STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315376	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Health Care Center	301 Sicomac Ave Wyckoff, NJ 07481

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Complaint #2708006Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to, a.) administer a medication (med) to a resident (Resident # 239) without a valid physician's order (PO) and b.) document the administration of med and reason as to why med was not administered according to PO (Resident #371), in accordance with professional standards and facility's policies and procedures. The deficient practices were identified on 2 of the 38 residents medications reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual 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. 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. 1.On 2/19/26, Surveyor #1 (S #1) reviewed the electronic and paper medical record (MR) for Resident #239. A review of the MR revealed a Resident Face Sheet (RFS, an admission summary) that reflected that the resident was previously admitted with diagnoses that included but were not limited to hypertension (high blood pressure) and hyperlipidemia (excessive amounts of fats specifically cholesterol and triglyceride in the blood). A review of Resident #239's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/24/25, reflected, in Section C-Cognitive Status, that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated that Resident #239 had moderate cognitive impairment. On 2/24/26 at 11:39 AM, S #1 interviewed the Unit Manager (UM) for the unit where Resident #239 had resided and asked if they remembered the resident and if there were any concerns the resident voiced. The UM stated that they did recall the resident somewhat but wanted to check their notes and get (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back to S #1. On 2/24/26 at 11:49 AM, S #1 interviewed the Social Worker (SW) assigned to the unit where Resident #239 had resided and asked if they remembered the resident and if there were any concerns the resident voiced. The SW stated that they did remember the resident but wanted to check their notes for anything specific and get back to S #1. On 2/24/26 at 1:08 PM, S #1 asked the Director of Nursing (DON) about the information requested from the UM and SW. The DON stated that they would check. On 2/25/26 at 9:51 AM, the DON provided the requested information that S #1 requested for Resident #239. The provided documents revealed incident reports and timelines, progress notes (PN), individual statements, and records of remedial education. A review of the document titled Statement Form dated 12/22/25, reflected a statement from a nurse that they had given the resident a med intended for another resident. The statement reflected that the med was Omeprazole (a med used for excessive stomach acid, reflux or ulcers). A second Statement Form dated 12/21/25, reflected a statement from a different nurse that the resident had reported to them that another nurse had given them an antacid pill and they refused a thyroid pill that was offered because they were not on that med. A document titled Record of Additional/Remedial Education dated 12/22/25, reflected that the nurse who stated that they gave med to the wrong resident received additional education on safe med administration. The facility did not provide any further pertinent information. A review of the facility's Policy: Medication Administration, dated effective 1/26, the policy reflected under, 3. Identify resident/patient using 2 identifiers: photo in the MAR (Medication Administration Record) and or patient/resident identification wrist band, and/or ask and confirm the resident/patient's name if cognitive intact .10. Ensure that the six rights of med administration are followed. a. Right resident b. right drug . 2.On 2/17/26 at 10:51 AM, Surveyor #2 (S #2) observed Resident #371's door with posted sign for EBP (Enhanced Barrier Precautions). Inside the room, the Resident Representative (RR) was seated in a regular chair and Resident #371 was on bed, awake and non-verbal. The RR informed S #2 that the resident fell from home, hospitalized , and sustained a brain bleed. S #2 reviewed the MR for Resident #371. A review of the RFS, reflected that Resident #371 was admitted to the facility with the diagnoses which included but not limited to; traumatic subdural hemorrhage (a type of traumatic brain injury that causes dangerous pressure on the brain) with loss of consciousness status unknown, subsequent encounter, history of falling, unspecified protein-calorie malnutrition, malignant neoplasm (cancerous) of unspecified part of bronchus or lung, and secondary malignant neoplasm of cerebral meninges (three layers of protective membranes that surround and protect the brain and spinal cord). A review of the MDS) revealed that it was in progress and to be completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the PO, dated 2/14/26, order for ondansetron HCL 8 mg (milligram) tablet (tab), give 1 tab (8 mg) by g-tube (gastrostomy tube; a medical procedure that creates an opening through the abdominal wall directly into the stomach to insert a feeding tube) route every 8 hours as needed (PRN) for nausea/vomiting. The above order for ondansetron was transcribed to the Resident Medication Administration Record (RMAR) as PRN med. The RMAR was signed for PRN on 2/18/26. A review of the PN, dated 2/15/26 at 11:58 AM, electronically signed by Registered Nurse #1 (RN #1), under action, keeping in mind that patient (also known as resident) vomited 11-7 shift after previous bolus (as reported by Registered Nurse #2 (RN #2). Further review of the PN revealed the following documentations: -On 2/16/26 at 7:09 AM, electronically signed by RN #2, Resident had 1 x vomit episode at 6:20 AM. -On 2/16/26 at 11:50 PM, electronically signed by Licensed Practical Nurse (LPN), Patient c/o (complaint of) nausea: ondansetron HCL 8 mg tab PRN given with positive results. -On 2/19/26 at 2:54 PM, electronically signed by RN #3, under response: PRN Zofran (also known as ondansetron) given for nausea with relief. Further review of the MR revealed that there was no documented evidence that the PRN ondansetron was administered on 2/15/26, 2/16/26 at 7:09 AM or as to why the med was not administered when the resident had c/o nausea or vomiting. In addition, there was no documented evidence that the RMAR was signed by nurses when the PRN ondansetron was administered on 2/16/26 at 11:50 PM and 2/19/26 at 2:54 PM according to the PN. On 2/24/26 at 12:31 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and S #2 notified them of the above findings and concerns with regard to PRN ondansetron. A review of the facility's Policy: Medication Administration that was provided by the DON, with an effective date of 1/26, revealed under policy, medications (meds) are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice.Policy Explanation and Compliance Guidelines: 11. Review MAR to identify med to be administered.17. Sign MAR after administered. On 2/25/26 at 11:21 AM, the survey team met with the LNHA and DON in responses to the above concerns. The DON stated that the ondansetron administered should have been signed by the nurse in the RMAR and should have followed the PO. She also acknowledged that there should have been documentation as to why the PRN ondansetron was not administered and the non-pharmacological interventions were tried first prior to giving med. NJAC 8:39-11.2(b); 29.2 (b)(d)