STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allaire Rehab & Nursing	115 Dutch Lane Road Freehold, NJ 07728

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ185442 and NJ187702 Based on interview and review of pertinent facility documents on 6/30/25, 7/1/25, and 7/2/25, it was determined that the facility failed to ensure residents' New Jersey Universal Transfer Forms (UTF) for discharge to the hospital were completed fully and accurately. This deficient practice was identified for 3 of 3 residents reviewed (Resident #2, Resident #3, Resident #6), and was evidenced by the following: Reference: NJ.gov: https://www.nj.gov/health/forms/hfel-7instr_1.pdf:INSTRUCTIONS FOR COMPLETING THE NEW JERSEY UNIVERSAL TRANSFER FORM dated [DATE], The purpose of the New Jersey Universal Transfer Form: A form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs. It conveys the patient information required under federal regulations and conveys specific facts that the physician and nurse need to begin caring for a patient. The word patient is used throughout the form but refers to resident/client or the terminology used by a specific facility or program. Complete all boxes #1 - 29.1.Resident #2 was not available for interview during survey. The resident was reviewed as a closed record.A review of Resident #2's admission Record (AR; an admission summary), revealed that they were admitted to the facility with a diagnosis that included but was not limited to; cerebral infarction (a condition where a part of the brain tissue dies due to a lack of blood supply). A review of Resident #2's comprehensive Minimum Data Set MDS), an assessment tool dated 6/2/25, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating that resident was moderately cognitively impaired.A review of Resident #2's Progress Notes (PN) included a note dated 6/24/25 at 8:52 AM, that the resident was not responding at baseline to verbal stimuli, and their left pupil was dilated significantly larger then then their right. The vital signs were blood pressure (BP) 118 millimeters of mercury (mmHg) over 70 mmHg (118/70), temperature (T) 100.0 degrees Fahrenheit (F), oxygen saturation (O2 sat; measurement of oxygen saturation in the blood) 96%, respiration rate (RR; measurement of breaths per minute) 18, blood sugar (BS) 189. The Nurse Practitioner (NP) ordered the resident to be transferred to the hospital via emergency services (911) by ambulance. A review of Resident #2's Order Summary Report (OSR) dated active orders as of 6/24/25, included the resident had physician's orders (PO) for a code status of do not resuscitate (DNR; do not perform cardiopulmonary resuscitation) and do not intubate (DNI).A review of Resident #2's UTF, which instructed on the top of the form Items 1 - 29 must be completed, were blank for the following areas:2. Transfer time.6. Code status.27. Sending Facility Contact information. A further review of the UTF revealed that the documented vital sign of BP 140/59, pulse rate (PR) 84, RR 18, T 97.6 were not the same vital signs that were documented in resident's progress notes.On 7/2/25 at 3:41PM, during an interview with the Director of Nursing (DON), the DON reviewed the UTF with the surveyors and stated that the UTF should be accurate and complete. When questioned why the vital signs on the UTF were not the same as the vital signs documented in the resident's Progress Notes, the DON stated that vital signs were prepopulated from the previous vital signs that were documented in electronic medical system's vital signs. 2. Resident #3 was not available for interview during survey. The resident was reviewed as a closed record.A review of Resident #3's AR revealed that they were admitted with a diagnosis that included but was not limited to lock-in -state (a rare neurological condition where a person is conscious and aware but completely paralyzed, except for possible control of eye movements. It is characterized by preserved cognitive function and awareness).A review of Resident #3's quarterly MDS dated [DATE], revealed that the resident had a BIMS score of 15 out of 15, indicating that resident was cognitively intact. A review of Resident #3's OSR dated active orders as of 6/1/25, included a dietary PO for regular diet, puree texture, mild thick consistency (liquids), [teaspoon] only, and a PO for code status as full code (in the event of an emergency, the resident wished to receive all possible medical interventions and life-saving measures).A review of Resident #3's PN dated 6/18/25 at 7:17 PM, revealed that the resident began to cough, the nurse was called, and the resident was observed exhibiting seizure like activity. The oxygen saturation was 79% (indicated low percentage of oxygen), and emergency services (911) was called, and the resident left with emergency medical services (EMS). A review of Resident #3's UTF dated 6/18/25, revealed the following areas were blank:6. Code status 9. Form Completed By A further review revealed that in section 16, the resident's diet was indicated as a regular diet, which did not reflect the resident's ordered diet of regular diet, puree texture with mildly thick consistency liquids During an interview with the surveyor on 7/2/25 at 3:41PM, the DON reviewed the UTF for Resident

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #: NJ185442 Based on interviews, medical records review, and review of other pertinent facility documentation 6/30/25, 7/1/25, and 7/2/25, it was determined that the facility failed to obtain and administer narcotic pain medication according to physician's order (PO) in a timely manner. This deficient practice was identified 1 of 3 residents reviewed for pain management (Resident #6), and was evidenced by the following: Resident #6 was not at the facility at the time of the survey. A closed record review was conductedA review of Resident #6's Resident admission Record (AR; admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to cell death and potential brain damage); dystonia (a neurological disorder that causes excessive involuntary muscle contraction), and gastrostomy tube (g-tube; a flexible tube surgically inserted into the stomach to deliver nutrition and medication). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 4/7/25, reflected that the resident had short-term and long-term memory problems with severely impaired decision making. A further review reflected that the resident was on a scheduled pain medication regimen and received as needed (PRN) pain medication.A review of Resident #6's individualized comprehensive Care Plan (ICCP) included a focus area initiated 10/16/24, that revealed that the resident had generalized pain related to dystonia and anoxic brain injury. Interventions included to administer medications per physician order.A review of Resident #6's Progress Notes (PN) revealed the following nursing notes:On 4/3/25 at 2:16 PM, that new orders were received from physician to discontinue oxycodone (a narcotic pain medication) and start Tramadol 50 milligrams (mg) (narcotic pain medication) via g-tube every eight hours for pain.On 4/3/25, at 10:14 PM, the nurse documented that the Tramadol 50 mg was waiting delivery from the pharmacy. A review of the Order Audit Report, include a PO dated 4/3/25 at 1:53 PM, for Tramadol Hydrochloride (HCl) 50 mg; give 1 tablet every eight hours via g-tube for severe pain.A review of Resident #6's April 2025 Medication Administration Record (MAR) revealed the following: A PO dated 4/4/25 at 6:00 AM, for Tramadol HCl 50 mg tablet; give 1 tablet via g-tube every eight hours. (This was dated one day after the nurse documented the physician changed the medication.)The MAR further revealed that the first dose of Tramadol was administered to the resident on 4/4/25 at 2:00 PM, with a documented pain of zero. The nurse then signed a 9 that indicated to see progress notes for the 4/4/25 at 10:00 PM dose.A review of the Progress Notes did not include a corresponding note related to the 4/4/25 at 10:00 PM, Tramadol dose.A review of Resident #6's Individual Patient's Controlled Drug Record for Tramadol HCl 50 mg revealed that the facility received 30 tablets on 4/5/25, and the nurse signed that the resident received their first dose on 4/5/25 at 6:00 AM. On 7/2/25 at 10:46 AM, the surveyor conducted a telephone interview with the Provider Pharmacy (PP), who stated that the pharmacy received Resident #6's Tramadol HCl 50 mg prescription on 4/4/25 at 1:30 PM. The PP stated that the pharmacy delivered the Tramadol on 4/5/25 at 3:30 AM. The PP continued that the facility received medication deliveries twice a day, early morning and evening, seven days a week. The PP stated that depending on the time the pharmacy received the order, determined when the medication was delivered. During an interview with the Unit Manager (UM) on 7/1/25 at 2:26 PM, she stated that she received an order via telephone from the Physician for Tramadol. The UM stated the order was entered in the electronic system and she assumed the doctor had sent the [electronic prescription]. The UM further stated that it was important to ensure that residents were receiving their prescribed medication, because it is their right. On 7/2/25 at 3:15 PM, the surveyor interviewed the ADON, who confirmed that Resident #6 did not receive any Tramadol until their 4/5/25 at 6:00 AM dose. The ADON also confirmed the facility did not have Tramadol in their back-up medication supply. The ADON stated that there should have been a medication intervention between 4/3/25, when the Tramadol was ordered, until the resident received their first dose on 4/5/25. The ADON further stated that the nurse who received the order should have contacted the Physician for an alternative if the medication was not available.On 7/2/25 at 3:41 PM, the surveyor interviewed the Director of Nursing (DON), who confirmed the facility did not have Tramadol in their back-up medication supply. A review of the facility's Administering Medication policy dated reviewed/revised 1/2025, indicated under Policy Statement that medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation.3. Medication must be administered in accordance with the orders, including any required time frame.A review of the facility's Medication Errors policy dated reviewed/revised 1/2025, included under the Policy Statement that in the event of medication error, the facility will act promptly

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Complaint #: NJ185442 Based on interviews, review of the medical record, and other pertinent facility documents on 6/30/25, 7/1/25, and 7/2/25, it was determined that the facility failed to ensure controlled medications were appropriately destroyed in accordance with state and federal regulations. This deficient practice was identified for 1 of 3 residents reviewed for pain management (Resident #6), and was evidenced by the following:Resident #6 was not at the facility at the time of the survey. A closed record review was conducted.A review of Resident #6 admission Record (AR; an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to; anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to potential cell death and significant neurological damage) and gastrostomy (g-tube, a flexible tube surgically inserted into the stomach to deliver nutrition and medication). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 4/7/25, reflected that the resident had short term and long-term memory problems with severely impaired decision making. A further review reflected that the resident was on a scheduled pain medication regime and received as needed (PRN) pain medication. A review of Resident #6's individualized comprehensive care plan (ICCP) included a focus area dated 10/16/24, that the resident had generalized pain related to dystonia (movement disorder characterized by uncontrollable muscle by uncontrollable muscle contractions that cause twisting movements or abnormal postures) and anoxic brain injury. Interventions included to administer medications per physician order.A review of Resident #6's Order Audit Report include a physician order dated 4/3/25 at 1:52PM, for Tramadol Hydrochloride (HCl) 50 milligrams (mg); give 1 tablet every eight hours via g-tube for severe pain.A review of Resident #6's Individual Patient's Controlled Drug Record (IPCDR) for Tramadol HCl 50 mg tablet revealed that the facility received 30 tablets on 4/5/25. The IPDR revealed that the resident received six tablets of Tramadol that were signed as administered by the nurse with 24 tablets remaining. The disposition of unused portion of the prescription for the discharged resident was blank for the following: destroyed by; witnessed by; and date.During an interview on 7/2/25 at 2:26 PM, the surveyor reviewed the resident's IPCDR for Tramadol with the Unit Manager (UM). The UM confirmed the unused medication should have been destructed. The UM then stated there should always be two nurses when the controlled medication was discontinued with medication remaining who take the IDCDR sheet and the used medication to the Director of Nursing (DON) for destruction. During an interview with the surveyor on 7/2/25 at 3:15 PM, the Assistant Director of Nursing (ADON) stated that she and the DON were responsible to make sure that the declining inventory sheet (IPCDR) were completed. The ADON confirmed that there should have been signatures on the declining inventory sheet after destruction.During an interview with the surveyor on 7/2/25 at 3:41 PM, the DON stated that she was handed the [declining inventory sheet] and medication, it was placed in the drug buster, and she was called on a rapid response and did not sign the form. The DON confirmed that she should have signed Resident #6's IPCDR for the Tramadol destruction. A review of the facility's Controlled Substance Administration & Accountability policy dated reviewed/revised 1/2025, included Obtaining/Removing/Destroying Medications.d. Two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record, Controlled Drug Record. NJAC 8:39-29.4(i)