

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Aristacare at Whiting		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Schoolhouse Road Whiting, NJ 08759	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> complaint # 2563750Based on interview and record review, it was determined that the facility failed to develop and implement a care plan that meets the needs identified on the comprehensive assessment care for 1 of 25 residents reviewed for comprehensive care plans, Resident #14. This deficient practice was evidenced by the following:On 08/08/2025 at 09:37 AM during initial tour of the facility the surveyor observed Resident # 14 in bed with the door to their room open. There was a mesh stop sign attached to one side of the door and not connected to the other side. On 08/11/2025 at 09:11 AM the surveyor observed Resident # 14 sitting on their bed with the door open, the mesh stop sign was not connected to both sides of the door. A review of Resident # 14's admissions record revealed that, Resident # 14 was admitted with but not limited to bipolar disorder (a mental health condition characterized by extreme mood swings), Dementia (a decline in cognitive function that affects, memory, thinking and social abilities), and anxiety disorder. A review of Resident #14's admission Minimum Data Set (MDS) dated [DATE] revealed under section E that Resident # 14 has physical and verbal behaviors directed towards others. A review of the current Care Plan (CP) for Resident #14 revealed an intervention that was initiated on 07/14/2025 for a stop sign in front of resident's room to stop others from wandering into the room. During an interview on 08/13/2025 at 10:46 AM with the surveyor the Unit Manger Licensed Practical Nurse (UMLPN) said that care plan consists of focus areas for falls, pain, behaviors, all care areas, and certain medications. The UMLPN said that Resident # 14 was care planned to have a stop sign across their door to keep other residents out of the room. When asked if the stop sign is not in place was the care plan being followed, the UMLP replied, NO During an interview on 08/13/2024 at 12:47 PM with the surveyor, the Director of Nursing (DON) replied, yes when asked if staff should be following residents' care plans. A review of a facility provided policy titled, Care Plans revealed [facility name] care planning/interdisciplinary team, in coordination with the resident, his/her family develops and maintains a care plan for each resident. NJAC 8:39-27.1(a)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>NJ00182491, NJ00182879 NJ00186106Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to follow the prescriber's orders and accepted professional standards and principles by administering medications past the required time frame. The deficient practice was identified for 2 of 2 residents (Resident #144, and #27) reviewed and was evidenced by the following: Complainant stated pain medications ordered nightly were given late.</p> <p>The surveyor reviewed the resident's medical records. Review of the admission Records indicated Resident #144 was admitted to the facility with medical diagnoses that included but were not limited to fracture of left humerus (arm), congestive heart failure and depression.</p> <p>Review of the quarterly Minimum Data Set (MDS), an assessment tool dated 2/1/25 revealed the resident had a Brief Interview of Mental Status (BIMS) of 9, meaning the resident had moderate cognitive impairment. Review of section J of the MDS for pain assessment indicated the resident was on a pain regime and the resident had pain frequently in last five days and that the pain frequently interrupted day to day activities.</p> <p>A review of the physician orders showed an order for Oxycodone (narcotic pain medication) 5 milligram (mg) one tablet to be given every night at nine PM. Review of the medication administration record showed that the oxycodone was signed out as administered every night for the month of January 2025.</p> <p>A review of Resident #144 Medication Administration Audit Report for January 2025 revealed the Oxycodone for pain management was administered past the required time frame as follows:</p> <p>January 10, 2025-due at 9 PM administered at 10:07 PM</p> <p>January 19, 2025-due at 9 PM administered at 10:01 PM</p> <p>January 31, 2025-due at 9 PM administered at 10:30 PM</p> <p>On 8/13/25 at 10:15 AM the surveyor interviewed the Subacute unit Licensed Practical Nurse (LPN#1) regarding medications times. LPN #1 told the surveyor the nurses had one hour before to one hour after the ordered administration time. LPN #1 said if later than one hour after the order time it would be considered late.</p> <p>On 8/13/25 at 10:35 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) on the second floor. The surveyor asked what time a 9 PM medication should be given. The UM/LPN responded, You have one hour before to one hour after the prescribed time.</p> <p>A review of Resident #27's quarterly Minimum Data Set (an assessment tool) dated 05/11/2025, revealed that Resident #27 had a brief interview of mental status score of 15 which indicated he/she was cognitively intact. A review Resident # 27's diagnoses located in the Electronic Medical Record (EMR) include but are not limited to psoriatic arthritis.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #27 physician's orders revealed the following orders but not limited to Oxycontin ER 20 MG Give 1 tablet by mouth every 12 hours for chronic pain.</p> <p>A review of Resident #27's Medication Administration Audit Report for January 2025 reflected that the Oxycontin ER was administered past the required time frame as follows:</p> <p>05/02/2025 at 12:00 PM administered at 02:55 PM</p> <p>01/02/2025 at 09:00 PM administered at 10:52 PM</p> <p>01/04/2025 at 09:00 AM administered at 10:25 AM</p> <p>01/05/2025 at 09:00 AM administered at 10:07 AM</p> <p>01/06/2025 at 09:00PM administered at 10:03 PM</p> <p>01/07/2025 at 09:00 AM administered at 11:09 AM</p> <p>01/08/2025 at 09:00 AM administered at 10:13 AM</p> <p>01/10/2025 at 09:00 PM administered at 10:13 PM</p> <p>01/11/2025 at 09:00 AM administered at 10:29 AM</p> <p>01/13/2025 at 09:00 PM administered at 11:39 PM</p> <p>01/15/2025 at 09:00PM administered at 10:08PM</p> <p>01/18/2025 at 09:00 AM administered at 10:10 AM</p> <p>01/18/2025 at 09:00 PM administered at 10:24 PM</p> <p>The surveyor reviewed the policy titled, "Administering Medications", which stated medications must be administered in a safe and timely manner. Number eight of the policy stated medications must not be prepared in advance and must be administered within one hour of their prescribed time.</p> <p>NJAC 8:39-29.2 (d)</p>		