuse area.On 5/1/26 at 10:59 AM, the survey team met with the DON and AIT. The LNHA had no additional information.A review of the facility's Waste Handling Policy, dated 3/1/26, did not mention a policy for the refuse area.NJAC 8:39-19.3(a),19.7 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to follow appropriate hand hygiene practices for 5 of 11 staff (3 Certified Nursing Aides and 2 Kitchen Leadership Staff), during incontinence tour and kitchen tour, and follow appropriate infection control practices to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy.This deficient practice was evidenced by the following:<br><br>According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 revealed.Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications:<br><br>Immediately before touching a patient .Before moving from work on a soiled body site to a clean body site on the same patient .After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal.<br><br>Know How to Wash Hands with Soap and Water:<br><br>Wet hands with water. Apply the manufacturer's recommended amount of product to your hands. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water to prevent drying of the skin.<br><br>1.On 4/27/26 at 6:24 AM, Surveyor #1 (S #1) asked Certified Nursing Assistant #1 (CNA #1) to accompany S #1 for incontinence tour, and CNA #1 went to Resident #48's room. Upon entering the room, CNA #1 donned (applied) a pair of gloves without performing hand hygiene, explained to the resident what she was about to do, provided privacy, and checked the resident's incontinence brief. CNA #1 doffed (removed) off used gloves, exited the room, and performed hand hygiene with use of ABHR (alcohol based hand rub) outside the room. CNA #1 confirmed that Resident #48 was incontinent with both bladder and bowel elimination.<br><br>On 4/27/26 at 6:30 AM, S #1 interviewed CNA #2 who informed S #1 that she worked double shifts and had 16 residents at 11-7 shift today. CNA #2 accompanied S #1 to Resident #22's room for incontinence tour. CNA #2 donned a new pair of gloves inside the resident's room without performing hand hygiene, communicated with the resident, pulled the privacy curtain, checked the resident's incontinence brief, doffed off used gloves, and performed hand washing inside resident's room. S #1 observed CNA #2 scrubbed her hands with soap for seven seconds, dried hands with clean paper towel, and turned off the faucet with use of her left elbow.<br><br>Outside Resident #22's room, CNA #2 informed S #1 that hands should be scrubbed for at least 20 to 30 seconds, and a clean paper towel should be used for turning off the faucet. S #1 then notified CNA #2 of the above findings, and CNA #2 acknowledged that she should have used clean paper towel and not her elbow in turning off the faucet. She further stated that she was too tired that was why she forgot to use the towel.<br><br>On 4/27/26 at 6:40 AM, CNA #3 accompanied S #1 to Resident #194's room for incontinence tour. S #1 observed CNA #3 donned a new pair of gloves inside the resident's room without performing hand (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hygiene, checked resident's incontinence brief, doffed off used gloves, and performed hand washing for 13 seconds.<br><br>Outside Resident #194's room, S #1 asked CNA #3 how long she should scrub her hands, and she responded at least 20-30 seconds. S #1 then notified CNA #3 of the above concerns with hand hygiene.<br><br>On 4/29/26 at 11:07 AM, S #1 in the presence of the Director of Nursing (DON) interviewed the Infection Preventionist Nurse (IPN) regarding infection control and hand hygiene protocol. The IPN informed S #1 that she was responsible for infection control education and competencies for all staff in the facility including housekeepers, nurses, and CNAs, that included staff from 11-7 shift. She also added that at times, it was the Nursing Supervisors who assisted her to ensure that all staff were covered for infection control competencies and education.<br><br>At that same time, S #1 notified the IPN of the above concerns with the three CNAs hand hygiene. The IPN stated that the CNA should have performed hand hygiene prior to donning gloves, performed at least 20 seconds of hand scrub, and used the clean paper towel in turning off the faucet. The DON further stated that CNA #3 had notified him of the above concern for hand hygiene.<br><br>2. On 4/28/26 at 10:58 AM, Surveyor #2 (S #2) observed the Director of Safety (DS) washed their hands for 18 seconds and turned off the faucet with bare hands, and did not use a paper towel.<br><br>On that same date and time, S #2 observed the Director of Plant Operations (DPO) washed their hands for 18 seconds, with soap suds still on their right hand, proceeded to turn off the faucet with bare hands, and did not use a paper towel.<br><br>On 4/28/26 at 1:30 PM, S #2 notified the Licensed Nursing Home Administrator (LNHA) and the Administrator in Training (AIT) of the above concerns with hand hygiene.<br><br>On 4/30/26 at 11:47 AM, S #2 interviewed the IPN regarding infection control. The IPN stated, The most important in-service is hand hygiene and the process was to remove jewelry, rinse hands with water, good amount of so start, rubbing hands for 25-30 seconds, rinse, let water run through hands, use paper towel to dry hands, drop the used towels, and grab a new one to close the faucet. She further stated that the in-services for handwashing were done quarterly and randomly as needed.<br><br>On 4/30/26 at 12:38 PM, the survey team met with the LNHA, DON, AIT, and [NAME] President of Clinical Services (VPoCS), and S #1 notified them of the above findings and concerns with regard to three CNAs hand hygiene.<br><br>A review of the facility's Hand Hygiene Policy that was provided by the DON, with a reviewed/revised date of 1/12/26, revealed, all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.<br><br>Policy Explanation and Compliance Guidelines:<br><br>Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. Hand hygiene technique when using soap and water:<br><br>a. Wet hands with water.<br><br>b. Apply to hands the amount of soap recommended by the manufacturer.<br><br>c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers.<br><br>d. Rinse hands with water.<br><br>e. Dry thoroughly with a single-use towel<br><br>f. Use clean towel to turn off the faucet.<br><br>6. Additional considerations:<br><br>a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.<br><br>On 5/1/26 at 12:56 PM, the survey team met with the AIT, VPoCS, and DON for an exit conference, and there was no additional information provided by the LNHA.<br><br>NJAC 8:39-19.4(a)(1) |