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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, it was determined that the facility failed to: a) maintain kitchen equipment in a clean, safe and sanitary manner for 3 of 4 kitchenettes (2nd, 3rd, 4th), and b) maintain kitchen equipment in a clean, safe and sanitary manner 4 of 4 pantries (1st, 2nd, 3rd, 4th), on the nursing floors as evidenced by the following. On 4/09/26 at 11:50 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following on the nursing units:The kitchenette microwaves had multicolored food debris on the interior ceiling of the units for 3 of 4 units, (2nd, 3rd, and 4th). The FSD acknowledged and agreed that they were not cleaned according to facility policy. The pantry microwaves had multicolored food debris on the interior ceiling of the units and food particles on the rotating tray for 3 of 4 units (2nd, 3rd, and 4th). The FSD acknowledged and agreed that they were not cleaned according to facility policy. The refrigerators on 2 of 4unit pantries, (1st and 3rd,) were observed to have copious amounts of standing water on the glass top shelving in the refrigerator. The FSD acknowledged it and cleaned the water with several paper towels. He stated that it has been on ongoing issue since he started at the facility and that it has been entered in the electronic maintenance system several times. On 4/09/26 at 11:50 AM, the surveyor interviewed the FSD, who stated the kitchenettes are to be cleaned daily. Everything should be wiped down and if there are any issues noted by the staff regarding pest or equipment issues, they are instructed to let him know. He further stated that the cleaning of equipment should be done on a schedule to prevent food borne illness and maintain safe and sanitary environment for the staff and residents. The FSD acknowledged the surveyors concerns and agreed they were not done according to facility policy.On 04/09/2026 at 12:29 PM, the surveyor met with Licensed Nursing Home Administrator (LNHA). The LNHA acknowledged the surveyor's concerns. She stated that the equipment should be cleaned and maintained to prevent food borne illness, contamination, or injury; to ensure the safety of the residents and staff. She further stated that she was aware of the pantry unit freezers having an issue with draining into the refrigerator and that it was fixed recently after being serviced. A review of the facility's policy, Sanitation Inspection, with a revise date of 1/25, revealed. a basic sanitation is conducted.to ensure that the established procedures are being followed and that sanitation standards are maintained. A review of the Manufacturer Tray Dispenser / Plate lowerator, provided by the facility revealed; cleaning should be done daily by removing the dishes.wipe down any visible soiled areas and wet another cloth with sanitizer solution and apply, allow to dry. 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 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 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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview it was determined the facility failed to maintain the residents' living environment in a safe and homelike manner for 1 of 25 residents (Resident #12) reviewed. The deficient practice was evidenced by the following:On 4/8/26 at 12:15 PM, the surveyor observed Resident # 12 in bed. The surveyor observed a bed controller with the cord attached to it, which was laying on the resident's bedside. The cord sheath attached to the bed controller was broken in several areas and the wires were exposed. The resident stated that the cord was like that for many months and the resident had told the facility about it a while ago but it was never fixed.At 12:41 PM, the surveyor asked the Licensed Practical nurse (LPN), who cared for Resident # 12, to come into the resident's room. The surveyor showed the LPN the broken cord sheath. The LPN stated that she did not notice that the cord sheath was broken and she had been in the resident's room around about 11:45 AM.At 12:49 PM, the surveyor interviewed the Director of Nursing (DON), who also stated that she did not notice that the cord sheath was broken and exposed the wires and she will look into having it fixed as soon as possible.On 4/9/26 at 1:30 PM, the surveyor discussed the above concerns with the Administrator and DON. NJAC 8:39-4.1(a)11. 31.4 (a), (b), (c), (f)

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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)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review it was determined that the facility failed to ensure newly hired employees underwent criminal background checks before they began employment at the facility. The deficient practice was identified for 9 of 82 employee records reviewed (Employee #12, 13, 14, 17, 34, 38, 54, 55, 67). The deficient practice is evidenced by the following. On 4/13/26 and 4/14/26, the surveyor reviewed the Human Resources records including Criminal Background Investigations (CBI) for 82 employees who were hired since the previous Department of Health Recertification Inspection. The following concerns were revealed.Employee #12, a Certified Nursing Assistant (CNA), began employment on 10/20/25. The CBI was requested by the facility on 10/27/25.Employee #13, a nurse, began employment on 10/20/25. The CBI was requested on 2/10/26.Employee #14, a nurse, began employment on 12/15/25. The CBI was requested on 2/9/26.Employee #17, a nurse, began employment on 5/5/25. The CBI was requested on 10/3/25.Employee #34, a housekeeper, began employment on 6/2/25. The CBI was requested on 10/10/25.Employee #38, a CNA, began employment on 3/2/26. The CBI was requested on 3/18/26.Employee #54, a nurse, began employment on 12/22/25. The CBI was requested on 1/6/26.Employee #55, a nurse, began employment on 8/11/25. The CBI was requested on 2/11/26.Employee #67, a dietary aide, began employment on 10/6/25. The CBI was requested on 2/11/26.(None of the CBI results would have disqualified employment)On 4/14/26 at 1:00 PM, the surveyor discussed the concerns with the Administrator and the Director of Nursing. No further information or documentation was provided to the surveyor.The facility policy titled Abuse, Neglect and Exploitation, reviewed 5/20/25, indicated in the 'Screening' section, part A, Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. Background checks .shall be conducted on potential employees .NJAC 8:39-4.1(a)5

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on the interview and record review, it was determined that the facility failed to complete a quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 1 (one) of 1 resident (Resident#104), system selected for resident assessment for MDS record over 120 days old. This deficient practice was evidenced by the following: Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or look back) period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1) the Assessment Reference Date (ARD) of the Quarterly MDS (QMDS) was within 92 days after the ARD of the previous MDS, and 2) the completion date was no later than 14 days after the ARD. On 4/12/26 at 10:00 AM, the surveyor reviewed the electronic Medical Record (eMR) of Resident #104, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #104 was admitted with diagnoses that included but were not limited to unspecified dementia (loss of memory), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (feeling of worry). A review of the recent quarterly Minimum Data Set (Q/MDS) with an assessment reference date (ARD) (the last day of the of the observation period) of 12/5/25 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated that the resident had a severe impairment cognition. Further review of the eMR Resident #104's next Q/MDS was due on 3/5/26; the quarterly assessment was not completed until 4/14/26, 40 days later, after the surveyor's inquiry. On 4/14/26 at 10:13 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse, who stated that he missed the next MDS quarterly assessment on 3/5/26, and added that it was a mistake on their part. On 4/14/26 at 1:14 PM, the team of surveyors met with the Licensed Nursing Home Administrator and the Director of Nursing (DON). The DON acknowledged the concern with the late completion and submission of the MDS. NJAC 8:39-11.1

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	315452	A. Building B. Wing	04/15/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to a) provide pharmaceutical services in accordance with professional standards to ensure signing from the reconciliation form Controlled Drug Administration Record Tablet (CDART; declining inventory log) form after the dispensed and administered a controlled dangerous substance with high potential for drug diversion medication for 1 (one) of 1 resident (Resident #107) and b) follow physician orders for 1 of 1 resident (Resident #5) reviewed for medication storage and labeling. The 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 4/13/26 at 11:45 AM, the surveyor observed the medication cart on the 2nd floor with the Registered Nurse (RN). The surveyor observed that Resident#107's declining inventory log form for Lacosamide 200 mg (milligram) tablet had 15 tablets left, while the medication card had 14 tablets left. On 4/13/26 at 12:30 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #107, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #107 was admitted with diagnoses that included, but were not limited to, other seizures (when the normal flow of electrical signals in the brain is disrupted, causing sudden changes in movement). A review of the recent quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care) of 2/1/26 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident had intact cognition. Further review of Q/MDS reflected in Section N - High-Risk Drug Classes: Use and Indication that Resident #107 was taking an anti-convulsant medication. A review of the Order Summary Report (OSR) with an order date of 3/5/26, Lacosamide 200 mg oral tablet by mouth two times a day for seizure disorder (continued on next page)

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	315452	A. Building B. Wing	04/15/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the April 2026 electronic Medication Administration Record (eMAR) Lacosamide 200 mg tablet was signed as given on 4/13/26 at 9:00 AM. On 4/13/26 at 11:45 AM, the surveyor reviewed the CDART (reconciliation sheet) with a handwritten date of 4/12/26 at 8:00 PM with a signature of 15 tablets left. In the medication (bingo) card, there are 14 tablets left available. On 4/13/26 at 11:50 AM, the surveyor interviewed the RN, who stated that she was caught up and she needed to sign it because she had given the medications already this morning at 9:00 AM, and acknowledged that she did not sign the declining log sheet. On 4/14/26 at 11:55 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated that the nurse should sign the reconciliation sheet as soon as they removed the medication from the card. Then sign it in the eMAR as soon as the resident swallows the pills. On 4/13/26 at 1:40 PM, the team of surveyors met with the Licensed Nursing Home Administrator and the Director of Nursing (DON). The DON stated that it had already happened in August 2025, when the same nurse did not sign the controlled medications. A review of the facility policy titled Controlled Substance Administration & Accountability with a revised date on 1/19/26 revealed under Policy Explanation and Compliance Guidelines: h. The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration. 2.On 4/14/26 at 12:11 PM, the surveyor reviewed the electronic medical record (EMR) of Resident #5. The AR revealed Resident #5 had diagnoses that included, but were not limited to, dementia, Congestive Heart Failure (CHF; a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), hypertension, and a cardiac pacemaker. A comprehensive Minimum Data Set (MDS) assessment dated [DATE], indicated the facility assessed the resident's cognition using a Brief Interview Mental Status test. Resident #5 scored 11 out of 15, which indicated the resident had moderate cognitive impairment. A physician's order dated 3/15/26 indicated furosemide 40 mg tablet, give 1 tablet by mouth two times a day for CHF; Hold for systolic blood pressure (the top number in a blood pressure reading which measures the maximum pressure in your arteries when the heart beats) less than 100. A review of the March 2026 and April 2026 Medication Administration Record (MAR) revealed that there was no documentation of the resident's blood pressure (BP) at the time of the furosemide medication's administration. A review of progress notes revealed there was no documentation of the resident's BP result at the time of the medication's administration. A review of the Weights and Vitals section of the EMR revealed BP entries for March 2026 and April 2026 as follows: 3/3/26 at 12:24 AM BP=137/82 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/3/26 at 12:26 AM BP=137/82 3/11/26 5:53 PM BP 132/80 4/1/26 at 10:13 PM BP= 132/80 There were no documented BP results at the time of the furosemide medication's administration. On 4/14/26 at 12:42 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for Resident #5 about medications with parameters. The LPN stated the medication order entry in the MAR would prompt the nurse to enter BP results for the resident at the time of a medication's administration. The LPN further explained the physician's order indicated when a medication should be held per parameter. The surveyor reviewed with the LPN, Resident #5's Furosemide entry on the MAR. The LPN confirmed the medication order included parameters and there were no documented BP results at the time of its administration. The LPN with the surveyor reviewed the weights and vitals section and the progress notes in the EMR. The LPN acknowledged there were no BP results found in the EMR to be documented at the time of the medication's administration. On 4/14/26 at 12:47 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) about medications with parameters. The RN/UM stated that the BP would be assessed, the results documented in the supplementary section of the MAR entry at the time of the medication's administration, and the medication would be held according to the physician's order if needed. The surveyor with the RN/UM reviewed the March 2026 and April 2026 MAR entries for the furosemide order. The surveyor informed the RN/UM of the concern that there were no BP results found documented in the EMR at the time of medication's administration. The RN/UM acknowledged there were no BP results documented in the MAR which was the expectation. The RN/UM stated she would review to provide any additional information. On 4/14/26 at 12:55 PM, the surveyor informed the LNHA and the DON about the above concerns. The DON stated the RN/UM just informed her of the concern and the RN/UM was clarifying the order with the physician. On 4/15/26 at 11:07 AM, the DON and the LNHA met with the survey team. The DON provided a physician progress note documented after surveyor inquiry, which detailed that Resident #5's BP had been stable and did not require BP monitoring with every medication administration. There was no documentation provided which indicated the order was previously clarified with the physician. The surveyor reviewed the facility provided policy titled, Medication Parameters, with a last revised date of 5/15/25 which revealed under Policy: To establish and maintain clear medication administration parameters to ensure medications are administered safely, consistently, and in accordance with physician orders, clinical standards, and applicable state and federal regulations. Medication parameters shall be followed for all residents receiving medications, withholding instructions, monitoring requirements, or clinical conditions that may affect administration. (continued on next page)

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	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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility provided policy titled, Administration of Medication, with a last revised date of 1/5/25 which did not address medications with parameters. NJAC 8:39-27.1(a); 29.2

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Complaint #2613352Based on interview, and review of facility documentation, it was determined that the facility failed to provide services in compliance with applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles for a resident who was denied admission to the facility to provide services. This deficient practice was identified for 1 of 3 residents' referrals reviewed, Resident #138.This deficient practice was evidenced by the following:Reference: According to the Centers for Disease Control (CDC) guidelines dated 4/24/24, the Transmission-Based Precautions (TBP) and Enhanced Barrier Precautions (EBP) for Candida Auris (C. Auris; a multidrug- resistant fungus that can cause severe infections in very sick, vulnerable patients) are similar to those used for other multidrug-resistant organisms (MDROs). In most instances, facilities equipped to care for patients with other MDROs can also care for patients with C. Auris. In nursing homes and skilled nursing facilities, healthcare providers should use either Contact Precautions or EBP (an infection control intervention to wear gown and gloves during high contact care to prevent multidrug-resistant organism transmission), based on the situation and local or state jurisdiction recommendations.Reference: According to the local and state guidance from New Jersey Department of Health (NJDOH), dated 3/24/23 for C. Auris: Identification, Reporting and Infection Prevention Guidance Updates, under Key Points revealed .2) Most healthcare facilities can provide adequate care for C. Auris positive individuals and therefore should not deny admission to patients based upon their C. Auris diagnosis .On 4/8/26 at 10:00 AM, the survey team requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), all admission referrals, including declined admissions, from July 2025 to September 2025.On 4/8/26 at 1:09 PM, the LNHA provided the document, Provider Referral Rejection Report for July 2025 to September 2025.On 4/9/26 at 11 AM, the surveyor interviewed the Hospital Liaison (HL) of the facility, who was covering for Admissions Director who had recently resigned. The HL stated the facility received admission referrals through two electronic systems which the HL would complete a clinical and insurance review for referred residents. The HL further explained if the resident was clinically ok and their insurance approved, the resident would be accepted for admission to the facility. The HL stated if a resident's referral was declined or approved it would be documented in the electronic referral system, and the referring facility would be able to view the information.The HL explained reasons for denial of admission referrals included but were not limited to, insurance not covering the stay, the resident referral was outside of the service area (e.g. out of state), a resident needed a higher level of care, intravenous drug use, and residents on a ventilator. The surveyor reviewed with the HL the provided referral rejection report and asked if these were the only hospitals referrals were received from. The HL stated there was an additional list of referrals from the second electronic referral system. The surveyor requested a copy of the second list of referrals.On 4/9/26 at 12:10 PM, the LNHA provided the second admission referral list. The surveyor reviewed the list which included an entry for Resident #138 dated 8/9/25 with a declined reason of facility cannot provide for patient's need.On 4/9/26 at 12:35 PM, the surveyor requested from the DON additional information regarding the reason for the resident's denial for admission.On 4/9/26 at 2:01 PM, the LNHA provided a one-page document with the facility's letterhead which included Resident #138's denial of admission was due to candida auris.A review of the facility's Electronic Medical Record (EMR) system revealed that Resident #138 had a previous admission stay in the facility in 2024.On 4/13/26 at 11:00 AM, the LNHA provided the survey team with an additional document with the facility's letterhead which indicated the resident was denied admission due to limited availability of private rooms, increased vulnerability to the existing population, and need for strict infection prevention measures. In addition, the document detailed, .admission of residents with confirmed or suspected Candida auris may be declined when (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate isolation, staffing, and infection control resources are not available to safely manage care and protect the current resident population. On 4/14/26 at 10:26 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) about care for a resident with C. auris. The IP stated expectation was prior to admission it would be known about the diagnosis to adequately prepare and take appropriate precautions. The IP/RN further explained ensuring a private room for isolation was available and if possible, adjustments could be made to cohort residents to accommodate a resident who required isolation. The surveyor asked the IP/RN what type of precautions were required for C. auris positive residents. The IP/RN replied contact isolation precaution (an infection control measure used to prevent spread of germs transmitted by direct or indirect contact with a patient or their environment; key requirements included placing the patient in a private room, wearing gloves and gowns for all interactions, dedicated equipment use, and strict hand hygiene). On 4/14/26 at 11:05 AM, the surveyor requested from the DON the resident census report for 8/9/25 and 8/10/25.On 4/14/26 at 11:12 AM, the LNHA provided the surveyor with the Midnight census report for 8/9/25 and 8/10/25. A review of the Census report for 8/9/25 revealed rooms 109-1 (a private room), 115-1 and 115-2 were empty on the sub-acute unit. A review of the census report for 8/10/25 revealed rooms 109-1, 115-1 and 115-2 were empty on the sub-acute unit. On 4/14/26 at 12:55 PM, the surveyor informed the LNHA and the DON of the concern about Resident #138's admission referral being declined due to their C. auris diagnosis and there was no additional documentation which evidenced the resident required higher level of care or the facility being unable to care for the resident.The DON explained that there was concern for their resident population and for a resident with C. auris a room on one end of a unit wing was preferred, not in the middle of a unit or between other residents' room. The surveyors discussed that contact isolation precautions as with other infectious microorganisms were implemented to prevent the spread and there was no supportive documentation provided that indicated the resident needed a higher level of care or care could not be provided by the facility. The DON and LNHA had no verbal response at this time and would look to provide any additional information.On 4/15/26 at 11:07 AM, the LNHA and the DON met with the survey team. The LNHA and the DON had no additional information or response regarding Resident #138's denial of admission. A review of the facility provided policy titled, Admissions Criteria with a last reviewed date of May 2025, revealed under Policy: It is the policy of [the facility's name] to admit residents whose needs can be safely and appropriately met within the scope of services offered by the facility, in compliance with applicable federal and state regulations, including those established by the Centers for Medicare & Medicaid Services and the New Jersey Department of Health.A review of the facility provided policy titled Infection Prevention and Control Program, with a reviewed date of 2/19/26, revealed under Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.Under Policy Explanation and Compliance Guidelines, Isolation Protocol (Transmission-Based Precautions): .A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines.Residents on transmission-based precautions should be placed into a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards.NJAC 8:39-5.1(a),5.2(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate infection control measures to prevent the potential spread of infection for failing to ensure a midline intravenous (IV) connector cap was properly secured for 1 of 1 residents (Resident # 12) with a midline IV.The deficient practice was evidenced by the following: On 4/8/26 at 12:15 PM, the surveyor observed Resident # 12, in bed, with a midline IV on the resident's left arm with a date of 4/6/26 on the dressing which covered the IV site. The surveyor observed that the midline IV line was clamped but the connector was uncapped. The resident stated that the nurses gave the resident medicine in the IV yesterday.A review of the resident medical records revealed the following:Resident # 12 was admitted with diagnoses which included, but were not limited to sepsis and cellulitis of right lower limb.The Quarterly Minimum Data Set (MDS) (an assessment tool), dated 2/3/26, revealed that Resident # 12 had a Brief Interview for Mental Status (BIMS) score of 15/15, that indicated that Resident # 12 was cognitively intact.A review of the resident's Physicians Orders (PO) revealed a PO dated 3/16/26 for insert midline. A review of the electronic Medication Administration Record (eMAR) revealed an order for Ertapenem Sodium Solution Reconstituted 1 GM Use 1 gram intravenously one time a day for right leg cellulitis until 04/07/2026.At 12:41 PM, the surveyor asked the Licensed Practical nurse (LPN), who cared for Resident # 12, to come into the resident's room. The surveyor showed the LPN the resident's midline IV connector site, and the LPN stated that the resident had IV antibiotics and the last dose of antibiotic was yesterday via the midline. The LPN stated that the midline IV line was clamped but the connector should be capped and acknowledged that it was not. The LPN stated that she was not sure what happened with the IV line connector cap and she stated that she was last in the resident's room this morning around 11:45 AM, and she did not see that the connector uncapped.At 12:49 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the midline IV line was clamped but the connector should have been capped and the resident is now on hospice care services and the facility was waiting for the doctor to determine if the antibiotic and the IV line would continue to remain in place. The DON also stated that she would immediately contact the doctor and address this situation.On 4/13/26 at 9:45 AM, the DON told the surveyor that the midline IV was removed as the doctor determined that it will no longer be used. A review of the PO's revealed an order for remove midline on 4/8/26. On 4/13/26 at 12:52 PM, the surveyor interviewed that Infection Preventionist (IP), who stated that the midline IV connector cap should have been on to prevent the potential spread of infection to the resident.On 4/9/26 at 1:30 PM, the surveyor discussed the above concerns with the Administrator and DON. No further information was provided.NJAC 8:39-19.4 (a)