STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peace Care St Joseph's	537 Pavonia Avenue Jersey City, NJ 07306

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Complaint NJ# 2593527Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to include a resident in the planning of care by informing them of the risks and benefits of proposed care. This was observed in 1 of 2 residents (Resident #109), reviewed for use of anticoagulant medications.The deficient practice was evidenced by the following: On 4/9/26 at 11:11 AM, the surveyor interviewed Resident # 109 The surveyor asked the resident about his concerns with a discontinued medication in August of 2025. The resident answered My Eliquis was stopped at the end of May and The doctor never talked to me about it, there was no notice, no discussion, I found out when the cariologist caught it in July. The resident added The doctor never discussed it with my sister either. The cardiologist restarted it the day I saw him in July, and he figured out it was stopped. The resident acknowledged his sister was his durable power of attorney for health care. A review of Resident # 109's admission record indicates he was admitted to the facility with diagnoses including but not limited to: left side hemiplegia and hemiparesis following a stroke (the left side of the resident's body is weak or paralyzed) and a chronic embolism of the left upper extremity (a clot in the blood vessels of the left arm)A review of Resident #109's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which reflected that the resident's cognition was not impaired.A review of the Resident #109's physician's orders reflects an order for an anticoagulant (a medication to treat and prevent blood clots), Eliquis 2.5mg tablet, give one tablet by mouth 2 times daily. This order was in effect beginning 6/22/24 and was discontinued on 5/31/2025. A review Resident #109's electronic health record (EHR) revealed a physician progress noted dated 6/1/2025. Eliquis did not appear in the medication list contained in that progress note, there was no notation of a discussion with the resident of risks or benefits of continuing versus discontinuing the anticoagulation therapy.A review of Resident#109's EHR did not reflect any physician or facility professionals documented a discussion with the resident or his sister regarding the discontinuation of Eliquis prior to 5/31/25. The EHR contained a report of consultation from the resident's cardiologist, a provider outside of the facility, from an appointment on 7/22/25 that recommended restarting Eliquis 2.5 mg tablet, give 1 tablet 2 x daily.On 4/16/25 at 11:05 AM, the surveyor met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) and both confirmed the residents EHR does not reflect documentation that a conversation occurred with Resident#109 or his sister about discontinuing the resident's Eliquis medication prior to the discontinuation on 5/31/25. On 4/16/26 at 11:55 AM, the surveyor conducted a phone interview with Resident #109's primary physician of record during May 2025. The surveyor asked the doctor about the discontinuation of residents Eliquis in May of 2025. The doctor could not confirm the exact date of 5/31/25 during the phone call but acknowledged he discontinued the medication at around that time. When asked if he discussed discontinuing this medication the Dr. stated I probably had a discussion with the resident, but I cannot recall for sure, there would be a note the surveyor informed the doctor that the surveyor, the DON and The LNHA reviewed the EHR and found no documentation of this discussion, the doctor stated, I should have, that is my mistake.On 4/15/26 at 12:05 PM, the surveyor interviewed Resident #109's sister. The interview occurred in the resident's room, with the (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident present and participating. The resident's sister confirmed that no doctor or representative of the facility discussed the discontinuation of Eliquis before or after the medication was stopped on 5/31/25. The resident's sister stated I was shocked when the cardiologist asked why it was discontinued04/14/2026 12:45 PM, the surveyor met with LNHA and DON to discuss concerns with Resident#109's Eliquis medication. The LNHA and DON agreed the resident had the right to participate in the decision to discontinue the medication and that a risk and benefit discussion should have been held with the resident and/or his sister and documented accordingly. No further information provided by the facility.NJAC 8:39-4.1(a)2: 13.2: 13.3

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Complaint NJ-2803539 Based on observation, interview, and record review it was determined that the facility failed to ensure 1 of 2 residents (Resident #14) was free from neglect. The facility failed to provide personal care and assistance from the assigned Certified Nursing Assistant (CNA) for one 8-hour shift. The deficient practice is evidenced by the following.On 4/9/26 at 10:40 AM, the surveyor observed the resident awake in bed. The resident spoke to the surveyor in Arabic and did not understand the English language. At that time, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated a translator phone number is posted in the resident's room to communicate with the resident. He stated the resident's 2 daughters visit daily during the day shift.A review of the electronic medical record (EMR) revealed the following information.The 3/4/26 admission Minimum Data Set (MDS) assessment tool indicated that the resident had no cognitive deficits and exhibited no mood or behavioral concerns. The resident was noted to be independent eating meals after staff set-up the food tray.The resident's plan of care included a focus area of communication. An intervention indicated that staff were to use a translator phone to communicate with the resident when family was not present.On 4/9/26, the Director of Nursing (DON) provided the surveyor with a Facility Reporting Incident Data and Analysis Yield (FRIDAY) form, dated 3/13/26, regarding an allegation of neglect by a Certified Nursing Assistant (CNA) for failing to follow the resident's care plan.The form indicated the resident told the Assistant Director of Nursing (ADON) that the resident did not receive morning care from their assigned CNA (CNA #1) on the 8 AM to 4 PM day shift on 3/12/26. CNA #1 told the ADON she had distanced herself from the resident because the resident's family had been rude to her early in the shift. The CNA's documentation in the EMR reflected she did not provide care to the resident for the shift. Another CNA (CNA#2) was assigned to provide personal care to the resident during the 3/12/26 day shift.On 4/8/26 at 1:22 PM, the surveyor interviewed the DON. She stated on 3/12/26 the resident complained to the ADON that CNA #1 did not provide care. CNA#1 stated she distanced herself from the resident because the resident's family was rude to her early in the shift. She did not report this to her supervisor. The DON stated CNA #1 was suspended during the investigation. The CNA was terminated when the investigation was complete. The incident was reported on 3/13/26 to the Department of Health and the Long Term Care Office of the Ombudsman.On 4/9/26 at 10:40 AM, the surveyor interviewed the ADON. She stated CNA #2 reported to her that CNA #1 had not cared for the resident during the day shift. CNA #2 stated she performed personal care for the resident towards the end of the day shift. The ADON interviewed CNA #1 who stated she did not care for the resident because the family was rude to her. CNA #1 did not report this to her supervisor. The ADON stated if CNA #1 had come to her at the time of the alleged ?rudeness', the ADON would have immediately assigned another CNA to care for the resident.On 4/10/26 at 8:54 AM, the surveyor interviewed the resident's daughter by telephone. The resident's granddaughter acted as an interpreter. She confirmed the regular CNA did not come in to see the resident on the 3/12/26 day shift. She confirmed nurses were in for medication and treatment administration and the resident received their meals on the day shift.The surveyor reviewed the 3/12/26 Electronic Medication Administration Record (EMAR) and confirmed that nurses were in to see the resident 4 times during the day shift to administer medications.Additionally, the surveyor reviewed CNA #1's employee file and confirmed a criminal background check and 2 job references were obtained prior to the CNA's date of hire. The surveyor reviewed the facility's Abuse, Neglect and Exploitation policy, revised 5/2025. The document reflected that it is the facility's policy to protect residents from abuse, neglect, exploitation and misappropriation of resident property. Neglect was defined as the willful failure to provide services to the resident. On 4/15/26 at 1:00 PM, the surveyor discussed the concern of neglect with the Administrator and the DON.NJAC 8:39-4.1(5)