STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Center at Bloomingdale	255 Union Ave Bloomingdale, NJ 07403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS, an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 2 (two) of 21 residents (Resident #2 and #6) during the review of resident assessment. This deficient practice was evidenced by the following: The MDS is a comprehensive tool, a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 8/25/25 at 9:06 AM, the surveyor interviewed the Corporate Director of Clinical Reimbursement (CDCR) about the MDS Coordinator (MDSC). The CDCR stated that there are two MDSCs, one who works remotely and does not go to the facility, and the other one is working full-time but on vacation. The surveyor provided the CDCR with the list of 2 residents who had not completed an MDS in over 14 days. The surveyor also requested a copy of the resident's final validation report (generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On 8/25/25 at 12:06 PM, the surveyor interviewed the CDCR, who stated that the MDS was submitted late because the MDSC was on vacation. On the same day, the surveyor reviewed with the CDCR the 2 residents' MDS assessments that were not submitted within fourteen days of completion as follows: 1. Resident #2 admission MDS (A/MDS) assessment has an assessment reference date (ARD, the last day of the observation period) of 6/9/25. It was signed as completed on 6/17/25 and not transmitted until 6/30/25. 2. Resident #6 A/MDS assessment has an ARD of 7/21/25. It was signed as completed on 7/30/25 and not transmitted until 8/5/25. On 8/26/25 at 1:06 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Regional Clinical Coordinator (RCC) regarding the above concern but did not provide further information. NJAC 8:39-11.1

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Repeat Deficiency Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for two (2) of 21 residents, (Residents #15 and #114) reviewed for MDS accuracy, and was evidenced by the following: 1.The surveyor observed Resident #15 on 8/22/2025 at 12:00 pm eating lunch in the unit dining room. An observation of the resident’s room on 8/25/25 at 9:35 am revealed signage on the door leading to the room indicating the resident was on Enhanced Barrier Precautions (EBP). A plastic bin was placed at the entrance to the room in the hallway containing personal protective equipment (PPE). A review of the resident’s care plan indicated the resident was on EBP because of a history of multiple drug-resistant organisms (MDRO) in the urine. Additionally, the resident was care planned for a diagnosis of diabetes and the use of insulin therapy. The June 2025 Medication Administration Record (MAR) indicated the resident received Humalog (insulin) during the period of 6/12/25 through 6/19/25. A review of the 6/19/25 quarterly MDS indicated the facility failed to code the resident for having had a history of MDRO (Section I1700) and having had insulin in the past 7-day period of 6/12/25 to 6/19/25 (N0300). 2. On 8/25/2025 at 9:33 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #114, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #114 was admitted with diagnoses that included, but were not limited to, hypertensive heart disease without heart failure (conditions caused by high blood pressure) and dementia (loss of memory). A review of the admission MDS, dated [DATE], indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated that the resident had severe impaired cognition. Further review of the A/MDS in Section J – Fall History on Admission/Entry or Reentry B: Did the resident have a fall anytime in the last 2-6 months prior to admission/entry or reentry? 0. No. A review of the baseline Care Plan (CP) dated 10/2/24 under H. Safety Risks 31a. Specify fall during 2-6 months prior to admission revealed “as per daughter had a fall in July 2024.” A review of the “Admission/readmission Evaluation V6-V2” form dated 10/2/24 under “Section B. History of Falls (past 3 months) 2. 1-2 falls in the past 3 months and Section R. Fall Risk” revealed that Resident #114 has a score of 13.0. A review of the CP report with an initiated date of 10/3/2024, with the focus on the resident is at risk for falls/injury related to unsteady gait. On 8/28/25 at 9:15 AM, the surveyor interviewed the Corporate Director of Clinical Reimbursement (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CDCR) regarding the concern above, but did not provide further information. NJAC 8:39-33.2 (d)

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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. Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive, person-centered care plan (CP) for a resident on long-term use of insulin medication. This deficient practice was identified in 1 (one) of the 21 residents (Resident#6) reviewed for CP.This deficient practice was evidenced by the following: On 8/22/2025 11:00 AM, the surveyor observed Resident #6 sitting in bed awake, alert, and able to answer the surveyor's inquiry. Resident #6 confirmed to the surveyor that they have had diabetes and are taking insulin injections. On 8/25/2025 at 1:16 PM, the surveyor reviewed the electronic Medical Record (eMR)/hybrid medical record (paper and electronic) of Resident #6, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #6 was admitted with diagnoses that included, but were not limited to, type 2 diabetes mellitus (high blood sugar levels). A review of the recent admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) dated 7/21/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident had intact cognition. Further review of the A/MDS in Section N recorded that Resident #6 is receiving injections. A review of the Order Summary Report (OSR) is as follows: 1. Lantus 100 unit/ml (milliliter) inject 30 units subcutaneously (SQ, fatty layer of the skin) at bedtime with the start date of 7/30/25.2. Novolog flexpen 100 unit/ml inject 5 units SQ before meals with the start date of 7/28/25.3. Novolog flexpen 100 unit/ml inject as per sliding scale: if 150-200 = 2 units; 201-249 = 4 units; 250-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units greater than 400 call MD, SQ before meals with the start date of 7/15/25. A review of Resident #6's comprehensive CP report revealed no CP for the use of insulin medication. On 8/26/2025 at 12:24 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the concern above. The LPN stated that there should be a CP for insulin use. On 8/25/2025 at 12:28 PM, the surveyor interviewed the LPN supervisor, who stated that the resident's CP should include the use of insulin medications. On 8/27/25 at 1:07 PM, the surveyor met with the Licensed Nursing Home Administrator, Director of Nursing, and Regional Clinical Coordinator; no further information was provided. A review of the facility policy titled Care Plans, Comprehensive Person-Centered with the revised date of 3/2022 stated under Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. NJAC 8:39-11.2(d)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that the resident's primary physician accurately dated their physician progress notes (PPN) during their visit to ensure the resident's current medical regimen was up to date. This deficient practice was observed for 3 of 21 residents (Residents #3, #6, and #10). This deficient practice was evidenced by the following: 1. On 8/22/2025 at 10:24 AM, the surveyor observed Resident #3 sitting in a wheelchair in the activity room. On 8/27/2025 at 1:46 PM, the surveyor reviewed the electronic Medical Record (eMR)/hybrid medical record (paper and electronic) of Resident #3, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #3 was admitted with diagnoses that included but were not limited to seizure disorder (abnormal electrical activity in the brain). A review of the recent quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care) dated 5/29/25 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had intact cognition. A review of the PPNs in the eMR reflected the following Effective Date, Created Date, and/or Late Entry (any documentation that is recorded in the eMR beyond 24-48 hours of the encounter is classified as a late entry) designation which indicated the PPN of medical doctor (MD) was not documented on the effective date (Date of Service): 1. PPN with an effective date of 6/9/25 and a created date of 8/13/25. 2. PPN with an effective date of 7/11/25 and a created date of 8/13/25. 3. PPN with an effective date of 8/2/25 and a created date of 8/13/25. 2. On 8/22/2025 11:00 AM, the surveyor observed Resident #6 sitting in bed awake, alert, and able to answer the surveyor's inquiry. On 8/25/2025 at 1:16 PM, the surveyor reviewed the hybrid medical record of Resident #6, which revealed the following: A review of the AR reflected that Resident #6 was admitted with diagnoses that included, but were not limited to, type 2 diabetes mellitus (high blood sugar levels). A review of the recent admission Minimum Data Set (A/MDS) dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 14 out of 15, which indicated that the resident had intact cognition. A review of Resident #6's PPN of MD in the eMR reflected the following: 1. PPN with an effective date of 7/16/25 and a created date of 7/28/25. 2. PPN with an effective date of 7/19/25 and a created date of 7/28/25. 3. PPN with an effective date of 7/23/25 and a created date of 7/27/25. 4. PPN with an effective date of 7/25/25 and a created date of 7/28/25. 5. PPN with an effective date of 8/1/25 and a created date of 8/13/25. 6. PPN with an effective date of 8/11/25 and a created date of 8/13/25. 3. On 8/25/2025 at 9:40 AM, Resident #10 is in the shower room. On 8/27/2025 at 12:47 PM, the surveyor reviewed the hybrid medical record of Resident #10, which revealed the following: A review of the AR reflected that Resident #10 was admitted with diagnoses that included, but were not limited to, heart failure (the heart cannot pump enough blood to meet the body's needs). A review of the annual MDS (An/MDS) dated [DATE] indicated that the facility assessed the residents' cognitive status using a BIMS score of 15 out of 15, which indicated that the resident had intact cognition. A review of Resident #10's PPN of MD in the eMR reflected the following: 1. PPN with an effective date of 4/12/25 and a created date of 8/16/25. 2. PPN with an effective date of 5/13/25 and a created date of 8/16/25. 3. PPN with an effective date of 6/11/25 and a created date of 8/16/25. 4. PPN with an effective date of 7/12/25 and a created date of 8/16/25. 5. PPN with an effective date of 8/4/25 and a created date of 8/16/25. On 8/27/2025 at 10:56 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the MD notes. The LPN stated that all the documentation is in their system. LPN added that she does not see the MD sitting in the nurses' station to document since she will do it remotely. On 8/27/2025 at 11:05 AM, the surveyor interviewed the MD over the phone, who stated that she is aware of the above concern and that she is uploading the PPN altogether at the same time because the company needed it for billing purposes. On 8/27/2025 at 1:07 PM, the team of surveyors met with (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Clinical Coordinator to discuss the above concern but did not provide further information. A review of the facility policy titled Physician Visits under Policy Interpretation and Implementation 5. The attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. 6. A physician visit is considered timely if it occurs not later than ten (10) days after the date the visit was required. However, the subsequent visit must be timed in relation to when the previous one was due, not to when it was made. NJAC 8:39-23.2(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Repeat Deficiency Based on observations, interviews, and record review, it was determined that the facility failed to ensure that all medications (meds) were administered without error of 5% or more. During the morning med administration observation on 8/26/25, the surveyor observed 1 (one) nurse administering meds to 1 resident (Resident #115). There were 25 opportunities, and 3 errors resulting in a total error rate of 12%.The deficient practices were evidenced by the following: On 8/26/25 at 8:24 AM, during the morning med administration pass (med pass), the surveyor observed a Licensed Practical Nurse (LPN) preparing to administer meds to Resident #115. At that time, the surveyor observed that the LPN prepared and administered crushed meds to Resident #115 that included the following: - two tablets (tabs) of ascorbic acid 500 mg. (milligrams) [2 tabs=1000 mg] -one tablet (tab) of vitamin B-12 1000 mcg. (microgram)-one tab Colace 100 mg. At that time, the LPN acknowledged that she gave two tabs of ascorbic acid for a total of 1000 mg [ERROR #1]. The LPN stated that the house stock for ascorbic acid comes in 500 mg tabs. At the same time, the LPN gave 1 tab of vitamin B12 1000 mcg, [ERROR #2], the LPN stated that the available house stock is vitamin B12 1000 mcg, and 1 tab Colace 100 mg [ERROR #3] orally to Resident #115. The LPN stated that the house stock of Colace comes in a tablet, and it needs to be crushed. The surveyor reviewed the electronic Medical Record (eMR) of Resident #115.A review of the admission Record (AR, an admission summary) reflected that Resident #115 was admitted with diagnoses that included but were not limited to pancytopenia (low amounts of all three types of blood cells) and type 2 diabetes mellitus (high sugar level in the blood) without complications. A review of the Order Summary Report (OSR) with an order date of 8/25/25 is as follows: 1. Vitamin C oral tablet (ascorbic acid), give 1000 mg by mouth one time a day as for supplement. 2. B-complex plus B-12 oral tablet (B-Complex Vitamins), give 1 tablet by mouth one time a day for supplement. 3. Colace oral capsule 100 mg (docusate sodium), give 1 capsule by mouth one time a day for constipation. On 8/26/25 at 1:06 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Coordinator regarding the above concern, but did not provide further information. A review of the facility policy titled Documentation of Medication Administration with the revised date of November 2022 stated under Policy Interpretation and Implementation 3. Documentation of medication administration includes, as a minimum: b. name and strength of the drug; c. dosage. A review of the facility policy titled Medication Orders with the revised date of November 2014 stated under Recording Orders 1. Medication Orders - When recording the orders for medication, specify the type, route, dosage, frequency, and strength of the medication ordered. NJAC 8:39-11.2(b), 29.2(d)