STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315349	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Inglemoor, LLC	333 Grand Ave Englewood, NJ 07631

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 0580 Level of Harm - Minimal harm or potential for actual harm 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. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #402154 (187228) Based on interviews, review of the closed medical records, and pertinent facility documents, it was determined that the facility failed to notify the Physician and Resident's Representative (RR) of resident's change in condition and status. This deficient practice was identified for 1 of 3 sampled residents (Resident #1), and was evidenced by the following: A review of the closed medical record for Resident #1 revealed: A review of the admission Record (AR) or face sheet (an admission summary) reflected that Resident #1 was admitted to the facility with a diagnoses that included but were not limited to; type 2 diabetes mellitus without complications, unspecified psychosis not due to a substance or known physiological condition, unspecified severe protein-calorie malnutrition, dementia in other diseases classified elsewhere, unspecified severity with agitation, and need for assistance with personal care. Further review of the AR revealed that the resident had two RR, Emergency Contact #1 (EC #1) and Emergency Contact #2 (EC #2). A review of the comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 5/9/25, reflected a brief interview for mental status (BIMS) score of 1, which indicated that the resident's cognition was severely impaired. A review of the Progress Notes (PN) revealed: Registered Nurse #1 (RN #1) documented on 5/9/25 at 9:51 PM that Resident #1 was in the dining area, mood remained labile and irritable, took all due medications (meds) well, was encouraged to walk with staff in the hallway with good effect, and ate their meals well. Registered Nurse #2 (RN #2) documented on 5/14/25 at 6:41 AM that Resident #1 slept all night, noted sedated, Seroquel (is an atypical antipsychotic medication used to treat various mental health conditions, including: Schizophrenia: Helps manage symptoms such as hallucinations and delusions. Bipolar Disorder: Used for both manic and depressive episodes. Major Depressive Disorder: can be prescribed in combination with other antidepressants) held this morning and was endorsed to morning shift nurse to communicate this side effects to physician or psychiatrist for meds adjustment. RN #1 documented on 5/15/25 at 11:26 PM that Resident #1 remained lethargic needed to be fed during dinner and meds. RN #1 documented on 5/16/25 at 10:13 PM that the resident was received in bed sleeping very hard to be awakened, remained sedated through the shift, and all due meds were held due to sedation. Registered Nurse #3 (RN #3) documented on 5/19/25 at 12:59 PM that the resident was seen by the Psychiatric Nurse Practitioner with new orders obtained and was carried out. Licensed Practical Nurse #1 (LPN #1) documented on 6/1/25 at 11:16 PM that resident's afternoon and evening meds were held and did not consume tray lunch, except for two cups of applesauce and 50% of Ensure. RN #1 documented on 6/2/25 at 6:51 AM that the resident remained sedated, Seroquel 25 mg po was held this morning. A review of the physician orders (PO) revealed: Date ordered 5/2/25, lorazepam 0.5 mg (milligram), to give one tablet (tab) by mouth at HS (bedtime) for anxiety/agitation. The order was discontinued (dc'd) on 5/9/25. Date ordered 5/2/25, mirtazapine 7.5 mg, to give one tab by mouth at HS for depression. The order was dc'd on 5/4/25. Date ordered 5/4/25, trazodone 50 mg, to give one tab by mouth at HS for depression. The order was dc'd on 5/9/25. Date ordered 5/9/25, trazodone 150 mg, to give one tab by mouth at HS for mood disorder and insomnia. Date ordered 5/2/25, Depakote sprinkle 125 mg, give two capsules (caps) for total of 250 mg 3x/day (three times a day) for mood disorder. The order was dc'd on 5/4/25. Date ordered 5/4/25, Depakote sprinkle 125 mg, give three caps (375 mg) 3x/day. Date ordered 5/3/25, Seroquel 25 mg, give 1 tab by mouth every 8 hours for psychosis, hold dose for sedation. Date ordered 5/19/25, Ativan (also known as lorazepam) 0.5 mg, to give one tab by mouth every six hours PRN (as needed) for anxiety for 30 days. Further review of the above PN revealed that there was no documented evidence that EC #1 and EC #2 were notified of the change in resident's condition, when the resident was noted sedated, meds were held, lethargic, and there were changes in resident's meds. There were no documented evidence that the physician was notified of resident's changes in condition on 5/14/25, 5/15/25, 5/16/25, and 6/1/25. On 11/7/25 at 1:33 PM, the surveyors met with the Director of Nursing (DON), who informed the surveyor that any residents who had change in condition, including lethargy or sedation that was not in their norm, it was an expectation that the nurse would notify the RR and the physician, and documented in the PN. At that same time, the surveyor notified the DON of the above findings and concerns that there were no documented evidence that the RR and the physician were notified of the change in the condition of the resident. The surveyor also asked for the facility's policy with regard to notification of change in condition. A review of the facility's Notification of Changes Policy that was provided by the DON, with a date reviewed/revised of 9/1/25, revealed that the facility promptly informs the resident, consults the

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #NJ187551 (402155)Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident received care and services for weight monitoring consistent with a physician's order and professional standards of practice. This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for nutrition. This deficient practice 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 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 regimes 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. On 11/7/25 at 9:00 AM, the surveyor reviewed the Electronic Medical Record (EMR) forResident #1. A review of Resident 1's admission Record (an admission summary) documented that the resident was admitted to the facility with diagnoses that included but were not limited to; severe protein-calorie malnutrition, dementia with agitation, persistent mood disorders, and unspecified psychosis. A review of the progress notes indicated the resident was admitted /readmitted to the facility from a geriatric psychiatric hospital. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference (ARD) of 5/9/25, reflected a Brief Interview Mental Status (BIMS) score of 1 out of 15, which indicated the resident had a severe cognitive impairment. Resident #1 was coded as having difficulty and or pain with swallowing. A physician's order (PO) dated 5/2/25, indicated weekly weights x 4 upon readmission/admission; A PO regular diet dated 5/2/25, and PO for ensure plus two times a day for help supplement dated 5/6/25. A review of the documented weights for Resident #1 revealed the following:- 5/2/25: 117.4 lbs (pounds)- 5/3/25: 118.6 lbs A review of the electronic Medication Administration Record (eMAR) and the electronic Treatment Administration Record (eTAR) for May 2025, revealed that there were no entries for the resident's weekly weights. A review of a Medical Nutrition Therapy Assessment by the Registered Dietitian (RD) dated 5/6/25, indicated Resident #1 was assessed as severely malnourished and underweight for their age. The RD recommended ensure twice a day and to honor the resident's food preferences. On 11/7/25 at 2:05 PM, the surveyor interviewed the Director of Nursing (DON), who stated that weights were completed upon admission, followed by one or two additional daily weights, then weekly weights for four weeks, and monthly weights for all residents. The DON confirmed that weekly weights had not been completed for Resident #1, as required by facility policy. On 11/7/25 at 2:14 PM, the surveyor conducted a telephone interview with the RD. The RD stated that the standard of practice was to obtain weights for all residents upon admission and daily for two or three days, then weekly for four weeks, and then monthly. The RD stated that she usually only monitored the residents' monthly weights. The RD acknowledged that Resident #1's weights should have been monitored weekly by her and the nursing staff. On 11/7/25 at 2:30 PM, the surveyor notified the DON, Licensed Nursing Home Administrator (LNHA), and [NAME] President (VP) of Clinical Services of the above observations and concerns. The DON acknowledged that the weekly weights were not done upon the resident's re-admission to the facility. A review of the facility's Weight Monitoring Policy, dated 9/1/25, revealed under Compliance Guidelines: .5. A weight monitoring schedule will be developed upon admission for all residents: a. Newly admitted residents- Weight on admission and monitor weight weekly for four weeks b. If clinically indicated- monitor weight daily c. All others- monitor weight monthly . NJAC 8:39-11.2(b); 27.1(a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review it was determined that the facility failed to maintain a complete record for 1 of 3 residents records reviewed (Residents #1). The deficient practice was evidenced by the following: A review of the closed medical record for Resident #1 revealed: A review of the admission record (AR) or face sheet (an admission summary) reflected that Resident #1 was admitted to the facility with a diagnoses that included but were not limited to; type 2 diabetes mellitus without complications, unspecified psychosis not due to a substance or known physiological condition, unspecified severe protein-calorie malnutrition, dementia in other diseases classified elsewhere, unspecified severity with agitation, and need for assistance with personal care. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 5/9/25, reflected a brief interview for mental status (BIMS) score of 1, which indicated that the resident's cognition was severely impaired. A review of the physician orders (PO) revealed: Date ordered 5/2/25, lorazepam 0.5 mg (milligram), to give one tablet (tab) by mouth at HS (bedtime) for anxiety/agitation. The order was discontinued (dc'd) on 5/9/25. The order was plotted in May 2025 electronic Medication Administration Record (eMAR) as administered except on 5/5/25 and 5/8/25. Licensed Practical Nurse #1 (LPN #1) on 5/5/25 documented 3 (hold/see Progress Notes) and LPN #2 on 5/8/25 documented 3. There were no documented evidence that LPN #1 and LPN #2 documented in the Progress Notes (PN) as to why the medication (med) was held. Date ordered 5/2/25, mirtazapine 7.5 mg to give one tab by mouth at HS for depression. The order was dc'd on 5/4/25. Date ordered 5/4/25, trazodone 50 mg, to give one tab by mouth at HS for depression. The order was dc'd on 5/9/25. The order was plotted in May 2025 eMAR as administered except on 5/5/25. LPN #1 on 5/5/25 documented 3 and there were no documented evidence that LPN #1 documented in the PN as to why the med was held. Date ordered 5/9/25, trazodone 150 mg, to give one tab by mouth at HS for mood disorder and insomnia. The order was plotted in May 2025 eMAR as administered except on 5/16/25, 5/25/25, and 5/31/25. Registered Nurse #1 (RN #1) on 5/16/25 documented 3, and RN #2 on 5/25/25 documented 3. RN #2 on 5/31/25 documented 9 (meant resident was sleeping). There were no documented evidence that RN #2 documented in the PN as to why the med was held on 5/25/25. Date ordered 5/2/25, Depakote sprinkle 125 mg, give two capsules (caps) for total of 250 mg 3x/day (three times a day) for mood disorder. The order was dc'd on 5/4/25. Date ordered 5/4/25, Depakote sprinkle 125 mg, give three caps (375 mg) 3x/day. Date ordered 5/3/25, Seroquel 25 mg, give 1 tab by mouth every 8 hours for psychosis, hold dose for sedation. Date ordered 5/19/25, Ativan (also known as lorazepam) 0.5 mg, to give one tab by mouth every six hours PRN (as needed) for anxiety for 30 days. The order was plotted in May 2025 eMAR as administered except on the following dates and times were coded 3, and there were no documented evidence that nurses documented in the PN as to why the med was held: 5/8/25 2200 (10:00 PM)5/13/25 10:00 PM (10 PM)5/14/25 0600 (6:00 AM)5/15/25 1400 (2:00 PM)5/16/25 2:00 PM (2 PM)5/25/25 10 PM5/31/25 2 PM and 10 PM (was coded 9) On 11/7/25 at 1:33 PM, the surveyors met with the Director of Nursing (DON), and the surveyor notified the DON of the above findings and concerns. On that same date and time, the surveyor and the DON reviewed the unit assignments for May 2025 and June 2025. The DON stated that the unit assignments were considered care of resident and part of medical records of the residents. The DON confirmed that the May 2025 unit assignments for the second floor were incomplete and the only available dates for review of the surveyor were from dates: 5/4/25 for 7-3 and 3-11 shifts, 5/11/25 for 7-3 shift, and 5/15/25 for 3-11 and 11-7 shifts. She also confirmed that the 6/2/25 for 3-11 and 11-7 shifts were missing. On 11/7/25 at 2:51 PM, the surveyors met with the DON and the [NAME] President of Clinical Services, and there were no additional information provided by the DON. The DON acknowledged that the resident's medical records of resident should be complete. There was no policy provided with regard to medical records. NJAC 8:39-35.2 (d)(5)(6)(e)(f)(k)