STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315342	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Brick LLC	415 Jack Martin Blvd Brick, NJ 08724

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity during dining for one of 26 sampled residents (Resident (R)85) when staff stood while feeding the resident. This failure could cause humiliation, loss of self-worth, and increase the risk of choking and/or aspirating food or liquid into the lungs.Findings include: Review of R85's quarterly Minimum Data Set (MDS) assessment, located under the MDS tab of the electronic medical record (EMR) and with an Assessment Reference Date (ARD) of 08/04/25, revealed R85 admitted to the facility on [DATE] with diagnoses that included non-Alzheimer's dementia; gastritis, unspecified, without bleeding; and depression. It was recorded R85 scored five out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was severely cognitively impaired. It was recorded R85 received a mechanically altered diet. Review of R85's Care Plan, revised 08/31/23 and located in the EMR under the Care Plan tab, revealed, [R85] presents with pre-existing ADL [activities of daily living] function and self-care impairment related to vascular dementia. An intervention included, . Eating: The resident requires limited assistance x 1 staff occasionally for meals . Review of R85's Diet Order, dated 05/10/25 and located in the Order tab of the EMR, revealed, . Regular diet, Chopped texture, Thin Liquids consistency . Review of R85's Care Plan, dated 06/20/25 and located in the EMR under the Care Plan tab, revealed, . The resident has a swallowing problem r/t [related to] Complaints of difficulty with swallowing . An intervention included, . Monitor/document/report PRN [as needed] any s/sx [signs/symptoms] of dysphagia . Review of R85's eMAR (Electronic Medication Administration Record)-Medication Administration Note, dated 05/29/25 and located in the EMR under the Progress Note tab, revealed, . Pt [patient] requires distant supervision at all meals to increase safety. Utilize 1:1 feeding PRN and employ safe swallow strategies of small bites, alternating liquids and solids, and upright position during meals every shift slept through the night . During an observation on 09/11/25 at 12:16 PM, R85 was observed in her room, sitting in her wheelchair. Certified Nurse Aide (CNA) 2 was feeding R85 her noon meal. CNA2 was observed standing while feeding R85 bites of her food with a fork. R85 was served baked ziti, mashed potatoes, fruit, and a soda. CNA2 was asked if she was supposed to stand while feeding R85 and was there a chair for her to sit in. CNA2 looked around the room for a chair. CNA2 stated she was not supposed to stand, but there was no chair available. At 12:33 PM, CNA2 was observed still standing while feeding R85 her lunch. During an interview on 09/12/25 at 10:36 AM, Unit Manager (UM)1 was informed CNA2 was standing while feeding R85 on 09/11/25 at lunch and was asked if staff should stand to feed residents. UM1 stated, No, [CNA2] should be at the same level. UM1 acknowledged R85 had a chopped diet due to swallowing issues. During an interview on 09/12/25 at 12:18 PM, Regional Registered Dietitian (RRD) was asked if staff should stand while feeding R85. RRD confirmed CNAs should not be standing when feeding R85 as it is a dignity and safety issue. Review of the facility policy titled. Promoting/Maintaining Resident Dignity, dated 09/01/24 revealed, . It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality . NJAC 8:39-4.1(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the facility's policy, the facility failed to ensure the code status was updated in the electronic medical record (EMR) to match the code status ordered for one of 26 sample residents (Resident (R) 78) reviewed for code status. The deficient practice could result in a resident who did not want to be resuscitated receiving cardiopulmonary resuscitation. Findings include: Review of R78's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included a fracture of the left femur. Review of R78's Care Plan, located under the Care Plan tab of the EMR and dated [DATE], revealed the resident's advance directive was a ''Do not resuscitate, No intubation.'' Review of R78's ''Profile'' screen, located under the ''Profile'' tab, and ''Physician's Orders,'' located under the ''Orders'' tab of the EMR, revealed Full code ordered on [DATE]. Do Not Resuscitate (DNR) and Do Not Intubate (DNI) were ordered on [DATE]. Review of R78's quarterly ''Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] and located under the ''MDS'' tab of the EMR, revealed R78 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R78's DNR/DNI/Do Not Hospitalize (DNH) Protocol Form,'' located under the ''MISC'' tab of the EMR and dated [DATE], had an ''checkmark'' next to DNR'' and DNI and was signed by both R78 and the nurse practitioner. Review of R78's Progress Note, located under the Prog Notes tab of the EMR and dated [DATE] at 12:47 PM, revealed Palliative Nurse Practitioner (NP) 1 had documented, . Discussed complex medical decisions and preferences for care. [R78] stated she has a living will and her cousin is her surrogate decision maker. She requests DNR/DNI. Facility DNR/DNI ordered. Introduced POLST [physician orders for life-sustaining treatment] document and reviewed differences between POLST and living will. She declined more information on POLST. All questions and concerns addressed . During an interview on [DATE] at 1:49 PM, R78 stated she had a living will and wished to be DNR and did not want life saving measures. During an interview on [DATE] at 2:02 PM, Licensed Practical Nurse (LPN) 1 stated, [R78's] code status is DNR, DNI, Full code,'' while looking in the EMR. She stated, I would initiate full code until I could verify code status is clarified even though DNR/DNI is included. During a follow-up interview on [DATE] at 2:23 PM, LPN1 stated [R78's] advance directive and EMR were reviewed. When the advance directive was updated on [DATE] by the palliative nurse practitioner, the full code order was not discontinued. The advance directive has been reviewed, and full code status has been discontinued. Her code status in the EMR is DNR, DNI. During an interview on [DATE] at 5:40 PM, the Director of Nursing (DON) and Administrator stated, Code status can be found in the EMR, on POLST, and in the hard chart. If a resident had both DNR and Full Code on the profile screen of the EMR, CPR would be initiated until the code status could be clarified. All residents on admission are full code until advance directives are verified. We have already completed a full audit of all residents' code status to verify that code status was entered correctly into the EMR.'' During an interview on [DATE] at 5:40 PM, the Director of Geriatric and Palliative Care Medical Services Nurse Practitioner (DGPCMS) stated she had conversation with NP1. She stated NP1 was able to recall the resident, R78, and recalled the conversation she had with R78 regarding code status. She stated that NP1 stated that normally she would discontinue the previous code status order. The DGPCMS stated that she reminded NP1 to be conscientious of changing code status orders and to be sure to discontinue the old order. Review of the facility's policy titled, Advance Directives,'' updated [DATE], included Advance directives will be respected in accordance with state law and facility policy. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.The resident has the right to refuse treatment. whether or not he or she has an advance directive. A resident will not be treated against his or her own wishes. In (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accordance with current OBRA [Omnibus Budget Reconciliation Act] definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include but are not limited to.Do Not Resuscitate DNR - indicates that in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy. or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatment or methods are to be used. NJAC 8:39-4.1(a)NJAC 8:39-27.1(a)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to develop and implement a baseline care plan that included instructions needed to provide effective and person-centered care related to dialysis within 48 hours of admission for one of 26 sample residents (Resident (R) 51) reviewed for baseline care plans. Failure to develop and implement a baseline care plan could place residents at risk for unmet care needs.Findings include: Review of R51's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was re-admitted on [DATE] with diagnoses that included dependence on renal dialysis and surgical aftercare following surgery on the circulatory system. Review of R51's Physician's Orders, located under the Orders tab of the EMR, revealed an order, dated 08/22/25, for dialysis. Review of R51's five-day Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 08/29/25, indicated the resident received dialysis on admission and while a resident and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 09/09/25 at 1:14 PM, R51 stated he had a dialysis catheter that had not been cleaned or cared for since he last had dialysis. R51's right chest dialysis catheter was observed with the dressing hanging from the catheter and the insertion site was exposed. Review of R51's Baseline Care Plan, dated 08/22/25, located under the Evaluations tab of the EMR, revealed Does resident require dialysis? was marked No. During an interview on 09/12/25 at 5:33 PM, the Director of Nursing (DON) confirmed that dialysis was not included on the baseline care plan and stated that the expectation was that dialysis should have been included on the baseline care plan. Review of the facility's policy titled, Baseline Care Plan, dated 09/01/24, revealed The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . The baseline care plan will: Be developed within 48 hours of a resident's admission . The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable . Interventions shall be initiated that address the resident's current needs including . Any special needs such as for intravenous (IV) therapy, dialysis, or wound care . NJAC 8:39-11.2

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop person centered comprehensive care plans for out-patient therapy, dialysis, and/or a dialysis catheter for two of four residents (Resident (R)51 and R5) reviewed for care plans out of a total sample of 26. This placed the residents at risk for decreased quality of life and quality of care. Findings include: 1. Review of R51's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was re-admitted to the facility on [DATE] with diagnoses that included dependence on renal dialysis and surgical aftercare following surgery on the circulatory system. Review of R51's five-day Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 08/29/25, indicated the resident received dialysis on admission and while a resident; and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 09/09/25 at 1:14 PM, R51 stated he had a dialysis catheter and was on dialysis until 08/27/25. R51's right chest dialysis catheter was observed with the dressing hanging from the catheter and the insertion site was exposed. Review of R51's Physician's Orders, located under the Orders tab of the EMR revealed an order, dated 08/22/25, for dialysis. Review of R51's Care Plan, located under the Care Plan tab of the EMR, revealed that the care plan did not indicate R51 was on dialysis or had a dialysis catheter. During an interview on 09/12/25 at 5:33 PM, the Director of Nursing (DON) confirmed that dialysis and the dialysis catheter were not included on the comprehensive care plan and stated that the expectation was that dialysis and the dialysis catheter should have been included on the comprehensive care plan. 2. Review of R5's quarterly MDS, with an ARD of 08/23/25 and located in the MDS tab of the EMR, revealed R5 was admitted to the facility on [DATE] and had diagnoses including hip fracture, encounter for other orthopedic aftercare, and rhabdomyolysis. It was recorded R5 had a BIMS score of 15 out of 15, indicating R5 was cognitively intact. It was recorded R5 was not receiving in-house therapy Review of R5's Orders, dated 05/07/25 and located in the EMR under the Order tab revealed Orthopedic consult and treatment. Review of R5's Orders, dated 05/08/25 and located in the EMR under the Order tab, revealed OT [Occupational Therapy] eval [evaluation] and treat for at least 3-5 days a week for 41 days including ADL [activities of daily living] retraining, neuro reeducation, thera act [therapeutic (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activity], thera exer [therapeutic exercise], w/c [wheelchair] management, group activity, patient/caregiver education/training and discharge planning . Review of R5's out-patient Orthopaedics notes facsimile (fax), dated 09/12/25 and provided by the facility, revealed, . Physical Therapy Plan of Care: Cold/hot Packs, Manual Therapy Techniques, Neuromuscular Re-Education, Electrical Simulation, Therapeutic Exercise, Ultrasound, PT [physical therapy]/OT [occupational therapy] Eval [evaluation] & [and] Treat, Home Exercise Program, Patient Education. Frequency: three times a week. Duration: 4 [four] weeks . Review of R5's Care Plan, located in the EMR under the Care Plan tab, revealed no care plan for therapy or rehabilitation services. During an observation on 09/09/25 at 3:18 PM, R5 was in her room sitting on the bed, dressed, and groomed. R5 stated she received out-patient therapy due to limitations on her managed care insurance plan due to her using up benefits earlier in the year. During an interview on 09/09/25 at 3:36 PM, the Director of Rehabilitation (DOR) was asked about R5's rehabilitation services and goals. The DOR stated R5's managed care insurance plan did not allow R5 to receive in-house therapy, so she was receiving out-patient therapy locally. The DOR stated the outpatient therapy determined her goals. During an interview on 09/11/25 at 10:18 AM, the Regional Social Worker (RSW) was asked about R5's therapy. The RSW stated R5 received therapy benefits under a respite status. RSW went on to say R5's insurance provided transportation to and from her out-patient therapy. During an interview on 09/12/25 at 9:39 AM, the Regional Nurse Consultant (RNC) was asked if R5 should have a care plan that addressed her out-patient therapy with goals. The RNC stated she would need to check. During an interview on 09/12/25 at 10:10 AM, the Director of Nursing (DON) provided the Orthopaedics notes. The DON was asked if there was a comprehensive care plan with goals in the facility's comprehensive care plan for R5's out-patient therapy as none was found in the EMR. The DON confirmed there was no therapy care plan in the EMR because R5 was considered respite, and she did not think a care plan for out-patient was required. Review of the facility policy titled, Comprehensive Care Plans, revised 03/01/25, revealed, . It is the policy of this facility to develop and implement a comprehensive person-centered care plan 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 . NJAC 8:39-11.2(e) thru (i) NJAC 8:39-27.1(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure regularly scheduled care conferences were conducted and residents were invited to participate in their care plan processes for two of four residents (Residents (R) 68 and R9) reviewed for care planning out of a total sample of 26. The deficient practice had the potential to cause poor health decisions and treatment and decrease resident satisfaction with care. Findings include: 1. Review of R68's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 08/06/25 and located in the MDS tab of the electronic medication record (EMR), revealed an admission date 04/30/22. It was recorded R68 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R68 was cognitively intact. It was recorded R68 had diagnoses of cancer, heart failure, and diabetes mellitus. Review of R68's Care Plan Note, dated 02/12/25 and located in the EMR under the Progress Notes tab, revealed, . Care plan meeting was held for resident. Resident, resident [family member], SW [social worker], and UM [unit manager] in attendance . Review of R68's MDS, located in the EMR under the MDS tab, revealed a comprehensive MDS assessment was submitted on 05/12/25 and a quarterly MDS assessment was submitted on 08/15/25. Review of R68's Progress Notes tab revealed no documented evidence care plan conferences were held for R68 following the 05/12/25 and 08/15/25 MDS assessments. On 09/10/25 at 9:37 AM, R68 was asked if he was invited and/or attended his care conferences. R68 stated he had not been invited or attended a care conference in a very long time. During an interview on 09/11/25 at 10:12 AM, the Regional Social Worker (RSW) was asked about R68's care conferences. The RSW stated she had only been at the facility for the past three weeks filling in, as the previous social worker's last day was 08/14/25. The RSW confirmed the care plan meeting notes were in the progress notes. The RSW was asked if there were any more care conferences for R68 since February 2025 as this was the last documentation in the progress notes and if there should have been care conferences held following the May and August MDS assessments. The RSW stated if nothing more was documented, she did not have anything more than what the surveyor had. 2. Review of R9's admission Record, located under the Profile tab of the EMR, revealed R9 was admitted to the facility on [DATE] with diagnoses that included iron deficiency anemia, hypertension, and anxiety disorder. Review of R9's annual MDS, with an ARD of 08/25/25 and located under the MDS tab of the EMR, revealed R9 had a BIMS score of 15 out of 15, which indicated R9 was cognitively intact. Review of R9's Progress Notes tab of the EMR revealed no documented evidence of care plan (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meetings for R9. During an interview on 09/09/25 at 11:10 AM, R9 stated she did not recall being invited to any care plan meetings or attending any care plan meetings since her admission. During an interview on 09/12/25 at 11:58 AM, the RSW stated that she had not found any documentation of any care plan meetings for R9 since her admission. The RSW stated she had scheduled a care plan meeting for 09/15/25 at 2:00 PM. Review of the facility policy titled, Care Planning-Resident Participation, dated 09/01/24, revealed, . This facility supports the resident's right to be informed of, and participate in his or her care planning and treatment (implementation of care) . The facility will honor the resident's right to participate in establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care . The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan . NJAC 8:39-11.2

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide care for a dialysis catheter after dialysis was discontinued for one of three residents (Resident (R) 51) reviewed for dialysis and failed to ensure the wound vac settings were correct for one of one resident (R97) reviewed for wound vac of 26 sample residents. The deficient practice has the potential to cause infection or tissue damage.Findings include: 1. Review of R51's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was re-admitted on [DATE] with diagnoses that included dependence on renal dialysis and surgical aftercare following surgery on the circulatory system. Review of R51's five-day Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 08/29/25, indicated the resident received dialysis on admission and while a resident and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 09/09/25 at 1:14 PM, R51 stated he had a dialysis catheter and was on dialysis until 08/27/25. R51's right chest dialysis catheter was observed with the dressing hanging from the catheter and the insertion site was exposed. During observation on 09/12/25 at 10:55 AM, R51's dialysis catheter dressing continued to hang from the dialysis catheter, not covering the insertion site. R51 stated staff have not cared for the dialysis catheter since he had dialysis on 08/27/25. Review of R51's Physician Orders, located under the Orders tab of the EMR, showed no order for care of R51's dialysis catheter. During an interview on 09/12/25 at 10:57 AM, the Director of Nursing (DON) stated that R51 no longer needed dialysis and that the physician was monitoring his blood work for a couple of weeks. The DON stated she was unable to provide any information regarding the care provided for R51's dialysis catheter but would find out. During an interview on 09/12/25 at 3:00 PM, the DON stated orders for the dialysis catheter care were obtained and the dialysis catheter site has been cleaned and dressed. The DON stated the type of dressing needed was a sterile central line dressing change which included the use of gown, mask, cleansing wipes, and clear occlusive dressing. The DON stated Unit Manager (UM) 2 changed the dressing and that Licensed Practical Nurses (LPNs) had been training in sterile dressing changes. Competencies for LPNs were reviewed. The DON stated that she was responsible for oversight of all nursing care. During an interview on 09/12/25 at 3:46 PM, UM2 stated that she completed the dressing change for R51's dialysis catheter and that she had received training on performing sterile central line dressing changes. UM2 stated the correct procedure for performing the sterile central line dressing change. UM2 stated the risks of not caring for the dialysis catheter could include risk of infection and sepsis. Review of the facility's policy titled, Care and Maintenance of Central Venous Catheter, dated 09/01/24, included Assess the central line routinely: Assess the site for signs of infection: redness, tenderness, pain or swelling at the insertion site; Ensure the dressing is clean, dry, and intact. Change immediately if soiled, wet, or dislodged . 2. Review of R97's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted on [DATE] with diagnoses that included cutaneous abscess of groin and disruption of external operation (surgical) wound. Review of R97's five-day MDS, located under the MDS tab of the EMR and with an ARD of 08/31/25, indicated the resident had a wound infection, surgical wound, received surgical wound care; and had a BIMS score of 12 out of 15, which indicated the resident was moderately cognitively impaired. Review of R97's Care Plan, located under the Care Plan tab of the EMR and dated 08/27/25, revealed the resident had a wound vac suctioning at 120 millimeters of Mercury (mmHg) to the left groin related to an abscess. During an interview on 09/09/25 at 12:50 PM, R97 stated his wound vac was not connected but the nurse would hook it back up shortly. R97 was observed without his wound vac connected. Review of R97's Physician's Orders, dated 08/27/25 and located under the Orders tab of the EMR, included an order to cleanse the wound to the left groin with normal saline solution and apply wet-to-dry dressing when the wound vac was (continued on next page)

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	315342	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Brick LLC	415 Jack Martin Blvd Brick, NJ 08724

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not in place. Review of R97's Physician Orders, dated 08/27/25 and located under the Orders tab of the EMR, revealed an order for a wound vac to the left groin, cleanse wound with normal saline solution, apply sponge to wound bed, apply skin prep to wound edges, and apply transparent drape over the sponge. It was recorded the wound care was to be completed Mondays, Wednesday, and Fridays, with continuous suction at 120 mmHg. During an observation on 09/11/25 at 1:46 PM, R97's wound vac setting was at 150 mmHg continuous suction. R97 stated he did not have any problems with the wound vac and that it had not been beeping. The wound vac setting was verified with Registered Nurse (RN) 1 at 150 mmHg continuous suction. RN1 went to the EMR to verify the wound vac order and stated the order was for 120 mmHg continuous suction. She stated the last dressing change was completed today (09/11/25) because it was in his groin and was difficult to maintain a seal. RN1 then went and adjusted the setting on the wound vac to 120 mmHg. Review of the facility's policy titled, Negative Pressure Wound Therapy (NPWT), dated 09/01/24, revealed, . Negative pressure wound therapy will be provided in accordance with physician orders, including the desired pressure setting, continuous or intermittent therapy, and frequency of dressing change. Clean technique shall be utilized unless otherwise specified by the physician . Monitoring throughout the use of NPWT shall include, but is not limited to, the following: pain associated with the therapy, device is functioning, Settings as prescribed. troubleshooting of any alarms, in accordance with pump/product specifications, and response of the therapy, including wound characteristics and progress towards healing . NJAC 8:39-27.1(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and review of facility policy, the facility failed to ensure one of three sampled residents (Resident (R) 6) reviewed for entrapment hazards did not have a large gap between their side rail and mattress. Large gaps between the siderails and the mattress have the potential to entrap the resident which could cause strangulation death or injury. Findings include: Review of R6's Care Plan, dated 08/11/24 and located under the Care Plan tab of the EMR, revealed focuses related to side rail safety. Goals included the resident maintaining independence and mobility using side rails and not incurring injury related to the side rails. Review of R6's significant change Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 07/21/25, revealed R6 had degenerative dementia, upper and lower extremity impairments on one side, required moderate help to rolling from side to side and from sitting to standing. It was recorded R6 had a Brief Interview of Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Review of R6's Physician Order, dated 09/01/25 and located under the Orders tab of the EMR, revealed an order for bilateral side rails for bed mobility. Review of R6's fall assessment, dated 09/07/25 and provided by the facility, revealed a new intervention of a perimeter mattress to help prevent falls from the bed. During an observation on 09/09/25 at 10:04 AM, R6 was lying in her bed on her back with the top two side rails on both sides of the bed up. A perimeter mattress was in place. During an observation and interview with the Unit Manager (UM) 1 on 09/11/25 at 9:40 AM, R6's side rails were observed. From the head of the bed and extending towards the foot of the bed two feet, a gap 4.5 inches wide was observed between the right siderail and the mattress. UM1 stated R6 had received a new mattress as a fall prevention intervention a few days earlier. UM1 verified the measurement of the gap. During an interview on 09/11/25 at 10:00 AM, the Maintenance Director (MD) confirmed there was a 4.5-inch gap between the right siderail and the mattress for R6. The MD stated safety checks were completed on all beds in the facility on 01/25/25; however, R6's bed was a hospice bed, and he was not allowed to touch the hospice beds. The MD provided a side rail check, dated 07/16/25, showing that R6's bed had been assessed for safety. There was no documentation provided to show R6's bed had been checked for safety after receiving the new mattress. During an interview on 09/11/25 at 10:25 AM, Hospice Aide (HA) 1 stated the gap had been noted when she arrived for her visit earlier in the morning. She stated a resident could get caught in the gap. Review of the facility's policy titled, Proper Use of Bed Rails, dated 09/01/24, revealed beds should be checked for the risk of entrapment between bedrails and mattresses. NJAC 8:39-5.1(a)NJAC 8:39-27.1(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of policies and procedures, the facility failed to provide a packed meal for dialysis according to the physician order for one of four residents (Resident (R) 100) reviewed for dialysis out of a total sample of 26. Failure to provide a diabetic and renal patient meals could result in a change in blood sugar levels or kidney function.Findings include: Review of R100's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R100 was admitted to the facility on [DATE] with diagnoses that included type II diabetes mellitus with mild non-proliferative diabetic retinopathy without macular edema, dependence on renal dialysis, and chronic kidney disease. Review of R100's Physician Order, dated 09/03/25 and located under the Orders tab of the EMR, revealed R100 was to receive a packed breakfast to take to dialysis on Tuesdays, Thursdays, and Saturdays. Review of the admission care plan, dated 09/05/25 and located under the Care Plan tab of the EMR, revealed a care plan to eat 50% of meals and follow the diet as ordered. Review of R100's Medication Administration Record (MAR), dated 09/2025, revealed no documented evidence R100 received the packed breakfast on 09/04/25, 09/09/25, or 09/11/25. There was no reason listed for not receiving the breakfast. It was noted on 09/06/25 that R100 did not receive the packed breakfast due to diarrhea. During an interview on 09/12/25 at 10:05 AM, R100 stated he did not receive a packed breakfast for dialysis on 09/11/25 as scheduled. He stated he would like a packed breakfast as he was starving when he returned home. During an interview on 09/12/25 at 11:00 AM, the Unit Manager (UM) 2 revealed R100 did not have a Brief Interview for Mental Status (BIMS) because he was a new admit but could be forgetful. During an interview on 09/12/25 at 11:05 AM, the Dietary Manager (DM) stated each day, dietary staff printed snack tickets for preparation and distribution to the first-floor pantry refrigerator, including R100's packed breakfast for dialysis. During an observation on 09/12/25 at 11:10 AM, the first-floor pantry resident refrigerator was inspected. Neither the previous day's packed breakfast nor a packed breakfast for 09/13/25 was found. The dietary manager confirmed at the time of this observation his breakfast meal was not in the refrigerator from the night before (Thursday) or the next day (Saturday) or any other day. During an interview on 09/12/25 at 11:15 AM, the Registered Dietician (RD) stated it was her expectation that the packed breakfast ordered by the physician be provided on each day of dialysis. Review of the facility's policy titled, Frequency of Meals, dated 09/28/24, revealed, . The facility will ensure that each resident receives at least 3-meals daily without extensive time lapses between meals . NJAC 8:39-27.1(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and review of policies and procedures, the facility failed to assess the entrapment risk of a new perimeter mattress used to prevent falls for one of three residents (Resident (R)6) reviewed for accident hazards out of a total sample of 26. Failure to assess and determine hazards could lead to injury, entrapment, or death.Findings include: Review of R6's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R6 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, unspecified severity without behavior disturbance, psychotic disturbance, mood disturbance and anxiety, muscle weakness, and delusional disorder. Review of R6's Care Plan, dated 08/11/24 and located under the Care Plan tab of the EMR, revealed focuses related to side rail safety. Goals included the resident maintaining independence and mobility using side rails and not incurring injury related to the side rails. Review of R6's significant change Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 07/21/25, revealed R6 had degenerative dementia, upper and lower extremity impairments on one side, required moderate help with rolling from side to side and from sitting to standing. It was recorded R6 had a Brief Interview of Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Review of R6's most recent side rail assessment, dated 07/25/25 and located in the Assessment tab of the EMR, revealed the assessment did not address the type of mattress and it's fit to the bed, gaps between the bed and siderails, and if there was a threat to entrapment. Review of R6's fall assessment, dated 09/07/25 and provided by the facility, revealed a new intervention of a perimeter mattress to help prevent falls from the bed. Review of R6's Assessment tab revealed no documented evidence R6's bed, mattress, and siderails were assessed for accident hazards after the new mattress was provided. During an observation and interview with the Unit Manager (UM) 1 on 09/11/25 at 9:40 AM, R6's side rails were observed. From the head of the bed and extending towards the foot of the bed two feet, a gap 4.5 inches wide was observed between the right siderail and the mattress. UM1 stated R6 had received a new mattress as a fall prevention intervention a few days earlier. UM1 verified the measurement of the gap. During an interview on 09/11/25 at 10:00 AM, the Maintenance Director (MD) confirmed there was a 4.5-inch gap between the right siderail and the mattress for R6. The MD provided a side rail check, dated 07/16/25, showing that R6's bed had been assessed for safety. There was no documentation provided to show R6's bed had been checked for safety after receiving the new mattress. The MD stated R6's bed belonged to hospice and he was not allowed to touch the hospice beds. Review of the facility's policy titled, Proper Use of Bed Rails, dated 09/01/24, showed in item three that assessments of hazards such as climbing over the rails or through and around the rails should be done. Item four showed the need to assess the risk of entrapment between the bedrails and mattresses. NJAC 8:39-5.1(a)NJAC 8:39-27.1(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interview, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 46) observed for medication administration was free from significant medication errors when R46 did not receive the correct ordered dosage of Gleevec (a chemotherapy, cancer treatment medication) of 26 sample residents. This failure had the potential to cause adverse drug reactions with the lack of effectiveness of the medications in the event of underdosing.Findings include: Review of R46's admission Record, located in the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with diagnoses that included chronic myeloid leukemia having not achieved remission. Review of R46's admission Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 07/01/25 revealed R46 had a diagnosis of cancer. Review of the September 2025 Medication Administration Record (MAR), revealed the order for Gleevec Oral Tablet 400 MG [milligrams] (Imatinib Mesylate), Give two tablets by mouth one time a day, which originated on 09/07/25. During a medication administration observation at the Lightening Hall medication cart with Registered Nurse (RN) 1 on 09/11/25 at 9:13 AM, RN1 pulled a medication card out of the medication cart for R46 that contained Imatinib 400-mg tablets. RN1 entered R46's room and administered one 400-mg tablet of Imatinib to the resident, then returned to the cart and signed the order as completed. She then moved on to the next resident. During an interview on 09/11/25 at 10:27 AM, RN1 confirmed she administered one 400-mg tablet of Imatinib to R46 and confirmed the order on the MAR and in the resident's record was for 800 mg. RN1 confirmed she should have administered two 400-mg tablets of Imatinib to R46 instead of one 400-mg tablet, and would provide the additional necessary medication for a total dose of 800 mg. During an interview on 09/0512/25 at 5:33 PM, the Director of Nursing (DON) stated medications should be administered as ordered by the physician, following the six rights of medication administration. The DON stated Imatinib was considered a significant medication as it was a chemotherapy medication used to treat cancer.Review of the facility's policy titled, Medication Administration, dated 09/01/24, revealed Medications 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.Ensure that the six rights of medication administration are followed: Right resident, Right drug, Right dosage, Right route, Right time, Right documentation . Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. NJAC 8:39-29.2(d)