| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315362 | A. Building<br>B. Wing | 03/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Complete Care at Park Place LLC | 2 Deer Park Drive<br>Monmouth Junction, NJ 08852 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>Based on observation, interviews, and facility document review, the facility failed to ensure personal protective equipment (PPE) was worn by laundry staff in one of one laundry rooms while sorting soiled resident clothing and bed linens. This had the potential to infect the staff and/or residents with pathogens which could potentially lead to the development of infectious diseases.Findings include:During an observation conducted with the Infection Preventionist (IP) on 03/13/26 at 9:42 AM, upon entrance to the laundry room, the Laundry Aide was observed reaching into a soiled container of linens and loading them into the washing machine. The Laundry Aide wore disposable gloves but did not wear a protective gown. During the observation, the Laundry Aide stated that he/she had forgotten to don (put on) a protective gown prior to handling the soiled items. At 9:44 AM, The Director of Environmental Services (DES) entered the area and confirmed the Laundry Aide was required to don a protective gown since this was a potential infection control issue. The IP stated that the Laundry Aide should have been wearing a gown, as the staff member was handling soiled linens and resident clothing, which constituted an infection control concern.During an interview on 03/13/26 at 10:04 AM, the Director of Nursing (DON) stated it was his/her expectation that laundry staff don gowns and gloves prior to handling soiled items since this could spread infection for the workers and others.Review of an undated document provided by the facility titled Sorting Soiled Linens, indicated, . The laundry room must have a process in place to effectively sort soiled linen without cross contaminating clean linen . This requires employees to use proper PPE . NJAC 8:39-19.4 |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observation, interview, and document review, the facility failed to maintain a safe, clean, comfortable, and homelike environment on the memory care unit. Specifically, the floor in the dining/activity area was observed to be sticky. Additionally, a large table surface was visibly dirty. The sticky floor posed a potential risk for residents who ambulate, as it could contribute to loss of balance of falls. The unclean condition of the table had the potential to attract pests. Findings include:During an observation conducted on 03/10/26 at 10:35 AM of the memory care unit's main dining/activity room, there were multiple staff and residents in the area participating in activities. The floor was observed to be dull and sticky. There was a rectangular table that faced the back wall and cabinets. The table's surface was visibly smudged, contained fingerprints, and had large areas of dry, raised substance. The observation ended at 12:10 PM. During an observation conducted on 03/10/26 at 1:52 PM, the memory care's dining/activity room had a small group of residents who were participating in an activity with staff in the area. The floor was sticky. The rectangular table that faced the back wall and cabinets was soiled with fingerprints, smudges, and a thick, dry raised substance. The observation ended at 3:58 PM. During an observation conducted on 03/11/26 at 8:36 AM, the memory care's main dining/activity room had a few residents waiting for breakfast. The floor was still sticky. The rectangular table still had fingerprints, smudges and a thick dried, raised substance on it. No residents were served their breakfast meal on this table. The observation ended shortly after observing the breakfast meal being served and eaten by the residents. During an observation conducted on 03/11/26 at 12:00 PM, the memory care's dining/activity area had a few residents waiting for the lunch meal. The floor continued to be sticky. There were a few residents sitting next to the rectangular table. In addition, there were three unknown residents and visitors sitting at this table. The Activity Aide (AA) 1 stated that he/she noticed the soiled rectangular table and would alert a staff member to clean it off. AA1 stated that housekeeping typically cleaned the area. On 03/11/26 at 12:16 PM, the floor technician arrived and donned (put on) gloves, sprayed the table and was able to effectively clean off the fingerprints, smudges, and the dried substance. The floor technician verified the condition of the soiled table. One of the two visitors who wanted to remain anonymous stated that the sticky floors were from using too many chemicals and stated he/she used to work in a nursing home. The second visitor began to stand up and attempted to walk away from the rectangular table, and his/her shoes stuck to the floor. On 03/11/26 at 12:45 PM, the Administrator entered the unit and walked through the dining/activity room. The Administrator stated that his/her shoes were stuck to the floor. During an interview on 03/11/26 at 12:58 PM, the Housekeeper stated he/she cleaned the memory care's dining/activity area. The Account Manager, from another facility, stated that the cleaner that the facility used had a neutralizer which was to prevent the floor from being sticky. The Account Manager confirmed that the dining/activity floor was sticky. During an interview conducted on 03/11/26 at 2:07 PM, the Director of Environmental Services (DES) stated that the Housekeeper arrives at 7:00 AM each morning and swept and then washed the dining/activity floor. During the interview, the facility provided a document titled Garden or Terrace for the 7:00 AM to 3:00 PM shift, which failed to contain evidence of the cleaning schedule for the memory unit's dining/activity area. During an interview on 03/12/26 at 12:03 PM, the Regional District Manager for the facility's housekeeping company stated that they were able to identify the cause of the sticky dining/activity floor. The Regional District Manager stated that the chemical used to wash the floor needed re-calibration. Review of a document provided by the facility titled Ecolab dated 03/12/26, indicated that the floor chemical dispenser was out of alignment and required replacement and calibration. The document confirmed that the floor was sticky. NJAC 8:39-4.1(a)(11)NJAC 8:39-31.4(a)(f) |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure that a comprehensive Minimum Data Set (MDS) assessment was completed accurately to reflect post-traumatic stress disorder (PTSD) for one of four residents (R87) reviewed for mood/behavior related to PTSD in the sample of 25 residents. This failure had the potential to affect the care planning and provision of needed services.Findings include:Review of R87's Face Sheet located in resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included PTSD. Review of R87's Hospital Notes dated 01/28/26 located in the EMR under the Misc tab revealed a diagnosis of PTSD effective 11/2024. Review of R87's admission MDS with an Assessment Reference Date (ARD) of 01/28/26 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Further review revealed no active diagnosis of PTSD indicated. Review of R87's Diagnosis tab of the EMR dated 02/05/26 revealed a diagnosis of PTSD. During an interview on 03/13/26 at 9:47 AM, the Minimum Data Set Coordinator (MDSC) stated the PTSD diagnosis should have come across on the diagnosis list, but the diagnosis was not entered into the EMR's diagnosis tab until 02/05/26, and somehow it was missed. It should have been indicated on the admission MDS. During an interview on 03/13/26 at 10:05 AM, the Director of Nursing (DON) stated that he/she expected MDS assessments to be completed accurately. Review of the Resident Assessment Instrument (RAI) User's Manual, dated 10/01/25 and located at https://www.cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf revealed, The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS. There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis . Specific documentation may be found in . hospital discharge summary . NJAC 8:39-33.2(d) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure the baseline care plan included information necessary to meet the care needs for one of two sampled residents (Resident (R) 91) reviewed for dialysis.Specifically, the baseline care plan did not address peritoneal dialysis (PD). This failure had the potential to result in staff lacking the necessary guidance to provide effective care and meet the resident's needs. Findings include:Review of R91's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed R91 was admitted to the facility on [DATE] with diagnoses that includes end stage renal disease (ESRD). Review of R91's Physician Orders, located in the EMR under the Orders tab, reflected an order, dated 02/27/26, for, Peritoneal dialysis: Exchange frequency: Q [every] 4 Hours. Exchange volume: 2L [liters] Dialysate: 2.5% Dianeal [sterile solution used for dialysis]. Instill PD Fluid over: 20mins [minutes]. PD fluids drain time: 20Mins. Continue with . Home prescription with a cycler [portable machine used for dialysis] . Patient uses a combination of 2.5% and 1.5% bags. (usually 2 green and 1 yellow bag). Every evening shift for PD. The Baseline Care Plan, located in the EMR under the Assessments tab, dated 02/27/26, failed to include the presence of peritoneal dialysis and interventions to implement for care.During an interview on 03/12/26 at 1:45 PM, Licensed Practical Nurse (LPN) 3 stated, The nurse responsible for the admission does the baseline care plan, or sometimes the unit manager. I'll be honest, I don't know. I have to look it up since I don't usually work the times we get the admissions.During an interview on 3/12/26 at 1:50 PM, LPN4 stated, I believe the supervisor does [the baseline care plans], but it may fall onto the unit manager. I'm not real sure since they are kind of new. Yes, I believe peritoneal dialysis should be included on it [the baseline care plan].During an interview on 03/12/26 at 4:48 PM, the Director of Nursing (DON) stated, The supervisor or nurse would write it, [the baseline care plan] and we would look at it the next morning. The staff on the 7AM to 3PM shift don't get many admissions. Just uncertain as to why it was missed.Review of the facility's policy titled, Care Plans- Baseline, updated on 10/2019, revealed, To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. The interdisciplinary team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the Resident's immediate care needs . NJAC 8:39-11.2 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of Resident Assessment Instrument (RAI) User's Manual, and policy review, the facility failed to develop person-centered, comprehensive care plans with measurable goals and interventions for two residents (Resident (R) 13 and R87) reviewed for care plans out of a sample of 25 residents. The failure placed R13 at risk for skin breakdown due to incomplete and/or inconsistent care to prevent pressure ulcers and placed R87 at risk for compromised emotional stability and impaired daily functioning related to a diagnosis of Post Traumatic Stress Disorder (PTSD).Findings include:<br><br>1. Review of R13's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/01/23.<br><br>Review of R13's EMR titled annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/25, located under the MDS tab indicated that the staff could not determine a Brief Interview for Mental Status (BIMS) score for the resident. The resident was identified to be at risk for the development of pressure ulcers. Review of the Care Area Assessment (CAA) indicated that the resident triggered for pressure ulcers and directed the staff to develop a care plan.<br><br>Review of R13's EMR titled Care Plan located under the Care Plan tab failed to contain evidence that the facility developed a care plan for pressure ulcers.<br><br>During an interview conducted on 03/12/26 at 11:21 AM, the MDS Coordinator (MDSC) stated that if an area triggers under the CAA, and directs staff to develop a care plan, then staff were to develop a care plan from the area that was triggered. The MDSC confirmed that there was no care plan for R13 being at risk for the development of pressure ulcers.<br><br>During an interview conducted on 03/12/26 at 4:47 PM, the Director of Nursing (DON) stated if the CAA triggered a care area and directed staff to develop a care plan, he/she would expect that this would be done. The DON stated it was important to develop an appropriate care plan since this was a guide for a resident's care.<br><br>Review of the Resident Assessment Instrument (RAI) User's Manual, dated 10/25, located at www.cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf,indicated . The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA (Care Area Assessment) process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based trigger conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers . After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT [Interdisciplinary Team] must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs .<br><br>2. Review of R87's admission Record located in resident's electronic medical record (EMR) under the<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included PTSD.<br><br>Review of R87's admission MDS with an ARD of 01/28/26 and located in the resident's EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.<br><br>Review of R87's Care Plan dated 01/28/26 and located in the residents' EMR under the Care Plan tab revealed the resident was at risk for PTSD; however, there were no interventions in place for staff to be aware of potential stressors or triggers.<br><br>During an interview on 03/12/26 at 1:59 PM, the Social Services Director (SSD) stated when a resident is admitted with a diagnosis of PTSD that it was discussed during the clinical meetings and morning support. He/she said that that specific diagnosis stays in the back of his/her mind as someone with trauma, but sometimes the residents did not tell him/her what their trauma was. She said R87 should have been care planned for PTSD, and he/she was unsure why it was missed.<br><br>During an interview on 03/13/26 at 10:05 AM, the DON stated that R87 would not discuss what his/her trauma was or potential triggers or stressors. The DON stated there was no documentation in the resident's medical record that staff had attempted to discuss R87's PTSD with him/her, and there should have been.<br><br>During an interview on 03/13/26 at 11:10 AM, R87 stated he/she had no issues with discussing his/her past trauma and that he/she saw psych providers regularly. R87 stated he/she had spoken with the SSD, but no staff had asked him/her about potential triggers or stressors.<br><br>Review of the facility's policy titled, Comprehensive Care Plans, dated 06/01/25, revealed, . 'Trauma-informed care' is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.<br><br>NJAC 8:39-11.2 (e) thru (i)<br><br>NJAC 8:39-27.1(a) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents received services to maintain or improve their activities of daily living (ADLs) for one of one resident (Resident (R) 19) reviewed for ADLs out of a sample size of 25 residents.Specifically, R19 was not properly assessed by the facility's interdisciplinary team prior to the staff altering the method of meal consumption by placing pureed food and thickened liquids into a plastic cup for the resident to consume.This had the potential for the resident to experience a decline in functioning. Findings include:1. Review of R19's electronic medical record (EMR) titled admission Record located under the Profile tab indicated that the facility admitted the resident on 12/13/24. Review of R19's EMR titled Care Plan located under the Care Plan tab dated 05/27/25, indicated that the resident required verbal cues during mealtimes provided by one staff member. There was no direction to provide the resident with a plastic cup to consume his/her meals. Review of R19's EMR titled physician Orders located under the Orders tab dated 07/29/25, indicated that the resident was to be provided with a pureed meal with nectar thick liquids. There were no other written orders that directed staff to use a plastic cup to allow the resident to consume his/her meals. Review of R19's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/26, located under the MDS tab indicated that the staff could not determine the resident's Brief Interview for Mental Status (BIMS) score. The resident had no impairment of bilateral upper body extremity function. R19 required supervision or touch assistance with eating. Review of R19's EMR titled dietary Progress Notes dated 01/06/26, located under the Prog (Progress) Notes tab indicated that the resident was losing weight, and this was to be expected since the resident received hospice services. There was no mention that the resident required his/her meals to be taken by drinking it out of a plastic cup. During an observation conducted on 03/10/26 at 12:30 PM, R19 was pulled up to a table. Certified Nurse Aide (CNA) 3, a hospice staff member assigned to the resident, had the resident's tray in front of R19. CNA3 placed the resident's pureed food in a plastic cup and then poured thickened liquids into the cup and stirred the contents. The resident picked up the cup and drank it. An interview took place at 12:47 PM, and CNA3 stated that the resident consumed his/her meals better with the food being placed in a cup instead of him/her assisting the resident with the meal. The meal ticket was provided during this interview. The meal ticket failed to direct the staff to pour the resident's pureed meal into a cup.During an observation conducted on 03/11/26 at 9:29 AM, CNA3 was present in R19's room and assisted the roommate of R19 with his/her meal during the interview. R19's tray was not sitting in front of him/her. R19's breakfast meal was 100 percent consumed. CNA3 confirmed that he/she poured R19's pureed breakfast meal into the plastic cup for the resident to be able to feed himself/herself. During an interview on 03/11/26 at 3:14 PM, the Regional Registered Dietician (RD) 2 stated he/she reviewed R19's clinical records and there was no note that would indicate that the resident was assessed to have his/her meal poured in a plastic cup. During an interview conducted on 03/12/26 at 11:15 AM, the Director of Rehabilitation (DOR) and the Speech Therapist (ST) stated that there was no prior assessment in place for R19 for the resident to use a plastic cup to ingest his/her meals. During an interview conducted on 03/12/26 at 4:47 PM, the Director of Nursing (DON) stated it was his/her expectation that for a resident to drink his/her meals from a cup, an assessment should be in place to identify the benefit, and it should then be care planned. Review of a facility policy titled, Activities of Daily Living (ADLs), dated 06/01/25, indicated, . The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable . 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to administer oxygen in accordance with physician orders, document oxygen use, and change oxygen tubing for one of two residents (Resident (R) 87) reviewed for oxygen therapy out of a total of 25 sampled residents. This failure had the potential to place the resident at risk for adverse outcomes related to improper oxygen administration, including hyperoxia, a condition in which cells, tissues, and organs are exposed to an excessive level of oxygen. Findings include:Review of R87's Face Sheet located in resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE], with diagnoses which included unspecified asthma.Review of R87's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/28/26 and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R87's Care Plan dated 01/28/26 and located in the resident's EMR under the Care Plan tab revealed there were no interventions in place for oxygen use.Review of R87's Physician Orders located under the Resident tab in the EMR indicated an order dated 01/29/26, for Oxygen: Administer oxygen (O2) via nasal cannula as needed for SOB [shortness of breath]/low O2 at: 2 [two] liters/minute [liters per minute] . There was no order to change the oxygen tubing.Review of the Medication Administration Record (MAR) dated March 2026 and located under the Orders tab revealed no documentation that oxygen was administered to R87.During observations on 03/11/26 at 12:35 PM and 03/12/26 at 10:46 AM, R87 was lying in bed with the oxygen concentrator approximately two feet from the left side of the bed administering oxygen at three liters per minute via nasal cannula. Further review revealed the tubing was undated. During an interview and observation on 03/12/26 at 10:46 AM, Licensed Practical Nurse (LPN) 3 confirmed R87's oxygen concentrator setting and stated, It is on three liters right now. LPN3 stated that he/she did not document on the MAR that R87 was using oxygen. LPN3 also confirmed the tubing was undated and stated he/she was not sure if the tubing had been changed; the night shift was responsible for that. During an interview on 03/13/26 at 10:05 AM, the Director of Nursing (DON) stated he/she expected the oxygen flow to be set at the correct amount or a revised order to be obtained for three liters per minute. The DON also stated staff should indicate as needed (PRN) oxygen use on the MAR, and the tubing should be changed and dated. No policy was provided. NJAC 8:39-27.1(a) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure that, prior to the installation of bed rails, alternative measures were attempted, discussions regarding the risks versus benefits were documented, and signed informed consent was obtained for one of four residents (Resident (R) 108) reviewed for bed rails out of 25 sampled residents. The failure to complete these required steps before bed rail installation increased the potential risk for resident entrapment or for bed rails to be used as restraints. Findings include: Review of R108's admission Record in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE], with diagnoses of repeated falls and muscle weakness.Review of R108's Side Rail Assessment Screening located under Assessments tab in the EMR, dated 03/04/26, revealed no indication if bed/side rails would be used or not used. Further review revealed no documentation of risk versus benefits or signed informed consent. Review of R108's Care Plan located under the Care Plan tab of the EMR, dated 03/05/26, revealed no care plan for bed/side rail use. Review of R108's Physician Orders located under the Orders tab in the EMR, dated 03/10/26, revealed no order for bed/side rail use.Review of R108's 5-day Minimum Data Set (MDS) assessment under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/11/26 revealed a Brief Interview for Mental Status (BIMS), score of 15 out of 15 indicating intact cognition. Observations on 03/10/26 at 1:44 PM and on 03/11/26 at 3:10 PM, revealed R108 in bed with a side rail up on the right side. During an interview on 03/11/26 at 3:10 PM, Licensed Practical Nurse (LPN) 4 revealed residents use bed/side rails for repositioning and to turn side to side. LPN4 was unable to answer whether the facility explored alternatives prior to bed/side rail use and stated that all the bed/side rails were already on the beds. He/she was also unsure if the resident signed a consent form for bed/side rail use and stated he/she would need to talk to the unit manager about the care plan. LPN4 said the unit managers should be aware of bed rail use since the bed rails were already on the beds, so he/she did not need to tell anyone that a resident had bed rails. LPN4 completed the risk of entrapment for R108 and was unsure why he/she did not complete R108's bed rail assessment. LPN4 said the bed rail assessment should indicate whether the resident would use bed rails. LPN4 also verified that R108's bed rail consent was not completed or signed by the resident. During an interview on 03/13/26 at 10:05 AM, the Director of Nursing (DON) stated that staff should discuss the risks and benefits of bed/side rail use with the residents, and they should complete the informed consent form. The DON was unaware that alternatives were supposed be explored prior to bed/side rail use. Review of the facility's policy titled, Proper Use of Bed Rails, revised 10/07/25, revealed, it is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. NJAC 8:39-27.1(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315362 | A. Building<br>B. Wing | 03/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Park Place LLC | 2 Deer Park Drive<br>Monmouth Junction, NJ 08852 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>Based on interviews, record review, and hospice agreement review, the facility failed to obtain documentation of recertification of hospice services for one of one resident (Resident (R) 14) reviewed for hospice services out of a total sample of 25 residents. This had the potential to result in a lack of coordination of care and services. Findings include:Review of R14's electronic medical record (EMR) titled admission Record located under the Profile tab indicated that the facility admitted the resident on 02/22/17.Review of R14's EMR titled physician Orders located under the Orders tab dated 12/16/24, indicated the resident was ordered hospice services.Review of R14's EMR titled annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/25, located under the MDS tab indicated that the staff could not determine the resident's Brief Interview for Mental Status (BIMS) score. The assessment indicated that the resident was dependent on staff for all activities of daily living and had a diagnosis of having six months or less to live. Review of R14's EMR Misc (Miscellaneous) tab failed to show that the facility maintained the hospice recertification in the clinical record at the time of the survey. Review of R14's hospice book, a communication book between hospice visits and the facility, failed to contain evidence that the hospice provided the facility with copies of the hospice recertification. During an interview conducted on 03/11/26 at 9:14 AM, the Director of Nursing (DON) stated he/she would need to reach out to the Social Services Director (SSD) to locate the hospice recertification documents for R14. During an interview conducted on 03/11/26 at 10:44 AM, the SSD confirmed that R14's hospice book did not contain the recertification documents for the resident. The SSD stated that the interdisciplinary team met monthly with hospice to discuss the resident's care. The SSD stated the meetings were when hospice would notify the facility if a resident was recertified for hospice services or not. During an interview conducted on 03/11/26 at 10:59 AM, the Director of Clinical Services for hospice stated that he/she has only provided verbal notification of recertification of a resident for hospice services and had never provided the recertification documents to the facility. The Director of Clinical Services stated that hospice staff does meet with the facility once a month and verbally reports to the facility whether a resident has been recertified or not for hospice services. During an interview conducted on 03/11/26 at 11:13 AM, The DON brought in R14's recertification documents for the past year and confirmed that they were received on this date. The documents were not available in R14's clinical record prior to request. Review of a document provided by the facility titled, Nursing Facility Hospice, General Inpatient and Respite Care Services Agreement, dated 04/21/21, indicated that hospice would provide the facility with . a copy of the physician certification and recertification of the terminal illness specific to each Hospice patient . NJAC 8:39-5.1(a) |