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

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| Christian Health Care Center | 301 Sicomac Ave<br>Wyckoff, NJ 07481 |

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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>Based on observation, interview, and review of facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation in a manner intended to prevent the spread of food borne illness and in accordance with professional standards for food service safety. This deficient practice was evidenced by the following:On 2/17/26 at 9:54 AM, during the initial tour of the kitchen, in the presence of the Senior Director of Dining Nutrition Services (SDoDNS) and the Manager of DNS (MoDNS), the surveyor observed the following in refrigerator 3: a container of cottage cheese that was labeled with an open date of 2/9/26 and a use by date of 2/12/26. The MoDNS stated that the facility policy was to discard opened items seven days after they were opened. He added that someone probably put the wrong use by date on the label and that today was the last date. The surveyor asked the MoDNS if the open date was 2/9/26 then would the discard date seven days later be 2/16/26. The MoDNS confirmed and threw the item in the garbage. On 2/17/26 at 9:59 AM, in the presence of the SDoDNS and MoDNS, the surveyor observed the following in freezer 2: 1. 8 cups with lids that were labeled sb which had a sticker with exp (expiration) 2/2/26. 2. 5 cups with lids that were labeled clams that had a sticker with use by 2/16/26. 3. 1 cup with lid that was labeled clam sauce that had a sticker with use by 1/18/26. On 2/17/26 at 10:00 AM, in the presence of the SDoDNS and MoDNS, the surveyor observed the Chef who brought a tray of prepared food from the preparation area to the refrigerator area that had facial hair longer than a quarter inch. The Chef was not wearing a beard guard. The surveyor asked the SDoDNS if the Chef should be wearing a beard guard. The SDoDNS stated that the Chef should of had a beard guard on. On 2/24/26 at 12:45 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that the chef was not wearing a beard guard and four different items located in the refrigerator and freezer were past their use by date.On 2/25/26 at 11:21 AM, in the presence of the DON, the LNHA stated that they updated the policy on attire for the DNS staff and in-serviced the staff on wearing beard guards. The LNHA stated that the items were immediately discarded after surveyor inquiry and that they updated the policy to have both the prepared date and use by date. She added that the staff were in-serviced. A review of the facility's Dining and Nutrition Services Dress Code Policy with an effective date of 1/26, did not include any information on beard guards. A review of the facility's Food Storage Standards in DNS Policy with an effective date of 1/25, included the following:[name redacted] stored in refrigerators and freezers are to be covered, labeled and dated.NJAC 8:39-17.2(g) |

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 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on observation and interview, it was determined that the facility failed to, a.) post the State of New Jersey (State) inspection results in an area that was readily accessible to residents, families, and the public and b.) ensure reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction available for review. This deficient practice was observed in 2 of 2 common areas in the facility (reception desk and west lounge area).The deficient practice was evidenced by the following:On 2/20/26 at 11:35 AM, the surveyor asked Receptionist #1 (R #1) where the facility's survey results was and she responded that she was a Volunteer and she did not know, and she had to ask Receptionist #2 (R #2) who was the regular receptionist. At that time, R #2 was unable, and the surveyor was unable to locate the survey results.On 2/20/26 at 11:40 AM, the surveyor went to the Heritage Manor (HM) [NAME] unit and asked the Registered Nurse (RN) who were at the nursing station, where the survey result was, and she stated that she would have to ask someone.Afterward, the RN came back and stated that the survey results were on the other side of the HM [NAME] unit. The Concierge Manager (CM) came and accompanied the surveyor to the Hearth Area also known as the lounge area of the HM [NAME] unit, at the other end of the unit. The CM showed the white binder Annual Long Term Care Survey which was in the book shelf, next to the books. The CM confirmed that the survey result binder had the most recent recertification survey results dated 10/8/24, and that there was no other survey results printed and filed in the binder. The CM stated that she was unsure what the policy and requirements for posting survey results were.At that same time, the surveyor notified the CM that the survey binder result was not readily accessible, and unable to locate unless someone from the facility knew where it was. The CM did not respond.On 2/20/26 at 11:45 AM, the surveyor returned to the reception desk, the main entrance to the facility, and asked R #2 where the facility's survey results were, and she stated that it was inside a cabinet near the entry door, and it should be in the bottom of the cabinet. The surveyor located the cabinet and saw the white binder on the bottom of the cabinet. The survey binder results were not easily accessible.At that same time, the surveyor observed a white binder Annual Long Term Care Survey with survey results dated 10/8/24 and a Focus Infection Control (FIC) Survey dated 1/17/24. There were no other survey results in the binder except for the two survey dates.On 2/20/26 at 11:47 AM, the surveyor interviewed the Director of Nursing (DON) regarding the survey results in the white binder. The DON confirmed that the survey results inside the binder were from 10/8/24 recertification survey and the 1/17/24 FIC Survey. The surveyor asked the DON if she was aware of the regulation regarding survey results and she responded that they were required to put the most recent survey results which was the 10/8/24. The surveyor then asked for the facility's policy about survey results, and she stated that she would get back to the surveyor.On 2/20/26 at 1:50 PM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that the facility had no policy with regard to the posting of survey results. She further stated that as far as she knew the facility was required to have the last recertification survey which was the October 2024 results in the survey binder for residents and visitors. She further stated that she was not aware that it should be at least the 3 years surveys which could include recertification surveys and other surveys like complaint surveys.At that same time, the surveyor notified the LNHA of the concern that the survey results were not easily accessible for those two common areas, the reception desk and HM [NAME] nursing unit. The surveyor also notified the LNHA that the RN and R #1 were not aware where the survey results were located.On 2/24/26 at 11:12 AM, the LNHA provided a copy of Policy: Survey Binder Availability with an original date and effective date of 2/26, revealed under Policy: all surveys, certifications, and complaint investigations made of or about Christian Health during the 3 preceding years and any plan of correction in effect will be available for individuals to review. Definitions: place readily accessible<br>(continued on next page) |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | is an area (such as HM [NAME] (Hearth Bookcase) or other area frequented by most residents, visitors or other individuals where individuals wishing to examine survey results do not have to ask to see them. Results of the most recent survey means the Statement of Deficiencies (Form CMS-2567) generated by the most recent standard survey and any deficiencies resulting from any subsequent complaint investigation(s) The LNHA confirmed that the policy was formulated after surveyor's inquiry. On 2/24/26 at 12:31 PM, the survey team met with the LNHA, DON, and the surveyor notified them of the above findings and concerns with the posting of survey results. The LNHA stated, We corrected the survey binder and put the last three years survey results. The LNHA further stated that the survey results were out of the cabinet in the reception desk to be more accessible, after surveyor's inquiry. A review of the facility's survey history revealed that the facility had recertification survey on 6/14/23, FIC survey on 1/15/24, and complaint surveys on 7/2/24 and 12/16/25 which were not filed in the survey binders. NJAC 8:39-9.4(b)(c) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to include in the written notification of transfer that was provided to the Resident or Resident Representative (RR), the facility's bed hold reserve payment and the Long-Term Care Ombudsman (LTCO) information and appeals rights for 2 of 2 residents, (Resident #365 and Residents #369), reviewed for hospitalizations. This deficient practice was evidenced by the following:<br><br>1.On 2/25/26, Surveyor #1 (S #1) reviewed the hybrid (electronic and paper) medical records (MR) of Resident #365.<br><br>A review of Resident #369's Resident Face Sheet (RFS, an admission summary), reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, essential hypertension (high blood pressure) and type 2 diabetes mellitus (a chronic condition where the body resists the effects of insulin or fails to produce enough).<br><br>The MR revealed a New Jersey Universal Transfer Form (UTF) that the resident was transferred to a hospital emergency room for generalized weakness and to rule out sepsis.<br><br>A review of Resident #365's discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #365's cognition was intact. Further review of the MDS indicated that the resident was transferred to a short-term general hospital.<br><br>A review of Resident #365's electronic MR included a letter to the RR dated 1/4/26, which included that the resident was transferred to the hospital and admitted with a fever and that attached was a copy of the Notice of Bed-Hold Policy-Secondary Notification. The letter did not include the bed hold reserve payment amount. The letter did not include the LTCO information or the resident's appeal rights.<br><br>2.On 2/18/26 at 12:51 PM, Surveyor #2 (S #2) reviewed the hybrid MR of Resident #369.<br><br>A review of Resident #369's RFS reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; metabolic encephalopathy (a broad term for acute or subacute brain dysfunction caused by chemical imbalances, systemic illness, or organ failure), type 1 diabetes mellitus (chronic autoimmune condition where the immune system destroys insulin-producing beta cells in the pancreas, resulting in little to no insulin production which leads to high blood sugar (hyperglycemia), requiring lifelong insulin therapy, blood sugar monitoring, and careful management to prevent complications), and congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues).<br><br>A review of Resident #369's most recent discharge MDS reflected that the resident had a BIMS score of 14 out of 15, which indicated that Resident #369's cognition was intact. Further review of the MDS indicated that the resident was transferred to a short term general hospital.<br><br>A review of Resident #369's electronic MR included a letter to the RR dated 1/30/26, which included that the resident was transferred to the hospital and admitted with DKA (diabetic ketoacidosis) and (continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that attached was a copy of the Notice of Bed-Hold Policy-Secondary Notification. The letter did not include the bed hold reserve payment amount. The letter did not include the LTCO information or the resident's appeal rights.<br><br>On 2/20/26 at 9:31 AM, S #2 interviewed the Director of Admissions and Case Management (DoAaCM) regarding the written notification required when a resident was transferred to the hospital. The DoAaCM stated that after the confirmation that the resident was admitted to the hospital, the next morning the letter with the bedhold information was sent to the RR. S #2 asked if the bed reserve payment information was on the letter. The DoAaCM stated that the price was not on the letter and that it may be in the admission agreement. She added that this was a secondary notice and that the first notice was in the admission agreement which had the usual per diem rate and fee schedule.<br><br>On 2/24/26 at 12:45 PM, S #2 notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that Resident #369's written emergency transfer notification did not include the bed hold reserve payment and the LTCO and appeal information.<br><br>On 2/25/26 at 11:27 AM, in the presence of the DON, the LNHA stated that they changed the notice to include the appeal process and reserve payment. The LNHA stated that the admission staff were in-serviced on the new process.<br><br>A review of the facility's Transfer and Discharge (including AMA) Policy with an effective date of 11/25, included the following: Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source.10. Emergency Transfers to Acute Care.g. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated.<br><br>The LNHA revealed in the letter that was signed by the DSS that the letter was to inform of the bed hold policies of the facility. In accordance with NJ (New Jersey) Medicaid guidelines, the facility will reserve your bed for a period of 10 days if you are a Medicaid recipient.For short term resident whose payment is Medicare or private insurance, the bed hold provisions noted above for private pay residents will apply.<br><br>The policy did not provide any information regarding the contents for the notice of transfer and bed hold notice.<br><br>A review of the facility's admission Process Policy with an effective date of 4/2025, included the following: I. Bedhold: Pursuant to the terms outlined in the admission Contract, Resident's bed will be held in the following manner: a. Private Pay Residents: Preference regarding bed-hold is indicated at the time of admission. If bed-hold is elected, resident's bed will be held until return or until facility is otherwise notified to release bed-hold by resident or responsible party. b. Medicaid Residents: Resident's bed will be held for a period of 10 days as per current regulation. If resident has not returned to the facility before the end of the 10-day hold period expires, the resident may be readmitted to a different room (if previous room is no longer available) or placed on a waiting list and offered the next available bed. c. Beds will not be held for Short-Term Rehab patients. Primary Notice of Bedhold Policy is provided upon Admission. Secondary Notice of Bedhold Policy is provided the morning following confirmed discharge by contacting Resident Representative via mail with copy of notification to review the policy; email confirmation is provided if email is available.<br><br>NJAC 8:39-4.1(a)31; 5.1 |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure that the completion of the Minimum Data Set (MDS), a Significant Change in Status Assessment (SCSA), was done in a timely manner. This deficient practice was identified for 1 of 35 residents reviewed for resident assessments (Resident # 85), and was evidenced by the following:On 2/17/26 at 11:42 AM, the surveyor observed Resident #85 sitting up on a bed and a Certified Nursing Assistant (CNA) assisting the resident with the lunch tray. On 2/18/26 at 10:56 AM, the surveyor observed the resident lying in bed. The surveyor asked Resident #85 if they were okay, the resident nodded their head, and then closed their eyes.On 2/18/26 at 11:03 AM, the surveyor interviewed the License Practical Nurse (LPN) who stated that she was on duty when the resident fell on 9/30/25 in the hallway. The LPN also stated the resident was trying to grab something from their cart, the resident was with a CNA, and the resident lost their balance and fell. The LPN further stated that an X-ray was done which revealed a fracture of the right hip, was sent out to the hospital, and had surgery. The LPN stated that the resident used to walk, received therapy when the resident was re-admitted but did not follow directions, was not able to stand up, had poor balance, and a mechanical lift was now being used for transfers (Hoyer). On 2/18/26 at 4:15 PM, the surveyor reviewed the medical record for resident #85. A review of the Resident face sheet (an admission summary) reflected that the resident had diagnoses which included but not limited to;displaced intertrochanteric fracture right femur, subsequent for closed fracture with routine healing, history of falling; Alzheimer's disease, Parkinson's, age related osteoporosis without current pathological fracture, muscle weakness, and unsteadiness on feet.A review of the Care Plan (CP) revealed for Activities of Daily Living (ADL) dated 12/20/24, transfers independent, walking 10 feet independent, lower body dressing supervision or touching assistant. A CP for falls dated 10/13/25, additional detail- RLE (right lower extremity) ORIF (Open Reduction and Internal Fixation, a surgical procedure used to treat severe, displaced, or complex bone fractures. It involves opening the skin (open reduction) to realign fractured bones and using hardware like metal plates, screws, or rods to stabilize them for proper healing) 10/2025, Hoyer lift as needed for transfers, Weight Bearing as Tolerated (WBAT) RLE.A review of the Order Summary revealed the following: Monitor incision sites to right hip and thigh every shift dated 10/9/25; Notify Medical Doctor/Nurse Practitioner (MD/NP) to evaluate for staple removal today as per ortho (orthopedic) surgeon dated 10/13/25; Hoyer lift as needed dated 10/13/25; WBAT RLE dated 10/13/25.A review of the quarterly MDS (MDS) with an assessment reference date (ARD) of 9/19/25, revealed a Brief Interview of Mental Status (BIMS) with impaired cognition; lower body dressing with supervision or touching assistance; walked 10 feet independently; walked 50 feet independently; and transferred independently.A review of the comprehensive MDS dated [DATE], revealed, the resident with lower body dressing partial/moderate assistance; walking 10 feet-not attempted due to medical condition or safety concerns; walking 50 feet-blank. There was no SCSA MDS done when the resident was re-admitted on 10/2025. The resident was re-admitted with Right Hip ORIF, a surgical wound to right upper leg and a Hoyer transfer.On 2/20/26 at 11:32 AM, the surveyor interviewed the Rehabilitation Director, Physical Therapist (PT), who stated that the resident was on therapy program from 10/10/25- 2/4/26. She further stated that the resident came from the hospital with post fall and right femur fracture, was walking before that, had a complete change of function, and decline: maximal/total assist; Hoyer transfer; no progress in therapy, and reached maximum potential. The PT stated, I would say, a Significant Change, based on decline of physical function status, the resident was walking 25 feet contact guard on 6/30/25, now non-ambulatory, transfers were now dependent, lower body dressing prior level was maximal assistance and now total assistance. She further stated that she did not think we discussed Significant Change at that time.A review of the PT evaluation on 10/10/25, (continued on next page) |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revealed transfers prior level of function (PLOF) was minimal assistance and on 10/10/25, total dependent; ambulation PLOF 25 feet with contact guard assistance and on 10/10/25, non-ambulatory. A review of the OT (Occupational Therapy) evaluation on 10/10/25 revealed lower body dressing PLOF was maximum assistance and on 10/10/25 totally dependent.On 2/20/26 at 11:51 AM, the surveyor interviewed the MDS Manager/Registered Nurse (MDSM/RN), who stated, My Coordinator for the Long-Term Care was responsible for scheduling assessment for Significant Change MDS, with two or more decline. She further stated that if there were two areas of a decline, we do a Significant Change, as per the Resident Assessment Instrument (RAI) Manual (guidance to assess residents' clinical and functional needs). On 2/20/26 at 11:59 AM, interviewed the MDS Coordinator/RN (MDSC/RN) who stated, I did not complete this particular MDS, but multiple areas were triggered a Significant Change to be done. She also stated that the Assistant Director of Nursing (ADON) would let us know a decline, sometimes Social Worker would let us know of BIMS and if there were decline, the Dietician for weight changes. She further stated, we communicate as a team and send a notification. She added that If they did not have their baseline, then we triggered the Significant Change. MDSC/RN stated that she categorized all the ADLs as one area and would require another area of decline. On 2/20/26 at 1:11 PM, both the MDSM/RN and MDSC/RN provided the surveyor with an e-mail dated 10/17/25 from MDSC/RN addressed to ADON regarding a possible Significant Change. There was no evidence of a SCSA MDS being completed at this time.On that same date and time, the surveyor asked, according to the RAI manual, what was the timeframe to do a Significant Change assessment from the resident's physical status change. The MDSC/RN responded, I was not involved in resident's care, we did a team meeting 12/23/25, and rehab proceeded, the team did not designate a Significant Change. MDSC/RN further stated, if I was doing that MDS I would trigger a Significant Change.Furthermore, the MDSM/RN confirmed, it was 14 days to complete a SCSA from the day of the determination of a decline. The surveyor asked, this e-mail was dated 10/17/25, and the resident was re-admitted on [DATE], should a SCSA been completed before the 12/18/25, and the MDSM/RN responded Yes. On 2/24/26 at 12:32 PM, the survey team met with the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding the concern with SCSA not being completed within two weeks of resident not returning to their baseline.On 2/25/26 at 11:22 AM, the survey team met with the LNHA and DON stated with regard to the missed SCSA, we did an in-service, everybody was educated on the real time to do a SCSA.A review of the facility's Policy: MDS 3.0 Completion revealed under Policy Explanation and Compliance Guidelines .#2 (d) SCSA-a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements .a major decline or improvement in a resident's status that will not normally resolve itself without intervention by staff .impacts more than one area of the resident's health status .NJAC 8:39-11.1; 11.2(i) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on interviews and record review, it was determined that the facility failed to complete and transmit the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within 14 days as required, for 2 of 38 residents, (Resident #132 and Resident #347), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following:According to the Resident Assessment (RAI) Manual, dated October 2025, RAI-required Assessment Summary:-The admission (Comprehensive) assessment, the MDS completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The CAA(s) (Care Area Assessment) Completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The Care Plan Completion date is no later than CAA(s) Completion date + 7 calendar days. The Transmission date is no later than Care Plan Completion date + 14 calendar days.-The Discharge MDS assessment return not anticipated, the MDS completion date is the discharge date + 14 calendar Days. The Transmission date is MDS Completion date + 14 calendar days.On 2/19/26 at 11:17 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) and MDS Manager/RN (MDSM/RN) regarding MDS. Both the MDSC/RN and the MDSM/RN informed the surveyor that the facility followed the RAI Manual when completing an MDS assessment. They further stated that an Entry MDS to be completed and submitted or transmitted within seven days, for Discharge MDS to be completed within 14 days and plus another 14 days for transmission, and for Quarterly and comprehensive MDS to be completed within 14 days and plus 14 more days for transmission.On that same date and time, the surveyor asked if they had issues of not completing and transmitting the MDS within RAI manual timelines or requirements, or did they have late completion and transmission of MDSs. The MDSM/RN responded that there were one or two that were late but for the most part they were able to complete and transmit MDSs in a timely manner. The surveyor then asked the MDSM/RN for transmission reports for Resident #132 and Resident #347, and she stated that she would get back to the surveyor.On 2/19/26 at 12:40 PM, the MDSM/RN met with the surveyor and provided copies of MDS transmission reports for Residents #132 and #347. The MDSM/RN stated while showing the documents that Resident #347's Discharge MDS with an assessment reference date (ARD) of 10/17/25, was completed and submitted but did not show in the transmission report that it was transmitted or accepted by CMS. The MDSM/RN stated that she thought it was a glitched with the electronic records that they were using.On that same date and time, she also stated that for Resident #132's MDS, the comprehensive MDS with an ARD of 4/17/25, was submitted but it did not show in the transmission report that it was transmitted or accepted by CMS, and it was probably a glitch also.On 2/19/26 at 12:53 PM, the surveyor reviewed the MDS provided by the MDSM/RN and MDS in the electronic medical records, and revealed:1.Resident #132's comprehensive MDS assessment with an ARD of 4/17/25, admission date of 4/10/25, Care Plan Completion date was 4/23/2025, completion date was on 4/23/25 and was submitted (or transmitted) on 2/19/26. The comprehensive MDS was transmitted late, after 300 days, which should have been transmitted no later than Care Plan Completion date + 14 calendar days.2.Resident #347's Discharge MDS assessment return not anticipated (DRNA) with an ARD of 10/17/25, was completed on 10/30/25 and was transmitted on 2/19/26. The discharge MDS was transmitted late, after 112 days, which should have been transmitted MDS Completion date + 14 calendar days.On 2/20/26 at 9:43 AM, the MDSM/RN confirmed that Resident #132's MDS was submitted on 2/19/26 for an ARD of 4/17/25, which was the admission MDS because it was not transmitted and they did not know it was not transmitted until surveyor's inquiry. The DRNA MDS of Resident #347 was submitted 2/19/26 for an ARD of 10/17/25, which was transmitted after surveyor's inquiry. On 2/24/26 at 12:31 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the surveyor<br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | notified them of the above findings and concerns with regard to late transmissions of MDSs of Residents #132 and #347.A review of the facility's MDS.0 Completion Policy that was provided by the DON, with an effective and original date of 10/25, revealed under Policy Explanation and Compliance Guidelines .2. Types of OBRA (Omnibus Budget Reconciliation Act of 1987, in MDS refers to federal nursing home regulations establishing mandatory, standardized assessment schedules for all residents in certified facilities, regardless of payer type) Assessments: a. Entry Tracking 1. Complete and submit with every entry into the facility no later than entry date + 7 calendar days .b. admission Assessment-completed within 14 days of admission counting the day of admission as day #1 when: .f. Discharge Assessment-completed using the discharge date as the ARD, must be completed within 14 days of the discharge date /ARD On 2/25/26 at 11:21 AM, the survey team met with the LNHA and DON for responses for the above concerns, the LNHA did not provide additional information.NJAC 8:39 - 11.1 |

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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>Based on interview and record review, it was determined that the facility failed to accurately complete a portion of the Minimum Data Set (MDS), an assessment tool that facilitates the plan of care, to accurately reflect the resident's status for 2 of 38 residents reviewed (Residents #304 and #367).This deficient practice was evidenced by the following:<br><br>1.On 2/17/26 at 10:32 AM, Surveyor #1 (S #1) observed Resident #304 lying in bed asleep. Resident #304's private aid stated that sometimes the resident went outside with staff to smoke.<br><br>On 2/18/26 at 11:02 AM, S #1 interviewed the Registered Nurse (RN) who stated that Resident #304 was allowed to smoke one cigar a day but that the resident did not go out every day.<br><br>A review of Resident #304's Resident Face Sheet (RFS, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; dementia (a general term for a group of brain disorders that cause a decline in cognitive function, including memory, thinking, reasoning, language, and judgment), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), and nicotine dependence.<br><br>A review of Resident #304's individualized comprehensive care plan (CP) reflected a focus area for smoking.<br><br>A review of Resident #304's most recent comprehensive Minimum Data Set (cMDS) reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated that Resident #304's cognition was moderately impaired. Further review of the MDS indicated under Section J that the resident's current tobacco use was coded as no. The MDS was coded incorrectly.<br><br>On 2/24/26 at 11:15 AM, S #1 interviewed the MDS Manager/Registered Nurse (MDSM/RN) regarding the process for MDS assessment for a resident that smoked. The MDSM/RN stated that on the comprehensive there was a question for tobacco use. S #1 asked if Resident #304 smoked. The MDSM/RN stated that Resident #304 smoked. S #1 asked the MDSM/RN to view Resident #304's last cMDS. The MDSM/RN stated that she was not the one that did Resident #304's cMDS and that she would have to talk to the person who did.<br><br>On 2/24/26 at 11:58 AM, S #1 interviewed the Director of Nursing (DON) who stated that Resident #304 had smoked since she had been at the facility. S #1 asked the DON if Resident #304's MDS should indicate that the resident smoked, and the DON stated that she would expect it to be on the MDS.<br><br>On 2/24/26 at 12:45 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #304's MDS was not coded accurately for the resident's tobacco use.<br><br>On 2/25/26 at 11:26 AM, in the presence of the LNHA, the DON stated that the MDS was modified and that education was provided to staff on MDS accuracy.<br><br>The LNHA did not provide any additional information.<br><br>The facility did not provide a policy regarding MDS accuracy.<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 | 2. On 2/25/26 at 10:30 AM, Surveyor #2 (S #2) reviewed the MDS Section A revealed under Section A0310G, Type of Discharge, was coded as 2 - Unplanned.<br><br>Further review of the MDS Section A0310F reflected that the assessment was coded as 10 - Discharge assessment - return not anticipated, and Section A2105, Discharge Status, was coded as 01 - Home/Community. Section Q0400 indicated that active discharge (d/c) planning was already occurring for the resident to return to the community.<br><br>A review of the Nursing Progress Note (PN) dated 12/8/25 at 4:04 PM, revealed that the resident was discharged to home at 3:00 PM. The PN further indicated that the Resident's Representative (RR) and resident were informed of all d/c instructions, physician follow-up appointments, and medication reconciliation was completed. The resident left the building alert and verbally responsive with all belongings.<br><br>A review of the Medical Discharge Summary, electronically signed on 1/2/26, reflected a d/c date of 12/8/25, with a condition noted as stable, and follow-up with the primary care physician was scheduled within 35 days.<br><br>A review of the CP dated 12/2/25 revealed d/c goals including: the resident would be discharged within 30 days, would attain and be discharged at optimal level of functioning, and would be discharged to the appropriate level of care. All goals were documented as discharged with an effective date of 12/2/25.<br><br>A review of the therapy d/c summaries (Physical Therapy, Occupational Therapy, and Speech Therapy), all signed on 12/8/25 and 12/9/25, consistently documented the d/c reason as discharged to Home and reflected that the patient made progress throughout the plan of treatment and was discharged with family support. None of the therapy documentation indicated an unplanned or emergent d/c.<br><br>On 2/25/26 at 10:55 AM, S #2 interviewed the MDS Coordinator/RN (MDSC/RN) regarding the inaccuracy identified in Resident #367's MDS. The MDSC/RN stated, It is planned because he is going home. When asked if she saw the section checked off as unplanned, she responded, Yes I see it, and further stated, It should have been planned. She further stated that it was not a d/c against medical advice. She also stated that if the resident went home or to another facility it was usually a planned d/c. She added that a Per Diem MDS Coordinator completed the MDS assessment and the cause of the inaccuracy was human error.<br><br>A review of the facility's MDS 3.0 Assessment Process Policy, reviewed on 10/2025, by the DON, revealed under Policy that the current version of the RAI Manual will be utilized when conducting a comprehensive assessment. The MDS 3.0, according to federal regulations, requires the facility to conduct accurate and standardized assessments of each resident's functional capacity using the RAI, including for d/c planning .<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 - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>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:<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 2/19/26, Surveyor #1 (S #1) reviewed the electronic and paper medical record (MR) for Resident #239.<br><br>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).<br><br>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.<br><br>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 back to S #1.<br><br>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.<br><br>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.<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 - Few | 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.<br><br>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).<br><br>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.<br><br>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.<br><br>The facility did not provide any further pertinent information.<br><br>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 .<br><br>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.<br><br>S #2 reviewed the MR for Resident #371.<br><br>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).<br><br>A review of the MDS) revealed that it was in progress and to be completed.<br><br>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.<br><br>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.<br><br>A review of the PN, dated 2/15/26 at 11:58 AM, electronically signed by Registered Nurse #1 (RN #1), (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 - Few | 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).<br><br>Further review of the PN revealed the following documentations:<br><br>-On 2/16/26 at 7:09 AM, electronically signed by RN #2, Resident had 1 x vomit episode at 6:20 AM.<br><br>-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.<br><br>-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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>NJAC 8:39-11.2(b); 29.2 (b)(d) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>REPEAT DEFICIENCYBased on interview and record review, it was determined that the facility failed to follow the physician's orders with regard to enteral tube feeding administration to assure the total volume was administered. This deficient practice was identified for 1 of 2 residents, (Residents #11), reviewed for enteral tube feeding.This deficient practice was evidenced by the following:On 2/24/26 at 12:53, the surveyor reviewed the closed medical records of Resident #11 and revealed:A review of the Resident Face Sheet (an admission summary) revealed that Resident #11 was admitted to the facility with diagnoses that included but were not limited to; unspecified severe protein-calorie malnutrition, dysphagia unspecified (swallowing problem), encounter to gastrostomy (a medical procedure that creates an opening through the abdominal wall directly into the stomach to insert a feeding tube) and heart failure unspecified.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/19/26, with a brief interview for mental status (BIMS) score of 12 out 15, indicated that resident's cognitive status was moderately impaired. In Section K (Swallowing/Nutritional Status), Resident #11 was coded as receiving nutrition through a feeding tube while a resident.A review of the physician's order (PO) dated 1/16/26, indicated the resident was NPO [nothing by mouth].A review of the PO dated 1/16/26, reflected an order for tube feeding (TF) method via pump Jevity 1.5 continuous at 55 ml/hr (milliliters/hour) for 18 hours or until 990 ml has been delivered. Stop time: 1 PM (1:00 PM).The above order for TF was transcribed to the Resident Medication Administration Record (RMAR), plotted at 1:00 PM, and signed by nurses as administered from 1/17/26 to 1/27/26. The following dates were signed by nurses with no total volume (TV) indicated or TV documented was not according to the PO of 990 ml:2/19/26, TV documented was 703 ml2/20/26, TV documented was 8 ml2/25/26, TV was blank2/26/26, TV documented was 112 ml2/27/26, TV was blankOn 2/25/26 at 8:59 AM, the surveyor interviewed the Director of Nursing (DON) and asked what the facility's process and expectation for the nurses with regard to PO in the RMAR was. The DON responded, to follow the orders and clarify if needed. The surveyor notified the DON of the above findings and concerns with PO with regard to TV of 990 ml was not followed.A review of the facility's Policy: Enteral Feeding and Accidental Tube Displacement that was provided by the DON, with an effective date of 11/25, reflected under enteral feedings, preparation, 1. Verify physician's order.III. Additional Nursing Care/Responsibilities/Documentation.2. Document amount of residual, type and amount of feedings as administered.On 2/25/26 at 11:21 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON for responses for the above concerns. The LNHA and DON did not provide additional information.NJAC 8:39-25.2(c)2; 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>Repeat Deficiency Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services of residents that were receiving oxygen, according to the standard of clinical practice and the facility's policy and procedure, specifically, ensuring the appropriate rate of oxygen delivery was set for 1 of 3 residents, Resident #172 and by documenting the date and time the oxygen tubing was changed for 1 of 3 residents, Resident #102.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 2/17/26 at 10:25 AM, during the initial tour of the facility, the surveyor observed Resident #102 in bed, sleeping, with an oxygen (O2) nasal cannula (n/c) (tubing that supplies O2 to the body through small tubes in the nostrils), applied and connected to an O2 concentrator (a machine that takes room air and delivers concentrated O2 to a person through tubing). The surveyor observed that the concentrator was set to deliver 2 liters per minute (lpm) and the tubing was connected to a humidification bottle (a container of water that the O2 bubbles through to add moisture to the O2). The surveyor observed that the tubing and humidifier had the date of 2/6/26 written in marker.The surveyor reviewed the electronic medical record (eMR) for Resident #102.A review of the Resident Face Sheet (RFS; an admission record) that reflected that the resident was admitted to the facility with diagnoses which included but not limited to hypoxemia (a condition characterized by abnormally low levels of O2 in the blood) and chronic kidney disease (a condition where the kidneys do not function fully).A review of the resident's Quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/18/25, Section C, revealed a Brief Interview of Mental Status (BIMS) score of 5 of 15, indicating that the resident had severe cognitive impairment.A review of the resident's Physician Order Sheets (POS) (a list of the resident's active medication and other orders) revealed the following orders: 1) an order that reflected Monitoring: Check for use of O2 concentrator weekly - clean filter, change tubing and humidifier. Schedule: Every week on Thursday. 2) Respiratory Therapy: O2 n/c 2 lpm.A review of the Resident Medication Administration Record (RMAR) revealed an order for the 11:00 PM-7:00 AM shift that reflected: Check for use of O2 concentrator weekly - clean filter, change tubing and humidifier. The RMAR also reflected that the order was documented as completed on 2/5/26 and 2/12/26.A review of the resident's Comprehensive Care Plan (CCP) revealed an intervention that reflected: Check for use of O2 concentrator weekly - clean filter, change tubing and humidifier. 2. On 2/17/26 at 10:27 AM, the surveyor observed Resident #172, in their room, seated in a wheelchair (w/c) with an O2 n/c applied, connected to a concentrator. The surveyor asked the resident how they use their O2. The resident stated that they use it all the time and need it day and night. The surveyor observed the concentrator setting reflected 2.5 lpm.The surveyor reviewed the eMR for Resident #172.A review of the RFS reflected that the resident was admitted to the facility with diagnoses which included but not limited to chronic obstructive pulmonary disease (a progressive, incurable lung disease that causes obstructed airflow) and chronic respiratory failure (a<br>(continued on next page) |

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| | 315376 | A. Building<br>B. Wing | 02/25/2026 |

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| Christian Health Care Center | 301 Sicomac Ave<br>Wyckoff, NJ 07481 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | long-term condition where the lungs cannot properly exchange O2 and carbon dioxide, resulting in chronically low O2).A review of the resident's cMDS, with an ARD of 1/6/26, Section C, revealed a BIMS score of 15 of 15, indicating that the resident had no cognitive impairment. Section O revealed that the resident was receiving O2 therapy.A review of the resident's POS revealed the following orders: 1) an order that reflected: Respiratory Therapy O2: n/c, Continuous 2 lpm.A review of the RMAR revealed an order for O2: n/c, Continuous 2 lpm.A review of the resident's CCP revealed an intervention that reflected: O2: n/c, continuous 2 lpm.On 2/20/26 at 10:23 AM, the surveyor interviewed the facility nurse educator (NE) about the policy for O2 tubing dating and concentrator settings. The NE stated that both the respiratory therapist and nurses are responsible for changing tubing and appropriate settings.On 2/24/26 at 12:31 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the observations for Resident #102 and #172. The surveyor asked the DON who was responsible for changing tubing and O2 settings. The DON stated that both the respiratory therapist and nurses were responsible for changing tubing and appropriate settings. On 2/25/26 at 11:22 AM, the survey team met with the LNHA and the DON stated that education was conducted for staff relating to O2 tubing and humidifier dating and correct settings.The LNHA did not provide any further pertinent information.A review of the facility's Policy: Respiratory Therapy, date effective 2/26, the policy reflected, under Subject: Oxygen Therapy, Procedure: 14: Change all disposable equipment weekly or per Institution's infection control guidelines . NJAC 8:39-11.2(b); 27.1(a) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a.) the blood pressure medications were administered for Resident #11, in accordance with the physician's orders (PO) and b.) the insulin was administered and documented in accordance with the PO for Residents #4 and #369. The deficient practices were identified on 3 of the 38 residents medications reviewed.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 2/24/26 at 12:53, Surveyor #1 (S #1) reviewed the closed medical records of Resident #11 and revealed:<br><br>A review of the Resident Face Sheet (RFS; an admission summary) revealed that Resident #11 was admitted to the facility with diagnoses that included but were not limited to; unspecified severe protein-calorie malnutrition, dysphagia unspecified (swallowing problem), encounter to gastrostomy (a medical procedure that creates an opening through the abdominal wall directly into the stomach to insert a feeding tube) and heart failure unspecified.<br><br>A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/19/26, with a brief interview for mental status (BIMS) score of 12 out 15, indicated that resident's cognitive status was moderately impaired.<br><br>A review of the PO dated 1/16/26, reflected an order for midodrine 5 mg (milligram) tablet (tab), give 1 tab (5 mg) by peg tube (Percutaneous Endoscopic Gastrostomy (PEG) tube is a flexible feeding tube surgically inserted through the abdominal wall directly into the stomach to provide long-term nutrition, hydration, and medication) route every 8 hours as needed (PRN) for orthostatic hypotension (give for SBP (systolic blood pressure) below 100). Schedule: every 8 hours PRN. Protocol: hold if SBP greater than 130; do not administer midodrine 4 hours prior to bedtime. Monitor: blood pressure (BP).<br><br>A review of the PO dated 1/18/26, reflected an order for C-metoprolol suspension 12.5 mg/5 ml (milligram/milliliters), give 10 ml by g-tube (gastrostomy tube; also known as peg tube) route once daily with food (10 ml=25 mg) for heart failure. Schedule: every day at 8:00 AM (8 AM). Protocol: hold for SBP less than 100 and/or HR (heart rate) less than 60. Monitor: BP and pulse.<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The above order for midodrine was transcribed to the Resident Medication Administration Record (RMAR), plotted as PRN, and signed by nurses as administered on 1/18/26, 1/26/26, and 1/29/26 with following BP:<br><br>1/18/26 at 4:44 PM, BP 78/42<br><br>1/26/26 at 10:00 AM, BP 99/54<br><br>1/29/26 at 7:05 PM, BP 99/45<br><br>Further review of the PRN PO for midodrine revealed that the medication (med) was administered on 1/29/26 at 7:05 PM, which was four hours prior to bedtime, and the PO was not followed.<br><br>The above order for C-metoprolol was transcribed to the RMAR, plotted at 8 AM, and signed by nurses as administered, and there were no documented evidence that the BP was obtained when the med was administered from 1/19/26 to 1/27/26 according to PO.<br><br>On 2/25/26 at 8:59 AM, S #1 interviewed the Director of Nursing (DON) and asked what the facility's process and expectation for the nurses with regard to PO in the RMAR and medications (meds) with parameters were. The DON responded, to follow the orders and clarify if needed. The DON further stated that the parameters for BP should be monitored and documented in the RMAR.<br><br>On that same date and time, S #1 notified the above findings and concerns with PO with regard to meds midodrine and C-metoprolol and the order with regard to parameters were not followed. The DON also reviewed and printed the BP of the resident for January 2026 from the Monitoring tab of the electronic medical records, and she acknowledged that the BP did not include information that the BP was checked at 8 AM, or at least an hour before and an hour after as required in the PO for C-metoprolol. The DON also provided a copy of the midodrine administration audit report that showed that the resident received the midodrine med on 1/29/26 at 7:05 PM. The DON further stated that the bedtime hour was at 9:00 PM, and the 7:05 PM time when the midodrine was administered did not follow the PO.<br><br>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, meds are administered by licensed nurses as ordered by physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Policy Explanation and Compliance Guidelines: 8. Obtain and record vital signs, when applicable or per PO. When applicable, hold med for those vital signs outside the physician's prescribed parameters.<br><br>On 2/25/26 at 11:21 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON for responses for the above concerns. The LNHA and DON did not provide additional information.<br><br>2. On 2/17/26 at 11:00 AM, Surveyor #2 (S #2) observed Resident #4 lying in bed.<br><br>On 2/18/26 at 10:25 PM, S #2 reviewed the electronic medical record of Resident #4.<br><br>A review of Resident #4's RFS reflected that the resident was admitted to the facility with diagnoses which included but were not limited to pulmonary fibrosis and type 2 diabetes mellitus (chronic<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | metabolic condition where the body develops insulin resistance and cannot use insulin efficiently, leading to high blood sugar levels).<br><br>A review of Resident #4's most recent comprehensive MDS reflected that the resident had a BIMS score of 15 out of 15, which indicated that Resident #4's cognition was intact.<br><br>A review of Resident #4's February 2026 RMAR included the following order:<br><br>insulin lispro (U-100) 100 unit/mL subcutaneous (SQ) pen Dispensed: insulin lispro (U-100) 100 unit/mL SQ pen, inject by SQ route per prescriber's instructions. Insulin dosing requires individualization.<br><br>Protocol: Sliding Scale<br><br>201 - 250 = 4 Units<br><br>251 - 300 = 6 Units<br><br>301 - 350 = 8 Units<br><br>351 - 400 = 10 Units<br><br>If < 70 or > 400 Call MD (Medical Doctor)<br><br>Monitoring: Blood Sugar (BS) with a start date of 1/2/26<br><br>Further review reflected that the nurse did not indicate how many units of insulin were given at the 4:30 PM time on 2/1/26, 2/4/26, 2/5/26, 2/6/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26 and 2/14/26 and at the 9:00 PM time on 2/2/26, 2/4/26, 2/5/26 and 2/9/26.<br><br>On 2/19/26 at 10:10 AM, S #2 interviewed the Licensed Practical Nurse (LPN) who stated that the BS result, how many units of insulin, site where administered and the nurses initials were documented in the RMAR. S #2 asked the LPN to view Resident #4's RMAR. The LPN stated that the nurse should have written the dose given.<br><br>On 2/19/26 at 10:17 AM, S #2 interviewed the Assistant Director of Nursing (ADON) who stated that she would expect the units given would be documented since the dose depended on the BS result.<br><br>3. On 2/18/26 at 12:51 PM, S #2 reviewed the hybrid (electronic and paper) medical records of Resident #369.<br><br>A review of Resident #369's RFS reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; metabolic encephalopathy (a broad term for acute or subacute brain dysfunction caused by chemical imbalances, systemic illness, or organ failure), Type 1 diabetes mellitus (chronic autoimmune condition where the immune system destroys insulin-producing beta cells in the pancreas, resulting in little to no insulin production which leads to high blood sugar (hyperglycemia), requiring lifelong insulin therapy, blood sugar monitoring, and careful management to prevent complications)and congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues).<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #369's most recent Discharge Assessment Return Anticipated MDS (DRAMDS) reflected that the resident had a BIMS score of 14 out of 15, which indicated that Resident #369's cognition was intact.<br><br>A review of Resident #369's January 2026 RMAR included the following order:<br><br>insulin lispro (U-100) 100 unit/mL SQ solution Dispensed: insulin lispro (U-100) 100 unit/mL SQ solution, inject by SQ route before meals and at bedtime per sliding scale for dm<br><br>Protocol: Sliding Scale<br><br>150-200=1 Unit<br><br>201 - 250 = 2 Units<br><br>251 - 300 = 3 Units<br><br>301 - 350 = 4 Units<br><br>351 - 400 = 5 Units<br><br>for glucose greater than 400 give 6 units<br><br>If < 70 or > 400 Call MD<br><br>Monitoring: BS with a start date: 1/18/26<br><br>Further review reflected that the nurse did not indicate how many units of insulin were given at the 4:30 PM time on 1/18/26, 1/19/26, and 1/21/26 and at the 9:00 PM time on 1/18/26, 1/19/26, 1/20/26 and 1/21/26.<br><br>On 2/20/26 at 12:22 PM, S #2 interviewed the DON who stated that for insulin sliding scale order the expectation was for the nurse to document the units given, the site, the BS result and the nurses initials. The surveyor asked the DON to view Resident #369's RMAR. The DON confirmed that the units given was not documented on some shifts and that she was going to look into it.<br><br>On 2/24/26 at 12:45 PM, S #2 notified the LNHA and DON the concern that Resident #4 did not have the dosage of insulin units documented for multiple days and shifts on the February RMAR and Resident #369 did not have the dosage of insulin units documented for multiple days and shifts on the January RMAR.<br><br>On 2/25/26 at 11:27 AM, in the presence of the LNHA, the DON stated that she educated the nurse that had missed documenting the dose and that she also in-serviced all staff.<br><br>A review of the facility's Timely Administration of Insulin Policy with an effective date of 11/25, included the following, Policy: It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. Policy Explanation and Compliance Guidelines: 4. Procedure: f. Document on the medication administration record the time and location of the insulin injection.<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The policy did not contain any information on sliding scale dosage or documenting the amount of insulin given per sliding scale.<br><br>NJAC 27.1(a) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on observation, interview, review of the medical records and other facility documentation, it was determined that the facility failed to, a.) provide adequate monitoring for the use of psychoactive medications (meds) for 1 of 6 residents reviewed for psychotropic meds (Resident #371) and b.) ensure that the resident did not receive an unnecessary medication (med) by duplicate and incomplete med orders, for 1 out 3 residents, (Resident #374), observed during the med pass observation.The deficient practice was evidenced by:<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 2/17/26 at 10:51 AM, Surveyor #1 (S #1) 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 #1 that the resident fell from home, hospitalized , and sustained a brain bleed.<br><br>S #1 reviewed the medical records for Resident #371.<br><br>A review of the Resident Face Sheet (RFS, an admission summary) 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).<br><br>A review of the Minimum Data Set (MDS), an assessment tool, revealed that it was in progress and to be completed.<br><br>A review of the Physician's Orders (PO), dated 2/14/26, order for olanzapine (also known by the brand name Zyprexa, is an atypical antipsychotic med. It treats schizophrenia, bipolar I disorder, and treatment-resistant depression) 5 mg (milligram) tablet (tab), give 1 tab (5 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 once daily at bedtime for anorexia nervosa. The order was discontinued on 2/16/26.<br><br>A review of the PO dated 2/16/26, order for olanzapine 5 mg tab, give 1 tab (5 mg) by g-tube route<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | once daily at bedtime for depression. Schedule: every day at 9:00 PM (9 PM).<br><br>A review of the PO dated 2/15/26, monitor target behavior (TB) as per care plan (CP) for psychotropic meds.<br><br>The above order to monitor TB was transcribed to the Resident Medication Administration Record (RMAR), plotted for 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM, and signed by nurses as monitored. There was no documented TB in the RMAR. The RMAR was initialed by nurses.<br><br>A review of Resident #371's Care Plan Activity Report (CPAR) revealed a focus on Psychopharm with an effective date of 10/31/25, etiology: resident receives mirtazapine for depression and at risk for side effects (s/e). Additional detail: TBs: poor appetite, sadness, and fatigue.<br><br>Further review of Resident #371's CPAR revealed there was no documented evidence that a TB for med olanzapine to adequately monitor the use of this psychoactive med (are substances that affect the brain).<br><br>On 2/24/26 at 12:31 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the surveyor notified them of the above findings and concerns with regard to no adequate monitoring for the use of psychoactive med olanzapine and there was no CP for the TB of the med according to the PO.<br><br>A review of the facility's Policy: Psychotropic Drug Use that was provided by the DON, with an effective date of 11/25, revealed under purpose, to ensure that all resident's receiving antipsychotic, anti-anxiety agents.antidepressants.for the treatment of specific behavioral disturbances will be monitored for effectiveness of therapy and occurrence of potential s/e and will be documented appropriately.<br><br>On 2/25/26 at 11:21 AM, the survey team met with the LNHA and the DON stated that she acknowledged the lack of documentation for olanzapine and there was no CP for olanzapine. She further stated that whoever completed the baseline CP, it was missing the TB to adequately monitor the behavior for the use of olanzapine.<br><br>2. On 2/19/26 at 9:41 AM, Surveyor #2 (S #2) observed the Licensed Practical Nurse assigned to administer medications (meds) to Resident #374, prepare and administer due meds to Resident #374. During the observation, S #2 observed an order on the resident's RMAR that the LPN was preparing to administer.<br><br>The order reflected: polyethylene glycol 3350 17 gram/dose oral powder Dispensed: polyethylene glycol 3350 17 gram/dose oral powder, 1 CAPFUL (17 G) once daily as needed (PRN) Protocol: Mix with 4-8 oz (ounces) of water, juice, soda, coffee, or tea. Start Date: 2/16/26 at 5:16 PM.<br><br>S #2 asked the LPN why they were giving the med and what it was for, and the LPN stated that it was for constipation and the resident needs it. S #2 asked the LPN if med order that were PRN should have a reason to be given. The LPN stated yes, they should and that the order in question should be a routine regularly scheduled order for the resident since they need it.<br><br>S #2 observed the LPN administered the resident's due meds and concluded the observation.<br>(continued on next page) |

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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Christian Health Care Center | 301 Sicomac Ave<br>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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | S #2 reviewed the electronic medical record (EMR) for resident #374. The EMR revealed:<br><br>A review of the RFS reflected the resident was admitted to the facility with diagnoses which included but were not limited to chronic kidney disease (the long-term, gradual loss of kidney function) and anemia (shortage of healthy red blood cells to transport oxygen).<br><br>A review of Resident #374's comprehensive MDS with an assessment reference date (ARD) of 2/16/26, reflected, in Section C, that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #65 was cognitively intact.<br><br>A review of the resident's RMAR revealed the following:<br><br>An order scheduled for the 9:00 AM med pass that was discontinued after the observation of administration to the resident and not documented as given.polyethylene glycol 3350 17 gram/dose oral powder Dispensed: polyethylene glycol 3350 17 gram/dose oral powder, 1 CAPFUL (17 G) once daily PRN Protocol: Mix with 4-8 oz. of water, juice, soda, coffee, or tea. Start Date: 2/16/26 at 5:16 PM.<br><br>An order for the same timeframe with a start date of 2/19/26 9:59 AM (after the observation and surveyor inquiry) and documented as given.polyethylene glycol 3350 17 gram/dose oral powder, give 17 grams by oral route once daily as PRN For: Constipation Protocol: Mix with 4-8 oz. of water, juice, soda, coffee, or tea. Start Date: 2/19/26 at 9:59 AM.<br><br>An order that reflected to be used PRN:<br><br>polyethylene glycol 3350 17 gram oral powder packet, give 1 packet by oral route once daily PRN for constipation Protocol: Mix with 4-8 oz. of water, juice, soda, coffee, or tea. Start Date: 2/12/26 at 8:06 PM.<br><br>A review of the resident's order summary, order details revealed that the order in question was discontinued by the LPN after the observation and S #2's inquiry and the new order was added. As reflected by: First Entered By: (name redacted) on 2/19/26 at 9:59 AM; First Completed By: (name redacted) on 2/19/26 at 9:59 AM; Med Discontinued polyethylene glycol 3350 17 gram/dose oral powder, give 1 CAPFUL (17 G) once daily PRN.<br><br>On 2/24/26 at 12:31 PM, the survey team met with the LNHA and DON for concerns. S #2 notified the DON of the results of the med pass observation and the concern with Resident #374's med orders being incomplete and duplicate. S #2 notified the DON that the original PRN order had no indication for use and an additional PRN for the same med with an indication for use existed. S #2 notified the DON that the LPN changed the order after the observation and S #2's inquiry and documented that the new order was given.<br><br>On 2/25/26 at 11:22 AM, the survey team met with the LNHA and the DON stated that the order for Resident #374 was changed as S #2's had previously stated.<br><br>The LNHA did not provide any further pertinent information.<br><br>A review of the facility's Policy: Medication Orders, date effective 11/25, the Policy reflected under 3.k. PRN orders should also specify the condition, for which they are being administered .<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The policy did not reflect anything relating to duplicate med orders.<br><br>NJAC 8:39- 27.1(a); 29.2(d); 33.2(a) |