| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315349 | A. Building<br>B. Wing | 03/13/2025 |

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

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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>48781<br><br>Based on observation, interview, and record review it was determined that the facility failed to keep the call bell within reach for a resident who required assistance from staff and who was able to use a call bell. This deficient practice was identified for 1 of 17 residents reviewed, Resident #48, and evidenced by the following:<br><br>On 3/10/25 at 9:22 AM, the surveyor observed Resident #48's door closed. The Certified Nursing Assistant (CNA) was inside the room providing morning hygiene (AM) care to the resident.<br><br>On 3/10/25 at 9:50 AM, the surveyor entered the resident's room after the CNA was done with AM care. The surveyor observed the resident lying in their bed and the resident's call bell on the floor at the right side of the bed. The surveyor asked Resident #48 how they called for assistance. The resident stated, they would call the nurse by shouting out help!<br><br>On 3/10/25 at 12:13 PM, the surveyor entered to the resident's room and observed that the call bell remained on the floor on the right side of the bed. The CNA was asked to accompany the surveyor to the resident's room. The CNA confirmed the call bell was on the floor and stated, I don't know how it got there . It's supposed to be on the bed so [the resident] can reach it.<br><br>On that same date and time, the surveyor notified the CNA that the call bell was also observed earlier on the floor after AM care was provided. The CNA provided no additional response and proceeded to attach the call bell on the fitted sheet next to the resident within their reach.<br><br>On 3/10/25 at 1:00 PM, the surveyor reviewed the Electronic Health Record (EHR) of Resident #48.<br><br>A review of the Admission Record (face sheet; an admission summary) included the resident had diagnoses that included, but were not limited to; a fracture of the left femur (a long bone located in the thigh), heart failure, and multiple myeloma (a type of blood cancer).<br><br>A review of a comprehensive Minimum Data Set (MDS), an assessment tool, dated 2/16/25, reflected a Brief Interview of Mental Status (BIMS) score of 6 out of 15 indicating the resident had severe cognitive impairment. Additionally, Resident #48 required maximal assistance with Activities of Daily Living (ADLS) such as, oral hygiene, dressing, personal hygiene, and showering.<br><br>On 3/10/25 at 1:49 PM, the surveyor requested from the License Nursing Home Administrator (LNHA), the facility's call bell policy.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/11/25 at 10:56 AM, the surveyor interviewed Resident #48 regarding their call bell use. The resident explained that they used the call bell by pressing the button to call for staff assistance. The resident proceeded to pick up the call bell and demonstrate the red button on the call bell.<br><br>On 3/11/25 at 1:22 PM, the surveyor notified the LNHA, the Regional LNHA and the Regional [NAME] President of Clinical Services (RVPoCS) regarding the call bell concern, and that the CNA confirmed the call bell was not within reach of the resident.<br><br>On 3/12/25 at 2:14 PM, the LNHA and the Director of Nursing (DON) met with the survey team. The DON stated staff education was initiated. The LNHA acknowledged it was expected for residents to have access to their call bells and that it should be within reach of the resident.<br><br>A review of the facility's Call Lights Policy and Procedure dated 1/2025, revealed, Always position call light conveniently for use and within the reach of the resident.<br><br>NJAC 8:39-4.1(a), 27.1(a) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049<br><br>Based on observation, interview, record review, and review of other facility documents, it was determined the facility failed to ensure accurate documentation and review of a resident's advance directives for 1 of 3 residents, (Resident #13) reviewed.<br><br>This deficient practice was evidenced by the following:<br><br>1. On [DATE] at 12:09 PM, the surveyor reviewed the Electronic Medical Record (EMR) of Resident #13.<br><br>According to the Admission Record (admission summary) Resident #13 had diagnoses that included but were not limited to; respiratory failure, chronic obstructive pulmonary disease (a lung condition that blocks airflow and makes it difficult to breathe), and heart failure.<br><br>A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [DATE], reflected a Brief Interview Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact.<br><br>A review of physician's order (PO) dated [DATE], indicated the resident's code status as Do Not Resuscitate (DNR) and Do Not Intubate (DNI).<br><br>A review of the resident's care plan (CP) included a focus area which indicated [Resident #13] had an established advance directive DNR/DNI. The CP had an initiation date of [DATE].<br><br>On [DATE] at 12:24 PM, the surveyor reviewed the paper chart of Resident #13 which included a New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form, dated [DATE]. The POLST documented the resident desired attempt resuscitation/CPR [Cardiopulmonary Resuscitation] and Do not intubate. The form was signed by the resident and a physician.<br><br>On [DATE] at 12:30 PM, the surveyor interviewed the Director of Nursing (DON)about the facility's advance directives process. The DON stated nursing and social services, determined upon admission the resident's code status and if the resident had any advance directives. The nurse or social worker (SW) would provide education on advance directives to residents and offer them the opportunity to complete a POLST indicating their wishes. The physician would see the resident, discuss with the resident their wishes and sign the POLST once completed. The DON further explained nursing was responsible to ensure the PO and the resident's CP was updated.<br><br>On the same date and time, the surveyor reviewed with the DON the resident's chart which included the POLST dated [DATE], and the resident's EMR which included a DNR/DNI order. The DON stated the resident came in with a DNR/DNI status and had previously been DNR/DNI in the hospital. The DON stated she would have to clarify with the resident about their wishes as she was not the one who was present when the POLST was completed.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 2:06 PM, the surveyor interviewed the SW and the regional SW (RSW) about advance directives. The RSW stated residents were asked upon admission if they had any advance directives and would offer to help them make one if they did not. The residents and/or resident's representative (RR) would be provided information about advance directives and offered the opportunity to complete a POLST to make their wishes known. The SW, the nurses, and the nurse practitioner or physician took part in assisting a resident and/or the RR with completing a POLST. The RSW continued that the nurses were responsible for updating the EMR and entering the orders per the physician for a resident's advance directives.<br><br>On the same time and date, the surveyor discussed the above concerns for Resident #13's completed POLST and the PO. The SW stated that she had provided and reviewed the POLST with the resident. The SW stated that the resident had read the POLST, filled out the form on their own and signed it. The SW further explained that she believed the resident had verbalized wanting to be resuscitated. The SW could not speak to the nurses being aware of the POLST's completion. The SW and regional SW stated they would follow up with the DON to clarify the resident's POLST.<br><br>On [DATE] at 1:21 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the regional LNHA, and the Regional [NAME] President of Clinical Services (RVPoCS) of the above concerns. The RVPoCS stated the staff went to Resident #13 to clarify their code status and the physician also met with the resident. The RVPoCS stated the resident was unsure of their desired wishes, wanted to discuss it with their family, and the completed POLST for attempt to resuscitate/DNI would remain in effect.<br><br>On [DATE] at 2:13 PM, the DON and the LNHA met with the survey team. The DON stated that the resident's code status was clarified, and the resident completed a new POLST with their family to indicate DNR/DNI. The DON acknowledged that upon completion of the resident's POLST on [DATE], the code status in the EMR should have been updated to reflect the resident's wishes. There was no additional information provided by the facility.<br><br>A review of the facility's Advance Directives Policy, with a last updated date of [DATE], indicated under Policy Interpretation and Implementation: .9. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive .<br><br>N.J.A.C. 8:,d+[DATE].6 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>48781<br><br>Complaint NJ#161311<br><br>Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to conduct a thorough investigation to address an allegation of abuse. This deficient practice was identified for 1 of 7 residents, Resident #310, reviewed for alleged abuse and was evidenced by the following:<br><br>On 3/7/25 at 10:02 AM, during the entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), the regional LNHA, and the Regional [NAME] President of Clinical Services (RVPCS) for reportable event investigations from February 2023.<br><br>On 3/10/25 at 9:00 AM, the surveyor requested from the LNHA for Facility Reportable Event (FRE) investigations from February 2023 for Resident #310.<br><br>On 3/10/25 at 10:00 AM, the LNHA provided a FRE which included an AAS-45 (Reportable Event Record/Report) submitted to the NJDOH and an investigate summary and conclusion.<br><br>A review of the provided FRE documentation dated 2/8/23 revealed the facility submitted an AAS-45 to the NJDOH on 2/8/23. The AAS-45 identified Certified Nurse Aide (CNA) #1 as the staff involved in the incident. The report indicated on 2/8/23 at approximately 9:03 AM that CNA #1 reported Resident #310 sustained a cut to his/her left eyebrow when the overbed table hit the resident. The narrative of the report revealed CNA #1 stated that the resident was eating his/her breakfast, raised the head of the bed too high which caused the overbed table to tilt, and the resident's food to fall on the floor. The overbed table was stuck underneath the bed. CNA#1 tried to pull the table from underneath the bed, and at the same time the resident was raising the head of the bed with the remote. As the overbed table was released from underneath the bed, the end of the table hit the resident's left forehead. CNA #1 immediately reported to the nurse. The DON and the LNHA interviewed Resident #310 who stated that the CNA was moving the overbed table and hit his/her eye but believed it was not intentional.<br><br>Interventions of the AAS-45 included, Resident #310 was assessed for injury and had a 1 centimeter (cm) straight cut with acute bleeding on their left eyebrow; a pressure dressing was applied, and the resident was transferred to a hospital emergency room (ER) for further evaluation. The CNA and the nurse (not identified in the AAS-45) were suspended pending the outcome of the investigation; the local police department was notified, and officers interviewed Resident #310 and CNA #1.<br><br>The facility's Investigative Summary and Conclusion, completed by the DON and dated 2/9/23 revealed the following:<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Incident Summary: On 2/8/23 at approximately 9:05 AM, CNA #1 reported that Resident#310 sustained a cut to his/her left eyebrow. CNA #1 stated that the resident was eating his/her breakfast and raised the head of the bed too high which caused the overbed table to tilt, and the resident's food fell on the floor. The overbed table was stuck underneath the bed. CNA#1 tried to pull the table from underneath the bed, and at the same time the resident was raising the head of the bed with the remote. As the overbed table was released from underneath the bed, the end of the table hit the resident's left forehead. CNA#1 immediately reported it to the nurse. Resident #310 sustained a 1 cm cut to the left eyebrow which was actively bleeding. The site was cleansed with normal saline, and a pressure dressing was applied prior to the resident's transfer to the ER.<br><br>Conclusion: The LNHA and the DON at the time of the incident interviewed Resident #310. The resident reported, the CNA was moving the overhead table hastily, and it hit his eye and that the resident believed it was an accident, not intentional. The resident's family arrived during the event and alleged the nurse delayed first aid treatment. CNA #1 was interviewed and stated that the table inadvertently hit the resident's forehead when she removed the overbed table stuck underneath the bed. LPN#1 was interviewed and reported that she immediately attended to the resident and provided first aid to prevent bleeding as the resident was on a blood thinner medication. The police officers who arrived at the facility, took statements from Resident #310 and CNA #1, and the police report had not been received yet by the facility.<br><br>There were no witness statements or additional information provided with the facility's investigation.<br><br>On 3/11/25 at 1:54 PM, the survey team met with the LNHA, Regional LNHA and RVPCS. The surveyor asked if the investigation provided was the facility's complete investigation and if there was any supportive documentation including individual statements. The RVPCS stated the facility was continuing to look for the documentation. The RVPCS further explained that the current DON and LNHA were not present at the time of the event, it was a previous administration team, and it was difficult to locate where everything was stored.<br><br>The surveyor reviewed the Electronic Medical Record (EMR) of Resident #310.<br><br>The Admission Record (face sheet; a summary of important information about the resident) revealed Resident #310 had diagnoses which included but were not limited to, atherosclerotic heart disease (ASHD; damage or disease in the heart's major blood vessels).<br><br>A comprehensive Minimum Data Set (MDS) assessment, an assessment tool to facilitate plan of care, dated 1/17/23, reflected Resident #310 had a Brief Interview of Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact.<br><br>A physician's order dated 2/8/23 indicated to transfer the resident to the emergency room .<br><br>A physician's order dated 1/31/23 indicated Aspirin delayed Release 81 milligram (mg), give 1 tablet by mouth one time a day for ASHD.<br><br>A physician's order dated 1/31/23 indicated clopidogrel bisulfate 75 milligram (mg) tablet, give 1 tablet by mouth one time a day for anticoagulant (blood thinner).<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A progress note written by LPN #1 dated 2/8/23 at 1:20 PM documented at around 9:05 AM that the LPN was called by CNA #1 for assistance with Resident #310. LPN #1 wrote upon entering the room, .active bleeding was observed from the resident's left eye .Pressure was applied to stop bleeding, assessment completed; laceration to left eyelid noted, VS [vital signs] obtained, resident denies pain, dizziness or headache, site was covered with gauze and tape .Family came a few minutes after the event .MD contacted with order to send [resident] to the ER. 911called and the patient was transferred to the ER.<br><br>On 3/12/25 at 9:10 AM, the surveyor requested from the LNHA, the employee files of CNA #1 and LPN #1.<br><br>On 3/12/25 at 9:30 AM, the surveyor requested from the LNHA the hospital records for the resident's transfer to the ER.<br><br>On 3/12/25 at 10:10 AM, the surveyor interviewed the LNHA and asked if additional documentation for the FRE was located. The LNHA stated only the FRE documentation provided was found and the facility could not find any additional documents. The LNHA could not speak to what had occurred at the time of the incident as he was not working at the facility in 2023.<br><br>On 3/12/25 at 12:15 PM, the surveyor requested from the RVPCS the complete employee files of CNA#1 and LPN#1; the police report; the unit assignments from the time of the incident; and the timesheet for CNA #1 and LPN #1 in February 2023.<br><br>On 3/12/25 at 12:41 PM, the LNHA provided a police report dated and time 2/8/23 at 9:40 AM. The police report revealed the LNHA at the time of the incident called the police. Two officers responded to the call, interviewed Resident #310 and CNA#1. The report revealed Resident #310 stated that he/she had knocked off the food tray from the overbed table and it fell on the floor. The resident reported when the CNA came back to the room, she seemed frustrated with the resident and pushed the overbed table towards the resident and struck their left eyebrow causing a laceration.<br><br>According to the police report, the CNA was interviewed and reported after delivering the resident's food tray, while in the hallway she heard a loud bang come from the resident's room. The CNA went to check on the resident and observed the overbed table and food tray on the floor near the foot of the bed. The CNA attempted to stand the table back up for the resident and realized it was stuck underneath the bed. The CNA stated that when she leaned down to figure out why the table was stuck, the table came loose from underneath the bed and struck the resident on the left eyebrow causing a laceration. The CNA reported she immediately called for the nurse to render aid, and the family was contacted by the staff. The report documented the resident was being transferred to the hospital and the resident stated that if he/she wished to sign a complaint, they would do so at a later time.<br><br>On 3/12/25 at 12:52 PM, the surveyor interviewed the current DON, who was an MDS coordinator at the time of the incident. The surveyor asked the DON what she recalled about the incident. The DON stated that she recalled that there was an incident with the overhead table, the resident hit his/her face on the table, the nurse applied a pressure dressing, and the resident was sent out to the ER. The DON stated that it was deemed an accident, not intentional, and the suspended staff returned to work at the facility. The DON could not speak to the details of the investigation as it was before she became the facility's DON.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The surveyor asked the DON about the facility protocol for allegations of abuse. The DON stated that an allegation would be investigated by the facility immediately and typically took one to two days to complete. Additionally, other residents or staff would be interviewed for the investigation. If the police were involved, the staff would get the police number to follow up for the report.<br><br>On 3/12/25 at 1:05 PM, the LNHA provided the surveyor with the employee files of LPN #1 and CNA #1. The surveyor reviewed LPN #1's employee file, which included that the LPN completed abuse in-service education on 1/18/23. CNA #1 received in-service education after the incident. The LNHA stated that CNA #1 was provided in-service education, however they could not find the file of her previous education prior to the incident.<br><br>The surveyor reviewed the employee timesheet for 2/8/23 which reflected:<br><br>On 2/8/23, LPN #1 punched in to work at 7:18 AM and punched out at 2:24 PM. She was scheduled to work up to 3:30 PM.<br><br>On 2/8/23, CNA #1 punched in to work at 6:55 AM and punched out at 10:43 AM. She was scheduled to work until 3:00 PM.<br><br>A review of the New Jersey Universal Transfer Form dated 2/8/23 reflected Resident #310 was transferred to a hospital ER for laceration to left eyelid bleeding.<br><br>On 3/12/25 at 1:23 PM, the surveyor interviewed LPN# 2, who worked on the day of the incident with LPN #1. LPN #2 stated that at the time of the incident she was administering medication to residents and was not present in the room during the incident. LPN #2 recalled the resident's family, and the police came to the facility, the resident was sent to the hospital and LPN #1 and CNA #1 went home early that day.<br><br>On 3/12/25 at 1:30 PM, the surveyor interviewed CNA#2, who worked on the day of the incident. CNA #2 stated that she worked on the other side of the unit. CNA #2 stated she could only recall CNA #1 had to go home early that day. CNA #2 explained that management would ask staff to write a report and a statement when incidents occurred. CNA #2 could not recall details of the incident or if she was asked to write a statement for the incident.<br><br>On 3/12/25 at 1:41 PM, the surveyor called LPN#1 by phone for an interview regarding the incident on 2/8/23. The LPN could not recall any details of the incident and stated, I don't remember.<br><br>On 3/12/25 at 1:57 PM, the surveyor called CNA#1 by phone to interview her regarding the incident, there was no answer, and a message was left for a return call. CNA #1 did not return the surveyor's call.<br><br>On 3/12/25 at 2:25 PM, the surveyor informed the LNHA and the DON of the concern that a comprehensive investigation was not completed, and individual statements were not provided for Resident #310. The DON stated that the facility's process was for staff involved to be suspended until further investigation. Once the facility determined the allegation was unsubstantiated the staff could return to work. The DON stated that the conclusion of the facility's investigation was that the incident was an accident and not intentional. The LNHA stated that they couldn't find additional documentation of what was done at the time of this incident or where the complete investigation was kept.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/13/25 at 11:11 AM, the LNHA, the regional LNHA, and the RVPCS met with the survey team. The RVPCS stated, the facility had the AAS-45 but did not have individual statements for the investigation. The Regional LNHA stated they reviewed their files and could not find anything else for the investigation. The surveyor asked if it was expected for a completed investigation to include supportive documentation such as written individual statements. The RVPCS acknowledged that individual statements should be part of an investigation. There was no additional information provided by the facility's administration.<br><br>A review of the facility's Policy and Procedures titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated December 2024 revealed, Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.<br><br>A review of the facility's policy titled, Incidents Accidents Reports dated May 2024, revealed, If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or Administrator.<br><br>A review of the facility's policy for Compliance with Reporting Allegations of Abuse/Neglect/Exploitation dated October 2024 revealed, The Administrator or designee will obtain statements from direct care staff.<br><br>NJAC 8:39-4.1(a) 5 |

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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>38327<br><br>Based on interview and record review 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, in accordance with federal guidelines for 1 of 18 residents, (Resident #6), reviewed for accuracy for MDS coding.<br><br>This deficient practice was evidenced by the following:<br><br>On 3/7/25 at 10:52 AM, the surveyor observed Resident #6 was seated in a wheelchair inside their room with Certified Nursing Aide #1 (CNA#1). S#1 also observed CNA#2 with hoyer lift machine and Staffing Coordinator came out of the resident's room.<br><br>The surveyor reviewed Resident #6's medical records and revealed:<br><br>A review of the Admission Record (an admission summary) reflected that Resident #6 was admitted to the facility with medical diagnoses which included but not limited to; other Alzheimer's Disease, dysarthria (is a speech sound disorder resulting from neurological injury of the motor component of the motor-speech system) following unspecified cerebrovascular disease (stroke), unspecified osteoarthritis, unspecified site, contracture of left hand, and difficulty walking, not elsewhere classified.<br><br>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/16/25, with a brief interview for mental status (BIMS) score of 10 out of 15, reflected that the resident's cognition was moderately impaired. Section GG Functional Abilities reflected that Resident #6 had a functional limitation in range of motion (ROM) and impairment on upper extremity.<br><br>A review of the current Resident #6's personalized care plan (CP) reflected a focus CP for Chronic Pain on 12/3/24, fracture right 5th metatarsal that was revised on 12/4/24, that included interventions of NWB (non-weight bearing, a term used to describe a condition where a patient is not allowed to put weight on a specific limb or joint, often following surgery or injury) to right lower extremity per Ortho (Orthopedist) that was created on 12/11/24, by the Director of Nursing (DON).<br><br>A review of the Progress Notes (PN) that was created by the DON on 9/28/24, for effective date of 9/27/24, monthly review, reflected that Resident #6's musculoskeletal system reviewed and there were left upper extremity contracture, with left hand splint, left leg extremity weakness, and right leg extremity weakness.<br><br>On 3/12/25 at 10:29 AM, the DON stated that the resident with forgetfulness and required extensive assistance with activities of daily living, and the resident presented with left upper extremity contracture upon admission. The DON further stated that the resident had a fall incident on 12/2/24, resulted to fracture, and during that time, the resident was on NWB to right lower extremity and needed assistance with propelling wheelchair.<br><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 | On that same date and time, the surveyor notified the DON of the above findings and concerns regarding the 1/16/25 MDS and asked the DON should the MDS be accurate to reflect the status of the resident and the limitation on the extremities, and she stated yes.<br><br>On 3/13/25 at 11:11 AM, the Licensed Nursing Home Administrator (LNHA) confirmed that there was no policy for MDS, and the facility followed the RAI (Resident Assessment Instrument) manual for answering the MDS assessment.<br><br>On 3/13/25 at 12:17 PM, the survey team met with the LNHA, DON, RLNHA, RVPoCS, and Regional Nurse for an exit conference and no additional information provided by the LNHA and DON.<br><br>NJAC 8:39-33.2 (d) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>38327<br><br>Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to; a.) clarify the physician orders for 2 of 18 residents, (Residents #6 and #159), b.) ensure as needed (PRN) medications were sequenced according to pain severity for 3 of 18 residents (Residents #6, #48, and #159), and c.) ensure that medications were available for 2 of 3 residents reviewed during medication pass observation, (Residents #15 and #21), according to the standard of clinical practice and facility policy.<br><br>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 3/7/25 at 10:52 AM, Surveyor#1 (S#1) observed Resident #6 was seated in a wheelchair inside their room with Certified Nursing Aide #1 (CNA#1). S#1 also observed CNA#2 with hoyer lift machine and Staffing Coordinator came out of the resident's room.<br><br>S#1 reviewed Resident #6's medical records and revealed:<br><br>A review of the Admission Record (AR, an admission summary) reflected that Resident #6 was admitted to the facility with medical diagnoses which included but not limited to; other Alzheimer's Disease, dysarthria (is a speech sound disorder resulting from neurological injury of the motor component of the motor-speech system) following unspecified cerebrovascular disease (stroke), unspecified osteoarthritis, unspecified site, contracture of left hand, and difficulty walking, not elsewhere classified.<br><br>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/16/25, had a brief interview for mental status (BIMS) score of 10 out of 15, which reflected that the resident's cognition was moderately impaired.<br><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 - Some | A review of the current Resident #6's personalized care plan (CP) reflected a focus CP for chronic pain on 12/3/24, for fracture right 5th metatarsal that was revised on 12/4/24, and included interventions of NWB (non-weight bearing, a term used to describe a condition where a patient is not allowed to put weight on a specific limb or joint, often following surgery or injury) to right lower extremity per Ortho (Orthopedist) that was created on 12/11/24, by the Director of Nursing (DON).<br><br>A review of Resident #6's Physician's Order (PO) revealed:<br><br>-A PO order date 11/10/23, Ibuprofen 200 mg (milligrams) tablet (tab), give 2 tablets (tabs) by mouth every 6 hrs (hours) PRN for moderate pain.<br><br>-A PO order date 11/27/23, Tylenol 325 mg tab, give 2 tabs by mouth every 4 hrs PRN for mild pain.<br><br>On 3/10/25 at 1:13 PM, S#1 notified the DON of the above findings and concerns about the PRN orders for Tylenol and Ibuprofen of Resident #6. After reviewing the records, the DON immediately changed the orders to clarify the total amount, 650 mg for PRN Tylenol, and 400 mg for PRN Ibuprofen as total amount for 2 tabs. The DON stated that the orders should have been clarified to include the total amount in mg for the 2 tabs for each medications (meds).<br><br>2. On 3/7/25 at 10:47 AM, S#1 observed Resident # 159 lying on bed with head of bed elevated approximately 45 degrees, eyes closed, with tube feeding (TF) formula of Glucerna 1.2 running via a pump at 50 ml/hr (milliliters/hour), with 159 ml fed, and remaining in the container was 500 ml.<br><br>S#1 reviewed Resident #159's medical records and revealed:<br><br>A review of the AR reflected that Resident #159 was admitted to the facility with medical diagnoses which included but not limited to; type 2 diabetes mellitus without complications, gastrostomy status, unspecified protein-calorie malnutrition, adult failure to thrive, benign intracranial hypertension (is a condition characterized by increased intracranial pressure (pressure around the brain) without a detectable cause), other specified peripheral vascular diseases, and chronic systolic (congestive) heart failure.<br><br>A review of the most recent comprehensive MDS, with an ARD of 1/21/25, had a BIMS score of 1 out of 15, which reflected that the resident's cognition was severely impaired.<br><br>A review of Resident #159's PO revealed the following meds:<br><br>-A PO with an order date of 3/6/25, Pantoprazole Sodium suspension 2 mg/ml, give 20 ml via peg tube one time a day for GERD (Gastroesophageal reflux disease (GERD) is a chronic upper gastrointestinal disease in which stomach content persistently and regularly flows up into the esophagus, resulting in symptoms and/or complications) [20 ml=40 mg].<br><br>The above PO for Pantoprazole was plotted at 9:00 AM.<br><br>-A PO with an order date of 3/5/25, Sertraline HCL (hydrocholoride) tab 50 mg, give 2 tabs via peg one time day for Depression, 2 tabs=199 mg.<br><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 - Some | -A PO with an order date of 3/5/25, Enteral feed order every shift for nutrition Glucerna 1.2 cal (calorie), administer continuous via pump 50 ml continuous via pump 50 ml/hr.<br><br>-A PO with an order date of order date 3/5/25, Acetaminophen 325 mg tab, give 2 tabs via peg every 6 hrs PRN for mild to moderate pain.<br><br>-A PO with an order date of 3/6/25, Morphine Sulfate oral solution 20 mg/ml give 1 ml by every 4 hrs by mouth PRN for moderate to severe pain.<br><br>On 3/10/25 at 12:33 PM, S#1 interviewed Licensed Practical Nurse (LPN) #1 in the 2nd floor nursing station, who informed S#1 that Resident # 159 was declining cognitively and in adls (activities of daily living). The LPN stated that the resident was cognitively impaired and required extensive to total assistance with adls.<br><br>On that same date and time, S#1 asked LPN #1 about the Glucerna order, and she responded that the order was continuous. S#1 then asked if the order should include total volume (vol) to be infused, and LPN #1 responded after reviewing the orders and the electronic Medication Administration Record (eMAR) that she was unsure why there was no total vol in the order, and that she would notify the DON.<br><br>At that same time, S#1 asked LPN #1 about the PRN orders for Tylenol and Morphine Sulfate. The LPN after reviewing the orders and the March 2025 eMAR, S#1 asked LPN #1 if the PRN orders should have been clarified. The LPN did not respond.<br><br>Furthermore, S#1 also asked about the order for Sertraline, and LPN #1 responded after reviewing the March 2025 eMAR that it should have been total of 100 mg, and not 199 mg. The LPN further stated that the order for Sertraline should have been clarified.<br><br>On 3/10/25 at 12:54 PM, S#1 notified the DON of the above concerns and findings about meds Pantoprazole liquid, Sertraline, PRN Tylenol and Morphine Sulfate, and Glucerna. The DON confirmed that the Pantoprazole liquid should be administered in an empty stomach. She stated that she will contact the Dietician about the Glucerna order in order to accommodate the administration of Pantoprazole and to determine the total vol to be fed. The DON stated that the order for PRN Tylenol and Morphine Sulfate should have been clarified.<br><br>At that same time, the DON immediately changed the order to clarify the order for PRN Tylenol and PRN Morphine Sulfate.<br><br>On 3/11/25 at 1:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Regional LNHA (RLNHA), and Regional [NAME] President of Clinical Services (RVPCS), and Surveyor #2 (S#2) discussed the above concerns and findings with Resident #6 and #159.<br><br>On 3/12/25 at 2:13 PM, the survey team met with the LNHA and DON, and the DON stated, we reviewed all residents with PRN pain orders for sequencing, for mild, moderate, and severe. The DON further stated that for Resident #6, the order should have been clarified to include the total amount in milligrams for 2 tabs, for PRN Tylenol and Ibuprofen. The LNHA stated that Resident #159's concern for Zoloft order, was a typo error, and should have been clarified.<br><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 - Some | At that same time, the DON stated that Resident #159 was in the hospital, when the resident return to the facility, the order for TF will be addressed to reflect the total vol.<br><br>A review of the facility's PRN Medications Policy, with a reviewed date of 10/2024, revealed: Policy Explanation and Compliance Guidelines:<br><br>2. Orders for meds to be given on an PRN basis shall have clear instructions about how and when to administer them. Examples include, but are not limited to:<br><br>b. How much of the medication may be given (the dose), and in some instances how much may be given in a set period of time (i.e., one dose five minutes apart of maximum of three doses) .<br><br>On 3/13/25 at 12:17 PM, the survey team met with the LNHA, DON, RLNHA, RVPCS, and Regional Nurse for an exit conference and no additional information provided by the LNHA and DON.<br><br>48781<br><br>3. On 3/10/25 at 9:22 AM, Surveyor #3 (S#3) observed Resident #48's door closed and the resident was receiving personal hygiene care from staff.<br><br>A review of Resident #48's paper chart reflected the resident was receiving hospice care for heart failure (the heart cannot pump enough blood to meet the body's needs).<br><br>On 3/10/25 at 9:37 AM, S#3 interviewed the DON about Resident #48 who stated the resident had recently started receiving hospice care services. The DON added the resident had a history of a fall at home with a sustained fracture requiring surgery and multiple myeloma (a type of blood cancer). The DON stated Resident #48 was receiving meds for pain management.<br><br>On 3/10/25 at 9:50 AM, S#3 observed Resident #48 lying in their bed, alert and verbally responsive. The resident stated they did not have pain and had no concerns at this time.<br><br>On 3/10/25 at 12:30 PM, S#3 reviewed the EMR of Resident #48.<br><br>A review of the AR included the resident had diagnoses that included, but were not limited to; a fracture of the left femur (a long bone located in the thigh), heart failure, and multiple myeloma (a type of blood cancer).<br><br>A review of the PO revealed:<br><br>-An order dated 2/28/25 for morphine sulfate oral solution 20 mg/5 ml, give 0.25 ml by mouth every 8 hours for Pain management.<br><br>-An order dated 2/28/25 for morphine sulfate oral solution 20 mg/5 ml, give 0.25 ml by mouth every 4 hours PRN for pain.<br><br>-An order dated 10/28/24 for acetaminophen 325 mg tab, give 2 tabs by mouth every 4 hours PRN for pain or headache (2 tabs = 650 mg).<br><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 - Some | -An order dated 10/28/24 for pain assessment every shift.<br><br>-An order dated 2/3/25 for [Company name] Hospice evaluation and treatment.<br><br>A review of a Comprehensive MDS with an ARD of 2/16/25, revealed a BIMS score of 6 out of 15 which indicated the resident had severely impaired cognition. The resident was coded as receiving hospice care.<br><br>A review of the CP included a focus area for alterations in comfort with an initiation date of 10/28/24. Interventions included: utilize pain scale, which was dated 10/28/24; and medicate resident as ordered for pain, monitor for effectiveness and side effects to report to physician as indicated, which was dated 10/28/24.<br><br>On 3/11/25 at 11:02 AM, S#3 interviewed LPN #1 who stated Resident #48 received routine morphine sulfate and PRN pain meds for pain management. The LPN further explained the resident would report any pain to the nurse and the resident's facial expressions would indicate when the resident was in pain. The LPN stated that she would assess the resident's pain by asking from a 0-10 pain scale. The LPN added .if [the resident] reported pain 1-3, it's mild; if it was 5, its moderate, and if 10, it was severe pain .I would start with Tylenol for mild pain.<br><br>S#3 asked LPN #1 how she would determine which prn pain med to give to Resident #48. The LPN replied she would start with acetaminophen for mild pain. S#3 then asked how she would know to give acetaminophen for mild pain. LPN #1 replied that it would be indicated in the med orders. LPN #1, in the presence of S#3, reviewed the PRN pain med orders for Resident #48. The LPN acknowledged the orders did not indicate the pain level (mild, moderate or severe) for which the PRN pain med could be administered. The LPN replied, I'm going to talk to my DON. I should see the orders for pain med with pain levels.<br><br>On 3/11/25 at 11:23 AM, S#3 interviewed the DON who stated, nurses assessed residents for pain every shift. The DON stated a numerical 0-10 pain scale was used to assess pain, 0 equaled no pain; mild pain was 1-4; moderate pain was 5-7 and severe pain was above 7. The DON further explained PRN pain meds should include the pain level at which the med was indicated for. The DON, in the presence of S#3 reviewed Resident #48's med orders in the EMR. The DON acknowledged the resident's PRN pain med should indicate the pain level, and the pain meds should be sequenced. The DON stated she would speak to the physician to adjust the orders.<br><br>On 3/11/25 at 1:22 PM, S#3 notified the LNHA, the Regional LNHA, and the RVPoCS regarding the concerns for pain meds sequencing for Resident #48.<br><br>On 3/12/25 at 2:14 PM, the LNHA and the DON met with the survey team. The DON stated that Resident #48's pain med orders were clarified with the physician and all other residents with pain meds were reviewed. The DON acknowledged it was expected for pain meds to be sequenced to indicate at what pain level (mild, moderate or severe) a med was to be administered.<br><br>A review of the facility's Pain Management Policy, dated 10/2024, revealed, Pain Assessment 2(c), Asking the patient to rate the intensity of his/her pain using a numerical scale, a verbal or visual descriptor that is appropriate and preferred by the resident.<br><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 - Some | 49078<br><br>4. On 3/10/25 at 8:50 AM, during med administration (med-pass) observation on the 1st floor, Surveyor #4 (S#4) observed LPN #2 administer meds to Resident #21. The resident was scheduled in the eMAR to rinse their mouth with ACT mouthwash (a mouthrinse that contained fluoride used for anti-cavity treatment). LPN #2 stated that the resident's ACT mouthwash was not present in the med cart (med-cart). After administering the other due meds, LPN #2 had the resident rinse their mouth with a facility stocked mouthwash.<br><br>The surveyor asked LPN #2 if the ordered ACT mouthwash was available in the facility. The LPN stated that it was the resident representative (RR) who supplied the mouthwash, and she would call the family to bring it in. LPN #2 signed the ACT mouthwash as administered in the eMAR.<br><br>On 3/10/25 at 11:30 AM, the surveyor reviewed the manufacturer product information for ACT mouthwash and the product label for the facility provided stock mouthwash. The product information revealed that ACT contains as the active ingredient, .05% sodium fluoride. The surveyor requested from the DON and received a bottle of the house stock mouthwash. The label for the in-house stock mouthwash did not include sodium fluoride as an ingredient.<br><br>On 3/10/25 at 11:35 AM, S#4 reviewed the EMR for Resident #21. The EMR reflected an order dated 9/16/24, for ACT mouthwash 30 ml swish and spit every morning. The record did not reflect the RR supplying this item.<br><br>5. On 3/10/25 at 9:10 AM, during med-pass observation on the 2nd floor, S#4 observed LPN #1 administer meds to Resident #15. During the observation, the LPN stated she could not locate the resident's Lactobacillus Rhamnosus (Lactobacillus R.; a beneficial bacteria used as a supplement) and would attempt to obtain it from the pharmacy or the facility's in-house stock. S#4 observed LPN #1 call the facility's provider pharmacy to ask for the Lactobacillus R. med. The LPN stated to S#4 that the pharmacy told her the Lactobacillus R. was a probiotic and was an in-house stock item of the facility. The surveyor concluded the med-pass observation.<br><br>On 3/10/25 at 11:07 AM, S#4 interviewed LPN #1 and asked if Resident #15 was administered the Lactobacillus R. The LPN stated that the item was found in the facility's house stock and given to the resident. S#4 asked LPN #1 to see the bottle of what was administered to the resident. LPN #1 retrieved the bottle from the med-cart. S#4 observed the bottle with a labeled name of Probiotic and listed as the ingredient was Saccharomyces boulardii (a beneficial bacteria used as a supplement). The surveyor asked the LPN if this probiotic was the same as the med ordered by the physician in the eMAR. LPN #1 replied that it was a probiotic.<br><br>At that same time, S#4 reviewed with LPN #1 the bottle's label with the listed ingredient. The LPN stated she did not know that it was a different probiotic from what was ordered.<br><br>On 3/10/25 at 11:40 AM, S#4 reviewed the EMR for Resident #15. The EMR reflected an order dated 2/2/22 for Lactobacillis R., give 1 capsule by mouth twice a day.<br><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 - Some | On 3/10/25 at 3:20 PM, the surveyor interviewed the facility Consultant Pharmacist (CP) by telephone. The surveyor asked the CP if the ACT mouthwash and the facility's mouthwash were interchangeable. The CP stated no and that they were different items. The surveyor asked the CP if it was expected for staff to follow the PO for meds, and the CP stated, yes, that they should administer meds as per the PO. The surveyor asked the CP if Lactobacillus R. and Saccharomyces boulardii were the same. The CP stated, no, they were different items, but both considered a probiotic.<br><br>On 3/11/25 at 1:27 PM, S#4 notified the LNHA, RLNHA, and the RVPoCS of the concerns identified for Resident #15 and Resident #21 during the med-pass observation. S#4 asked if the nurse should follow the PO and administer what was ordered in the eMAR. The LNHA and RVPoCS both replied, Yes. S#4 asked if when administering med if it was expected for nurses to verify the med name and dosage on the med label matched with the orders on the eMAR, and the LNHA and RVPoCS both replied, Yes.<br><br>On 3/12/25 at 2:15 PM, the LNHA and the DON met with the survey team. The LNHA stated that the ACT mouthwash was in house, now placed in the med-carts and the nursing staff were made aware. The DON stated that the order for Lactobacillus R. was discontinued by the physician for Resident #15. Additionally, the DON stated that the facility will keep two kinds of probiotic in stock and the staff was educated on what they were. There was no additional information provided by the facility.<br><br>A review the facility's Administering Medications Policy, with an updated date of October 2024, reflected under item 5: The individual administering the med must check the label against the PO to verify the .right med .before giving the med.<br><br>N.J.A.C 8:39-11.2(b), 27.1 (a), 29.2 (d) |

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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>38327<br><br>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, by failing to ensure; a.) that the physician order was clarified, b.) care plan (CP) intervention was revised, and c.) the fall investigation included the statement of the staff to complete the investigation, and in order to determine root cause analysis. This deficient practice was identified for 1 of 2 residents, (Resident #6), reviewed for accidents and 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 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 well-being, and executing medical regimes 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>On 3/7/25 at 10:52 AM, Surveyor #1 (S#1) observed Resident #6 was seated in a wheelchair inside their room with Certified Nursing Aide #1 (CNA#1). The surveyor also observed CNA#2 with hoyer lift machine and Staffing Coordinator came out of the resident's room.<br><br>The surveyor reviewed Resident #6's medical records and revealed:<br><br>A review of the Admission Record (an admission summary) reflected that Resident #6 was admitted to the facility with medical diagnoses which included but not limited to; other Alzheimer's Disease, dysarthria (is a speech sound disorder resulting from neurological injury of the motor component of the motor-speech system) following unspecified cerebrovascular disease (stroke), unspecified osteoarthritis, unspecified site, contracture of left hand, and difficulty walking, not elsewhere classified.<br><br>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date of 1/16/25, indicated a brief interview for mental status (BIMS) score of 10 out of 15, which reflected that the resident's cognition was moderately impaired.<br><br>A review of the current Resident #6's personalized CP reflected a focus CP for Chronic Pain on 12/3/24, fracture right 5th metatarsal that was revised on 12/4/24, that included interventions of NWB (non-weight bearing, a term used to describe a condition where a resident is not allowed to put weight on a specific limb or joint, often following surgery or injury) to right lower extremity per Ortho (Orthopedist) that was created on 12/11/24, by the Director of Nursing (DON).<br><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 | A review of the Physician's Orders (PO) revealed:<br><br>-A PO order date 12/11/24, NWB right lower extremity fractured right 5th metatarsal.<br><br>A review of the Progress Notes (PN) that was created by the DON on 3/1/25, for effective date of 2/26/25, reflected that the resident was on WBAT (weight bearing as tolerated) to right lower extremity with boot per Ortho.<br><br>On 3/10/25 at 1:13 PM, S#1 asked the DON in the 1st floor nursing station, the DON claimed that it was her responsibility to update and revised CP. The surveyor notified the DON of the concerns regarding the 12/11/24 order for NWB to right lower extremity and the PN was documented for WBAT to right lower leg. After reviewing the records, the DON stated that the CP for weight bearing status should have been revised to WBAT since 2/12/25 and the order for NWB should have been clarified to reflect WBAT.<br><br>On 3/11/25 at 1:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Regional LNHA (RLNHA), and Regional [NAME] President of Clinical Services (RVPoCS), and Surveyor #2 (S#2) discussed the above concerns and findings with Resident #6's CP and order for NWB to right lower extremity.<br><br>On 3/12/25 at 8:10 AM, the LNHA provided a copy of resident's fall investigation and informed the surveyor that there was only one fall incident happened for the last 6 months.<br><br>A review of the provided fall investigation dated 12/2/24, revealed that the fall incident happened in resident's room, where the Maintenance Staff (MS) found the resident on the floor. The fall investigation also reflected that the resident slid out of their chair and hit their right ankle on the floor, the resident was assessed and resident complained of right ankle pain. The Physician, DON, and the Resident Representative (RR) were notified, and the physician ordered an x-ray. The fall incident was prepared by the Licensed Practical Nurse (LPN).<br><br>Further review of the provided 12/2/24 fall investigation did not include a statement from the MS. There was no documented evidence that the MS's name was identified.<br><br>On 3/12/25 at 10:29 AM, S#1 interviewed the DON regarding the 12/2/24 fall investigation, and the DON confirmed that the MS did not have a statement when the MS found the resident on the floor as part of a complete investigation. The DON stated that it was her responsibility to ensure that she followed up with LPN#1 at that time who was the MS and that the statement was obtained. She further stated that LPN#1 was on leave right now and unable to reach out to gather the information of who was the MS.<br><br>On 3/12/25 at 2:13 PM, the survey team met with the LNHA and DON, and the DON stated that updated the CP and PO for weight bearing status was clarified after the surveyor's inquiry.<br><br>On that same date and time, S#1 notified the LNHA and the DON of the new concerns regarding Resident 6's fall investigation on 12/2/24 that there was no documented evidence that the MS provided a statement.<br><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 | A review of the facility's Incident Accident Reports Policy, with a reviewed date of 5/2024, reflected under Compliance Guidelines:<br><br>15. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the DON and/or Administrator.<br><br>A review of the facility's Care Plans, Comprehensive Person-Centered Policy, with an updated date of 10/2024, revealed:<br><br>Policy Statement: A comprehensive, person-centered CP that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.<br><br>Policy Interpretation and Implementation:<br><br>13. Assessments of residents are ongoing and CP are revised as information about the residents and the residents' conditions change .<br><br>On 3/13/25 at 12:17 PM, the survey team met with the LNHA, DON, RLNHA, RVPoCS, and Regional Nurse for an exit conference and no additional information provided by the LNHA and DON.<br><br>NJAC 8:39-3.2 (a,b); 11.2(b); 27.1(a) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>46049<br><br>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a) obtain weights for a resident according to the physician's orders and facility policy for 1 of 2 residents (Resident #13) reviewed for nutrition; and b) monitor and document the fluid intake for a resident with a physician's order for fluid restrictions for 1 of 2 residents (Resident #28) reviewed for nutrition.<br><br>This deficient practice was evidenced by the following:<br><br>1. On 3/7/25 at 10:50 AM, the surveyor observed Resident #13 sitting in a wheelchair in their room, being provided care by staff.<br><br>On 3/12/25 at 9:06 AM, the surveyor reviewed the paper chart and the Electronic Medical Record (EMR) of Resident #13.<br><br>The Admission Record (a summary of important information about the resident) documented Resident #13 had diagnoses that included but were not limited to, respiratory failure, chronic obstructive pulmonary disease (a lung condition that blocks airflow and makes it difficult to breathe), and heart failure.<br><br>A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated 2/18/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #13 scored a 13 out of 15, which indicated the resident was cognitively intact. Resident #13 was coded as having a significant weight loss of 5% or more in 1 month or a significant weight loss of 10% or more in 6 months, while not on a physician-prescribed weight loss regimen.<br><br>A physician's order dated 12/27/24 indicated weekly weights x 4 upon readmission/admission.<br><br>A physician's order dated 12/27/24 indicated monthly weights every 30 days once in the morning.<br><br>A review of the documented weights for Resident #13 revealed the following:<br><br>- 12/29/24: 146.2 pounds (lbs.)<br><br>- 1/2/2025: 149.0 lbs.<br><br>- 2/2/2025: 125.0 lbs.<br><br>- 2/7/2025: 131.2 lbs.<br><br>On 1/2/25 the resident weighed 149 lbs. and on 2/7/25 the resident weighed 131.2 lbs. resulting in a weight loss of 11.95% in 1 month.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the progress notes indicated the resident was sent out of the facility on 1/9/25 and returned 1/18/25 to the facility after being hospitalized for pneumonia. The resident was sent to the hospital on the 1/29/25 and returned on 1/30/25 to the facility after being hospitalized for respiratory failure.<br><br>A review of the January 2025 Medication Administration Record (MAR) revealed the entry for monthly weights scheduled for 1/27/25 was signed by the nurse with the chart code 7. The chart code 7 indicated other/see nurse notes. A review of the corresponding MAR note dated 1/27/25 indicated the resident's weight would be taken on February 1st.<br><br>A review of the February 2025 MAR revealed the entry for monthly weights scheduled for 2/26/25 was signed by the nurse with the chart code 7. A review of the corresponding MAR note dated 2/26/25 indicated the resident would be weighed at the beginning of the month.<br><br>A review of the March 2025 MAR revealed the entry for monthly weights remained scheduled for the end of the month, next due on 3/28/25.<br><br>A review of the MAR and the Treatment Administration Record (TAR) for January 2025 and February 2025 revealed there were no entries for weekly weights for the resident.<br><br>A nutrition note dated 2/7/25 by the Registered Dietician (RD) #1 revealed Resident #13 was assessed for a significant undesirable weight loss. RD #1 reviewed the resident's supplements and food preferences. The note documented a re-weigh was completed with a result of 131.2 lbs. The RD indicated the resident's weight loss could be contributed by the resident's history of edema (swelling caused by an excessive accumulation of fluid in the body's tissue) and recent hospitalization .<br><br>A nutrition note dated 3/5/25 indicated the RD #2 visited with Resident #13 to discuss weight loss concerns. The RD documented review of the resident's supplements, meals, and preferences. The RD indicated to continue to monitor oral intake and weight trends. The note did not include weight assessment for the resident.<br><br>On 3/12/25 at 10:25 AM, the surveyor interviewed Registered Nurse (RN) #1 about the facility's protocol for obtaining weights. RN #1 stated there was a weight book and the nurse from the night shift would inform the incoming shift who needed to be weighed for the next day. The RN stated weights for residents were taken upon admission, would be documented in the nursing assessment and in the weights/vitals section of the EMR.<br><br>On 3/12/25 at 11:03 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated weights for residents were completed in the first week of every month. If the residents had other orders for weekly weights, the LPN stated there would be an entry in the MAR. LPN #1 further explained monthly weights were part of the facility's standard protocol and a physician's order in the MAR or TAR was not required.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/12/25 at 11:13 AM, the surveyor interviewed the Director of Nursing (DON) who stated weights were completed upon admission, and day 2 of admission; for subacute residents, weekly weights x 4 weeks after admission were completed; LTC residents, if readmitted on ly weights upon admission were completed; and monthly weights for all residents were completed in the first week of the month. The DON added weights were expected to be done by the 10th of month, and she reviewed the results with the RD to identify any significant changes in a resident's weight. The DON stated if there were any changes identified, a re-weigh would be completed the same day upon request. If the weight was verified, the RD would assess the resident and make recommendations to address the weight changes.<br><br>The surveyor reviewed with the DON the listed weights for Resident #13 in the EMR. The surveyor discussed the concern that there were no weights upon the resident's re-admission on 1/18/25 or 1/30/25. The DON stated she would review and provide any additional information to the surveyor.<br><br>On 3/12/25 at 1:10 PM, the surveyor interviewed RD #2 who started the previous week at the facility. The surveyor asked the RD about the nutrition note completed on 3/5/25 and if the monthly weight for March 2025 for Resident #13 was reviewed. RD #2 stated monthly weights were still being obtained on the unit and that she had not reviewed the resident's weight yet.<br><br>The surveyor asked RD #2 where the resident's weight would be documented. RD #2 replied that it should be in the nurses' station in the weight binder and in the EMR. The RD was not sure who documented the weight results in the EMR and stated maybe the nurses were responsible.<br><br>RD #2 accompanied the surveyor to the resident's unit to obtain the list of resident weights. RD #2 provided a copy of the weights from the nursing staff. Resident #13's written weight on the log was illegible. RD #2 also could not read the weight that what was written and informed the nurse that the resident had to be re-weighed.<br><br>On 3/12/25 at 2:13 PM, the surveyor informed the DON and the Licensed Nursing Home Administrator (LNHA) about the concern for Resident #13's weights not being obtained per facility protocol and policy.<br><br>On 3/13/25 at 11:11 AM, the LNHA, the Regional LNHA, the DON and Regional [NAME] President of Clinical Services (RVPCS) met with the survey team. The DON acknowledged there were no weights found upon the resident's re-admission to the facility and the March 2025 weight was not completed by the 10th of the month. The DON stated in-service education was being provided to the staff to ensure completion of weights.<br><br>A review of the facility's policy titled Weight Policy, last reviewed in December 2024, revealed under Compliance Guidelines: .<br><br>5. A weight monitoring schedule will be developed upon admission for all residents:<br><br>a. Newly admitted residents- Weight on admission and monitor weight weekly for 4 weeks<br><br>b. If clinically indicated- monitor weights as per order<br><br>c. All others- monitor weight monthly .<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's policy titled Weight Assessment and Intervention last updated in October 2019, revealed under Weight Assessment: .<br><br>1. The nursing staff will measure resident weights upon admission once and weekly for four weeks. If no weight concerns are noted at this point, weights will be measured monthly thereafter.<br><br>2. Weights will be recorded in each unit's Weight Record or notebook and in the individual's medical record.<br><br>3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing. Verbal notification must be confirmed in writing .<br><br>2. On 3/12/25 at 10:10 AM, the surveyor reviewed the paper chart and the EMR of Resident #28.<br><br>The Admission Record documented the resident had diagnoses that included but were not limited to, End Stage Renal Disease.<br><br>A comprehensive MDS assessment, a tool to facilitate the management of care, dated 1/13/25, indicated the facility assessed the resident's cognition using a BIMS test. Resident #28 scored a 7 out of 15, which indicated the resident had severe cognitive impairment.<br><br>A physician's order dated 4/24/23 indicated no water pitcher at the bedside every shift.<br><br>A physician's order dated 4/25/23 indicated fluid restriction of 1200 milliliters per day (ml/day); Dietary: 840 ml (Breakfast-480 ml; Lunch-180 ml; Dinner-180 ml); and Nursing: 360 ml (120 ml for every shift).<br><br>A physician's order dated 11/20/24 indicated the resident went to dialysis every Monday, Wednesday, and Friday with a chair time of 6:30 AM.<br><br>A physician's order dated 3/7/25 indicated the resident was on a renal diet, puree texture, and thin liquids with a 1200 ml/day fluid restriction.<br><br>A review of March 2025 MAR and TAR revealed there were no entries that indicated the ordered fluid restrictions for the resident.<br><br>A review of the resident's care plan included a focus area for nutrition. An intervention of the care plan with a revision date of 7/6/23 indicated the resident was on fluid restrictions of 1200 ml/day. Additionally, the intervention included for staff to remind the resident about their fluid restriction.<br><br>On 3/12/25 at 10:24 AM, the surveyor observed Resident #28 was not in their room. The resident was scheduled for dialysis every Monday, Wednesday, and Friday.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/12/25 at 10:25 AM, the surveyor interviewed RN #1 assigned to care for Resident #28. RN #1 confirmed the resident was currently at dialysis. The RN stated a physician's order for fluid restrictions would be included in the MAR and an order to not to leave a water pitcher at the bedside. RN #1 further explained that it would be documented in the resident's diet order and on the resident's EMR profile that the resident was on fluid restrictions. The surveyor asked RN #1 if the resident's fluid intake would be documented by the nurses. The RN replied, usually no and that it would be documented for residents who had orders for strict intake and output monitoring.<br><br>The surveyor asked RN #1 if Resident #28 was on fluid restrictions. The RN replied, I'm not sure and proceeded to check the resident's physician orders in the EMR. RN #1 found the resident's diet order, reviewed it with the surveyor, and confirmed that the resident was on fluid restrictions. The surveyor asked RN #1 how a nurse knew that a resident was on fluid restriction if it was not documented on the MAR and TAR. The RN stated it would be documented in the nurses' 24-hour report (a document used to track a resident's condition, treatment, and any changes or needs over a 24-hour period). RN #1 accompanied the surveyor to Resident #28's room to check if there were any pitchers or beverages at the bedside. The surveyor observed there were no pitchers or other beverages found at the resident's bedside.<br><br>On 3/12/25 at 11:13 AM, the surveyor interviewed the DON about fluid restrictions. The DON stated that there should be a physician's order which would show up on the MAR or TAR to indicate the resident was on fluid restrictions. The surveyor informed the DON of the RN interview in which she wasn't sure if Resident #28 was on fluid restrictions and that there was no documentation of the resident's fluid restrictions in the MAR or TAR. The DON reviewed with the surveyor the EMR for Resident #28. The DON confirmed there was no fluid restriction order entry on the MAR and TAR for Resident #28. The DON could not speak to what happened and would investigate to provide additional information.<br><br>On 3/12/25 at 2:13 PM, the surveyor informed the DON and the LNHA of the above concern regarding the monitoring and documentation of Resident #28's fluid restrictions.<br><br>On 3/13/25 at 11:11 AM, the LNHA, the Regional LNHA, the DON and the RVPCS met with the survey team. The DON stated the resident's order for fluid restrictions was adjusted to show each shift in the MAR/TAR and to record fluid restriction intake. The RVPCS explained the order was there, but it was not coming up on the MAR or TAR. There was no additional information provided by the facility.<br><br>A review of the facility's policy titled Fluid Restriction, last reviewed in October 2024, revealed: It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders.<br><br>Under Compliance Guidelines of the policy indicated: 1. The nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department, and will be recorded on the medication record or other format as per facility protocol .<br><br>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>46049<br><br>Based on observation, interview, and record review, it was determined that the facility failed to ensure appropriate storage of a nebulizer treatment equipment in accordance with facility protocol and infection control. This deficient practice was identified in 1 of 1 resident (Resident #55), reviewed for respiratory care.<br><br>The deficient practice was evidenced by the following:<br><br>On 3/7/25 at 1:40 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 about the changing of nebulizer (neb) tubing and mask equipment. LPN #1 was not sure of the facility's policy regarding changing of oxygen (O2) tubing and neb tubing equipment. LPN #1 accompanied the surveyor to the Resident #55's room to observe the resident's neb machine equipment. Resident #55 was sitting on their bed, alert and verbally responsive. The neb mask was resting on the resident's nightstand uncovered attached to a tubing which was connected to the neb machine. LPN #1 stated the date on the neb mask was 2/18/25.<br><br>On 3/7/25 at 1:44 PM, the surveyor interviewed Minimum Data Set (MDS) Coordinator #1 about the changing and storage of neb equipment. MDS Coordinator #1 stated the facility's policy was to change neb tubing weekly and there would be a physician's order to indicate the weekly change. The surveyor discussed the observation of Resident #55's neb mask resting on table uncovered and having a labeled date of 2/18/25. MDS coordinator #1 acknowledged the neb mask should have been changed after a week from the date.<br><br>The surveyor reviewed the Electronic Medical Record (EMR) of Resident #55.<br><br>A review of the Admission Record (an admission summary) revealed that Resident #55 was admitted with diagnoses that included, but were not limited to, type 2 diabetes mellitus, and dysphagia (difficulty swallowing foods or liquids).<br><br>A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 2/18/25, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated that the resident was cognitively intact.<br><br>A review of the physician's order (PO) dated 2/8/25, indicated Budesonide Inhalation Suspension 0.5 milligram/milliliter (mg/ml), 2 ml inhale orally two times a day for asthma.<br><br>There was no PO for weekly change for neb tubing equipment.<br><br>A review of care plans (CP) revealed there were no CP related to the resident's respiratory care.<br><br>On 3/7/25 at 2:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated O2 and neb tubing changes occurred every Sunday on the night shift. The DON further explained there was a PO for weekly neb tubing change and the nurses would sign the task completed in the electronic Treatment Administration Record (eTAR). The surveyor asked the DON about storage of a neb mask when not in use. The DON replied to the surveyor that it should be stored in a plastic bag when not in use.<br><br>(continued on next page) |

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| | 315349 | A. Building<br>B. Wing | 03/13/2025 |

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| Complete Care at Inglemoor, LLC | 333 Grand Ave<br>Englewood, NJ 07631 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The surveyor notified the DON of the interview with the staff and the observation of Resident #55's neb equipment. The DON acknowledged the mask should have been stored in plastic bag and the neb mask should have been changed weekly as per the facility's protocol.<br><br>The surveyor notified the DON that there was no respiratory CP found for Resident #55 and if there should have been one. The DON replied that there should have been a CP for the resident as they received routine neb treatments and had a diagnosis of asthma.<br><br>On 3/11/25 at 1:21 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Regional LNHA, and the Regional [NAME] President of Clinical Services (RVPoCS) of the concerns for Resident #55's neb tubing equipment not being changed weekly and the mask not being stored appropriately.<br><br>On 3/12/25 at 2:13 PM, the LNHA and the DON met with the survey team. The DON acknowledged there was no PO for changing of Resident #55's neb tubing. The DON stated the neb tubing was changed and stored appropriately after the surveyor's observation with staff. Additionally, the resident's CP was updated to include a respiratory CP.<br><br>A review of the facility's Oxygen Administration Policy, with an updated date of October 2024, revealed it did not address storage of O2 or neb equipment.<br><br>There was no additional policy provided by the facility.<br><br>NJAC 8:39-27.1(a) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>38327<br><br>Based on interviews and review of other facility documentation, the facility failed to ensure that the physician must include an evaluation of the resident's condition and total program of care, by signing orders that included medications and treatments, and a decision about the continued appropriateness of the resident's current medical regimen. The orders reflected that it was 982 days overdue for review. This deficient practice was identified for 1 of 18 residents, (Resident #159), reviewed for physician services.<br><br>This deficient practice was evidenced by the following:<br><br>On 3/7/25 at 10:47 AM, Surveyor #1 (S#1) observed Resident # 159 lying on bed with head of bed elevated approximately 45 degrees, eyes closed, with tube feeding (TF) formula of Glucerna 1.2 running via a pump at 50 ml/hr (milliliters/hour), with 159 ml fed, and remaining in the container was 500 ml.<br><br>S#1 reviewed Resident #159's medical records and revealed:<br><br>A review of the AR reflected that Resident #159 was admitted to the facility with medical diagnoses which included but not limited to; type 2 diabetes mellitus without complications, gastrostomy status, unspecified protein-calorie malnutrition, adult failure to thrive, benign intracranial hypertension (is a condition characterized by increased intracranial pressure (pressure around the brain) without a detectable cause), other specified peripheral vascular diseases, and chronic systolic (congestive) heart failure.<br><br>A review of the most recent comprehensive MDS, an assessment tool, with an assessment reference date of 1/21/25, had a brief interview for mental status (BIMS) score of 1 out of 15, which reflected that the resident's cognition was severely impaired.<br><br>A review of the electronic medical records (eMR) revealed that it was 982 days that the physician orders (PO) were overdue for review.<br><br>A review of the printed telephone orders that were filed in the resident's paper chart revealed that the PO on 10/13/23, 2/16/24, 5/14/24, 5/27/24, 6/5/24, 7/5/24, 7/15/24, 7/17/24, 11/6/24, 1/3/25, 1/4/25, 1/7/25, 2/9/25, and 3/5/25 were not signed by the Physician.<br><br>Further review of the paper chart revealed a Physician's Progress Notes (PPN) on 12/21/23, 2/15/24, 2/27/24, 5/10/24, 5/27/24, 6/3/24, 6/5/24, 6/10/24, 6/14/24, 6/17/24, 6/20/24, 7/2/24, 7/6/24, 7/10/24, 7/16/24, 7/22/24, 8/16/24, 8/30/24, 9/4/24, 9/11/24, 10/1/24, 10/24/24, 11/1/24, 12/2/24, 12/6/24, 1/6/25, 1/8/25, 1/20/25, 1/24/25, and 1/27/25, did not reflect that the Physician reviewed all medications (meds) of the resident.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/10/25 at 12:33 PM, S#1 interviewed the Licensed Practical Nurse (LPN) in the 2nd floor nursing station, who informed S#1 that Resident # 159 was declining cognitively and in adls (activities of daily living). S#1 asked the LPN when and where the Physician sign the orders, and the LPN responded that she was unsure what was the facility's process was about signing of monthly orders and telephone orders.<br><br>On 3/10/25 at 12:54 PM, S#1 notified the DON of the above concerns regarding signing of monthly orders and telephone orders. The DON confirmed after checking the chart and eMR that the Physician did not signed monthly orders for 982 days and the notes did not include meds review in their PPN.<br><br>On 3/11/25 at 1:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Regional LNHA (RLNHA), and Regional [NAME] President of Clinical Services (RVPoCS), and Surveyor #2 (S#2) discussed the above concerns and findings with Resident #159.<br><br>On 3/12/25 at 2:13 PM, the survey team met with the LNHA and DON, and the DON stated that the Physician was counseled about reviewing and signing of orders.<br><br>A review of the facility's Physician Services Policy, with a reviewed date of 10/2024, that was provided by the LNHA reflected, the purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality.<br><br>On 3/13/25 at 12:17 PM, the survey team met with the LNHA, DON, RLNHA, RVPoCS, and Regional Nurse for an exit conference and no additional information provided by the LNHA and DON.<br><br>NJAC 8:39-23.2(b); 35.2(d)(8) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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>49078<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medications and medical supplies safely and per standards of practice. This deficient practice was identified in 1 of 2 medication storage areas observed on the 2nd floor of the facility.<br><br>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 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>On 3/10/25 at 11:19 AM, the surveyor observed on the 2nd floor unit, in the presence of the assigned Licensed Practical Nurse (LPN) the following:<br><br>1. The surveyor observed adjacent to the nurses' station, one medication (med) storage cabinet, containing various in-house stock medications (meds), which was not locked.<br><br>2. The surveyor observed two other storage cabinets containing various medical supplies that was unlocked and did not have a lock affixed.<br><br>The surveyor interviewed the LPN if the cabinets should be locked when not in use. The LPN stated yes that they should always be locked. The LPN attempted to locate a key to lock the cabinets but was unable to lock the cabinets. The LPN stated she would call maintenance to get a key.<br><br>On 3/10/25 at 3:20 PM, the surveyor interviewed the facility Consultant Pharmacist (CP) by telephone. The surveyor asked the CP if the facility should store all meds and medical supplies securely and prevent unauthorized access. The CP stated yes, they should always be secured.<br><br>On 3/11/25 at 1:27 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the regional LNHA, and the Regional [NAME] President of Clinical Services (RVPoCS) of the concerns with the med storage cabinets not being secured on the 2nd floor. The surveyor asked if all meds and medical supplies be kept secured from unauthorized persons accessing them. The LNHA and RVPoCS both replied, Yes.<br><br>On 3/12/25 at 2:15 PM, the LNHA and the Director of Nursing (DON) met with the survey team. The LNHA stated that the med cabinets on the 2nd floor had new locks installed and were secured. Additionally, the LNHA stated the staff had been educated about keeping meds secured. There was no additional information provided by the facility.<br><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 - Few | A review of the facility's Medication Storage Policy, with a last reviewed date of October 2024, reflected under 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments ( .cabinets .).<br><br>NJAC 8:39-29.4(h) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>48781<br><br>REPEAT DEFICIENCY<br><br>Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to maintain sanitation in a safe and consistent manner to prevent food borne illness.<br><br>This deficient practice was evidenced by the following:<br><br>On 3/7/25 at 9:35 AM, the surveyor, in the presence of the Food Service Director (FSD), observed the following during the initial kitchen tour:<br><br>1. The surveyor observed the main stove-back splash with heavy, dry, thick brown substances. The FSD stated, It's grease .we clean it every two weeks sometimes a bit more with degreaser. The surveyor observed the FSD attempt to wipe off the thick brown substance on the back splash with his fingers, but the brown substance only smeared further.<br><br>2. The surveyor observed the stand-up oven next to the main stove which had a dry, white colored substance splattered on the side of the stand-up oven.<br><br>3. On the inside of the stand-up oven, the surveyor observed thick, grease-like substances, black, brown in color, more evident at the back of the oven and around the fan. The surveyor asked what the expectation was for equipment cleanliness. The FSD stated, The oven should not be like that.<br><br>4. The surveyor observed a large, rectangular ice cream freezer, with frost all around the upper edge of the freezer. The FSD stated the freezer was cleaned once a week on Fridays or Saturdays. The surveyor asked if frost should be there in the freezer and FSD replied, No, there should not be any frost . I don't know the reason for it.<br><br>On 3/7/25 at 10:26 AM, the surveyor requested from the Regional [NAME] President of Clinical Services (RVPoCS), the Licensed Nursing Home Administrator (LNHA), the Regional LNHA (RLNHA), and the Director of Nursing (DON), for the facility's policy and procedure of kitchen equipment cleaning.<br><br>On 3/7/25 at 1:10 PM, the RLNHA provided the surveyor with the facility's General Kitchen Cleaning policy.<br><br>On 3/10/25 at 1:01 PM, the surveyor conducted a follow up tour of the kitchen and interviewed the District Manager (DM) and the FSD. The DM stated the oven, stove backsplash and freezer were cleaned after the surveyor's observation. The DM further explained stoves and ovens were cleaned every two weeks and as needed. The surveyor asked the FSD if there was a log for when appliances were cleaned and a schedule for when staff cleaned the freezers, stoves and ovens. The FSD replied that there was no log and that he would write down on the dietary staff's assignment for the day tasks that were to be completed including cleaning equipment.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On the same date and time, the surveyor asked what the expectation was for when there was buildup of grease in the oven and frost build up in the freezer in between scheduled cleaning. The DM replied, it should be cleaned as needed and when staff observed that equipment required cleaning. The DM stated if staff had issue cleaning equipment they inform the FSD so that it could be addressed. The DM and FSD acknowledged the stove, oven, and the freezer should have been cleaned. The FSD provided the surveyor the weekly cleaning schedule. The schedule did not indicate when the stove, oven, and freezer were last cleaned.<br><br>On 3/11/25 at 1:22 PM, the surveyor notified the LNHA, the RLNHA, and the RVPoCS regarding the above concerns found during the kitchen tour.<br><br>On 3/12/25 at 2:14 PM, the LNHA and the DON met with the survey team. The LNHA stated that the concerns found in the kitchen were addressed and that moving forward they would ensure everything was taken care of.<br><br>A review of the facility's General Kitchen Cleaning Policy, with revised date of February 2024, revealed, The staff shall maintain the sanitation of the kitchen through compliance . Cleaning and sanitation tasks for the kitchen will be recorded.<br><br>NJAC 8:39-17.2(g) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>38327<br><br>Complaint NJ #179968; NJ #181921<br><br>Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain a complete, available, accurate, and readily accessible medical records. This deficient practice was identified for 5 of the 18 residents reviewed (Residents #3, #6, #24, #36, and #40).<br><br>This deficient practice was evidenced by the following:<br><br>1. On 3/7/25 at 10:52 AM, Surveyor#1 (S#1) observed Resident #6 was seated in a wheelchair inside their room with Certified Nursing Aide #1 (CNA#1). S#1 also observed CNA#2 with hoyer lift machine and Staffing Coordinator came out of the resident's room.<br><br>S#1 reviewed Resident #6's medical records and revealed:<br><br>A review of the Admission Record (AR, an admission summary) reflected that Resident #6 was admitted to the facility with medical diagnoses which included but not limited to; other Alzheimer's Disease, dysarthria (is a speech sound disorder resulting from neurological injury of the motor component of the motor-speech system) following unspecified cerebrovascular disease (stroke), unspecified osteoarthritis, unspecified site, contracture of left hand, and difficulty walking, not elsewhere classified.<br><br>A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of 1/16/25, had a brief interview for mental status (BIMS) score of 10 out of 15, which reflected that the resident's cognition was moderately impaired.<br><br>A review of the current Resident #6's personalized care plan (CP) reflected a focus CP for chronic pain on 12/3/24, fracture right 5th metatarsal that was revised on 12/4/24, that included interventions of NWB (non-weight bearing, a term used to describe a condition where a patient is not allowed to put weight on a specific limb or joint, often following surgery or injury) to right lower extremity per Ortho (Orthopedist) that was created on 12/11/24, by the Director of Nursing (DON).<br><br>A review of the Progress Notes (PN) that was created by the DON on 9/28/24, for effective date of 9/27/24, monthly review, reflected that Resident #6's musculoskeletal system was reviewed and there were left upper extremity contracture, with left hand splint, left leg extremity weakness, and right leg extremity weakness.<br><br>A review of the PN that was created by the Advance Practice Nurse (APN) for effective dates of 9/13/24 and 10/23/24, reflected that the APN examined the resident, the extremities had no edema and with normal ROM (Range of Motion, refers to the extent or limit to which a joint can be moved) x 4 (upper and lower extremities).<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Further review of the above PN revealed that there was discrepancy between the DON and the APN's PN with regard to limitations in resident's extremities.<br><br>On 3/10/25 at 1:13 PM, S#1 notified the DON of the above findings and concerns. The DON acknowledged the discrepancy on what the APN documented on their PN, and that should have been clarified to reflect the actual condition of resident, that the resident had limitations to left upper and right lower extremities. She further stated that the left upper extremity contracture and the right lower extremity weakness had been there since admission and was not something new to the resident,<br><br>On 3/12/25 at 2:13 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON, and S#1 notified them of the concerns about Resident #6's PN discrepancy with documentation regarding resident's limitations with left upper and right lower extremities.<br><br>On 3/13/25 at 11:11 AM, the survey team met with the LNHA, DON, Regional LNHA (RLNHA), and Regional [NAME] President of Clinical Services (RVPoCS). The DON stated that for Resident # 6's concerns, I spoke to the APN and we educated him. The RVPoCS also stated we spoke to primary physician of Resident #6 as well.<br><br>On 3/13/25 at 12:17 PM, the survey team met with the LNHA, DON, RLNHA, RVPoCS, and Regional Nurse for an exit conference and no additional information provided by the LNHA and DON.<br><br>49078<br><br>2. Surveyor #2 (S#2) reviewed the medical record for Resident #40 relative to the Facility Reported Event (FRE) of 11/16/24 which revealed the following:<br><br>A review of the AR reflected that Resident #40 was admitted to the facility with medical diagnoses which included but not limited to end stage renal disease (a condition when the kidneys stop working) and congestive heart failure (a condition where the heart does not pump efficiently due to fluid buildup).<br><br>A review of the qMDS, with an ARD of 9/26/24, had a BIMS score of 10 out of 15, which reflected that the resident's cognition was moderately impaired.<br><br>A review of the current Resident #40's CP reflected a focus CP for Documented Resident representative reported would like a room change.<br><br>A review of PN from nursing, physician and social services during the timeframe of the FRE revealed a Nurses Assessment note dated 11/16/24 that reflected the resident is expected to transfer rooms, reason was medical necessity, resident and resident's responsible party notified. The PN for any department did not reveal any other documentation related to the FRE or investigations related to the FRE.<br><br>3. S#2 reviewed the medical record for Resident #24 relative to the FRE of 11/16/24 which revealed the following:<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the AR reflected that Resident #24 was admitted to the facility with medical diagnoses which included but not limited to major depressive disorder (a mood disorder that causes a persistent feeling of sadness) and chronic obstructive pulmonary disease (a condition where damage to the lungs causes low airflow).<br><br>A review of the qMDS, with an ARD of 9/4/24, had a BIMS score of 15 out of 15, which reflected that the resident's cognition was intact.<br><br>A review of the current Resident #24's CP did not reveal any mention of a focus, goal or intervention related to the FRE.<br><br>A review of PN from nursing, physician and social services during the timeframe of the FRE, revealed hard copy physician PN in the physical chart dated 11/12/24, 11/16/24 and 12/24/24. These PN did not reflect any mention of the FRE or FRE investigation. Nursing PN in the electronic medical record (EMR) did not reflect any mention of the FRE or FRE investigation.<br><br>The medical record revealed a psychiatric consult dated 11/25/24 reflected that an incident that corresponds to the FRE occurred, but no other information.<br><br>4. S#2 reviewed the medical record for Resident #36 relative to the FRE of 12/23/24 which revealed the following:<br><br>A review of the AR reflected that Resident #36 was admitted to the facility with medical diagnoses which included but not limited to atherosclerotic heart disease (narrowing of the heart arteries) and hypothyroidism (low functioning thyroid gland).<br><br>A review of the qMDS, with an ARD of 11/30/24, had a BIMS score of 9 out of 15, which reflected that the resident's cognition was moderately impaired.<br><br>A review of resident #36's PN did not reveal any mention of the FRE, or investigation related to the FRE. The medical record did reveal a skin assessment, a pain assessment and a room transfer related to the FRE time frame.<br><br>The medical record revealed a psychiatry consult that mentioned the resident did not recall being hit by another resident.<br><br>5. The surveyor reviewed the medical record for Resident #3 relative to the FRE of 12/23/24 which revealed the following:<br><br>A review of the AR reflected that Resident #3 was admitted to the facility with medical diagnoses which included but not limited to osteoarthritis and cerebral infarction (stroke).<br><br>A review of the qMDS, with an ARD of 12/7/24, had a BIMS score of 0 out of 15, which reflected that the resident's cognition was severely impaired.<br><br>A review of Resident #3's CP revealed a Focus for a room change related to event of 12/23/24. No other Focus, Goal or Intervention related to the FRE.<br><br>(continued on next page) |

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| | 315349 | A. Building<br>B. Wing | 03/13/2025 |

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| Complete Care at Inglemoor, LLC | 333 Grand Ave<br>Englewood, NJ 07631 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of resident #3's PN did not reveal any mention of the FRE, or investigation related to the FRE under any discipline. The facility could not provide any other PN related to the FRE.<br><br>The facility provided separate investigative documentation, including but not limited to staff statements, investigative summaries, and reportable event documents for both FRE.<br><br>On 3/12/25 at 2:32 PM, the survey team met with the LNHA and the DON for concerns related to the FRE documentation. S#2 asked if there was an expectation for the staff to document in the medical record any type of timeline related to the incident when it was observed or reported. The DON stated yes, there should be a descriptive note. S#2 asked if all disciplines should be involved, and the DON stated yes, where appropriate.<br><br>At that same time, the DON stated that there were investigations that were completed as well as statements from staff. The surveyor asked if they were part of the medical record. The DON stated they were, but they were kept in a separate file/folder. S#2 asked if those files were kept in the paper chart or EMR. The DON replied no, they were separate.<br><br>A review of the facility's Incident Accident Reports Policy, dated 5/2024, reflected under Policy: It is the policy of this facility for staff to utilize (redacted EMR) to report, investigate and review any accidents or incidents that occur or allegedly occur .<br><br>Under Compliance Guidelines: 2. Licensed staff will utilize (redacted EMR) to report incidents/accidents and assist with completion of any investigative information to identify root causes.<br><br>The facility did not provide any further pertinent documentation.<br><br>NJAC 8:39-23.2 (a)(b); 35.2 (d)(6) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327<br><br>Based on interview, review of medical record, and review of other pertinent facility documents, it was determined that the facility failed to offer residents a pneumococcal and influenza vaccines or document the refusal and reason for ineligibility for the vaccines for 1 of 5 residents reviewed for unnecessary medications (Resident #55).<br><br>The deficient practice was evidenced by the following:<br><br>Reference:<br><br>According to the Centers for Disease Control (CDC) and Prevention, recommends pneumococcal vaccination (PCV) for many adults based on age, having certain risk conditions, and pneumococcal vaccines already received .<br><br>CDC recommends PCV15, PCV20, or PCV21 for adults who never received a PCV and are Ages [AGE] years or older Ages 19 through [AGE] years with certain risk conditions.<br><br>Chronic conditions and other factors that increase someone's risk for pneumococcal disease include Chronic heart, kidney, liver, or lung disease (Chronic lung disease includes chronic obstructive pulmonary disorder (COPD), emphysema, and asthma); Diabetes; Immunocompromising condition (having a weakened immune system).<br><br>According to CDC Public Law, dated 5/16/24, Influenza Vaccination Laws for State Long-Term Care Facilities, Flu vaccination laws for patients in long-term care facilities, All long-term care facilities .<br><br>In New Jersey, long-term care facilities must document evidence of annual vaccination against influenza for each resident.<br><br>The surveyor reviewed the Resident's #55's medical record which revealed the following information:<br><br>A review of the Admission Record (an admission summary) revealed that Resident #55 had been admitted to the facility with diagnoses which included but not limited to type 2 diabetes mellitus with hyperglycemia (is characterized by elevated glucose levels in the blood, typically above 180 to 200 mg/dL [milligrams per deciliter]) and moderate protein-calorie malnutrition.<br><br>A review of the most recent comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of 2/18/25, had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. Further review of the cMDS reflected that the influenza vaccine was not offered to the resident and the pneumococcal vaccine was up to date.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the electronic record under immunization tab, revealed that there was no documented evidence of information about resident's influenza and pneumococcal immunization records. There was no documented evidence in the electronic record that the vaccines were offered and declined, nor there was a documentation that education was provided to the resident about the two vaccines.<br><br>A review of the provided folder for Influenza vaccine consent forms by the Infection Preventionist Nurse (IPN) revealed that Resident # 55 had no consents on files.<br><br>On 3/10/25 at 12:05 PM, the surveyor interviewed the IPN. The IPN confirmed that the influenza vaccine was being offered to all residents by end of September and end of March. The IPN stated that the pneumococcal vaccine, will check if resident was vaccinated, pneumococcal shot goes after 5 years, over [AGE] years of age which most cases, then if they got one we do not offer anymore. The IPN further stated that everything should be documented in the electronic medical records, in the immunization tab for history.<br><br>On that same date and time, the surveyor notified the IPN of the above findings and concerns that Resident #55 had no documented evidence that the influenza and pneumococcal vaccines were offered and declined, education provided to the resident, and history of immunizations were in the resident's records.<br><br>On 3/10/25 at 12:22 PM, the surveyor reviewed the paper chart of the resident, and the surveyor did not find documentation of resident's immunization records.<br><br>At that same time, the surveyor interviewed the Licensed Practical Nurse (LPN), who confirmed that she did not find resident's consent forms that were signed for vaccines. The LPN further stated that it was the responsibility of the admitting nurse and the IPN to ensure that the consent forms will be signed and offered to the resident. The LPN also stated that the vaccines should be offered to all residents as facility's practice.<br><br>On 3/10/25 at 12:26 PM, the surveyor interviewed the MDS Coordinator (MDSC) about resident's MDS was coded for influenza vaccine not offered and no documented evidence that the pneumococcal and influenza vaccines were offered to the resident. The MDSC stated she coded not offered to the influenza vaccine because at the time of assessment she did not find a consent form that the vaccine was offered.<br><br>On 3/12/25 at 2:13 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor followed up with the LNHA and DON for resident #55 immunizations concerns. There was no verbal response from the LNHA and DON.<br><br>A review of the Influenza Vaccine Policy that was provided by the LNHA on 3/7/25, reviewed 12/2024, revealed:<br><br>Policy Interpretation and Implementation:<br><br>1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized .<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record .<br><br>6. A resident's refusal of the vaccine shall be documented on the consent form and placed in the resident's medical record .<br><br>8. The Infection Preventionist will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff .<br><br>A review of the facility's Pneumococcal Vaccine Policy, with a reviewed date of 5/2024, that was provided by the LNHA revealed that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.<br><br>Policy Interpretation and Implementation<br><br>1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.<br><br>2. Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission.<br><br>3. Before receiving a pneumococcal vaccine, the resident or legal representative shall received information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record.<br><br>On 3/13/25 at 12:17 PM, the survey team met with the LNHA, DON, Regional LNHA, Regional [NAME] President of Clinical Services, and Regional Nurse for an exit conference and no additional information provided by the LNHA and DON.<br><br>NJAC 8:39-19.4(h)(i) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>38327<br><br>Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer a resident a COVID-19 Immunization. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #55).<br><br>The deficient practice was evidenced by the following:<br><br>The surveyor reviewed the Resident's #55's medical record which revealed the following information:<br><br>A review of the Admission Record (an admission summary) revealed that Resident #55 had been admitted to the facility with diagnoses which included but not limited to type 2 diabetes mellitus with hyperglycemia (is characterized by elevated glucose levels in the blood, typically above 180 to 200 mg/dL [milligrams per deciliter]) and moderate protein-calorie malnutrition.<br><br>A review of the most recent comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of 2/18/25, had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. Further review of the cMDS reflected that the COVID-19 vaccination was not up to date.<br><br>A review of the electronic record under immunization tab, revealed that there was no documented evidence of information about resident's COVID-19 immunization records. There was no documented evidence in the electronic record that the vaccine was offered and declined, nor there was a documentation that education was provided to the resident about the COVID-19 vaccines.<br><br>A review of the provided folder for COVID-19 vaccines consent forms by the Infection Preventionist Nurse (IPN) revealed that Resident # 55 had no consents on files.<br><br>On 3/10/25 at 12:05 PM, the surveyor interviewed the IPN, and the IPN confirmed that the COVID-19 vaccine was being offered usually when we have new vaccine available and on new residents. The IPN stated everything should be documented in the electronic medical records, in the immunization tab for history.<br><br>On that same date and time, the surveyor notified the IPN of the above findings and concerns that Resident #55 had no documented evidence that the COVID-19 vaccines were offered and declined, education provided to the resident, and history of immunizations were in the resident's records.<br><br>On 3/10/25 at 12:22 PM, the surveyor reviewed the paper chart of the resident, and the surveyor did not find documentation of resident's COVID-19 immunization records.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At that same time, the surveyor interviewed the Licensed Practical Nurse (LPN), who confirmed that she did not find resident's consent forms that were signed for COVID-19 vaccines. The LPN further stated that it was the responsibility of the admitting nurse and the IPN to ensure that the consent forms will be signed and offered to the resident. The LPN also stated that the vaccines should be offered to all residents as facility's practice.<br><br>On 3/10/25 at 12:26 PM, the surveyor interviewed the MDS Coordinator (MDSC) about resident's MDS was coded for COVID-19 not up to date and no documented evidence that COVID-19 vaccines were offered to the resident.<br><br>On 3/12/25 at 2:13 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor followed up with the LNHA and DON for resident #55 immunizations concerns. There was no verbal response from the LNHA and DON.<br><br>A review of the COVID-19 Vaccination Policy, with a reviewed date of 12/16/24, that was provided by the LNHA revealed that it was the facility's policy to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 by educating and offering residents and staff the COVID-19 vaccine .<br><br>On 3/13/25 at 12:17 PM, the survey team met with the LNHA, DON, Regional LNHA, Regional [NAME] President of Clinical Services, and Regional Nurse for an exit conference and no additional information provided by the LNHA and DON.<br><br>NJAC 8:39-19.4 (a) |