STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing & Rehabilitation Ctr	300 Broadway Newark, NJ 07104

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and facility policy review, the facility failed to thoroughly investigate an allegation of Staff to Resident Abuse and did not follow its policy titled Reporting & Investigation Policy, which states that all staff must receive periodic refresher training on the recognition of abuse and neglect. This deficient practice was identified for 1 out of 10 residents (Resident R#3) reviewed for abuse allegations, as evidenced by the following: Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/26 revealed that R3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia (without behavioral disturbance), psychotic disturbance, mood disturbance, anxiety, and Psychotic disorder with delusions due to a known physiological condition. R3 had a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognitive impairment.Review of the facility's investigation of the alleged abuse incident revealed the following: Review of the Facility Reporting Incident Data and Analysis Yield (FRIDAY) dated 02/29/26 (sic) and signed by the former Director of Nursing (FDON) revealed that Certified Nursing Aide (CNA) 6 was suspected of abusing R3.The investigation revealed: On 10/02/25, a [AGE] year-old cognitively impaired resident was observed with a new left periorbital injury and stated she was hit by an aide. No staff witnessed the incident, and multiple staff reported no injury earlier that morning. The involved CNA denied abuse and was suspended pending investigation. Due to lack of evidence, witnesses, and the resident's severe cognitive impairment, the allegation was unsubstantiated. Required notifications were completed, and the resident continues to be monitored.The report failed to reveal if other residents or the CNA were interviewed about the incident. The last abuse training was completed on 6/26/25, and no refresher training was offered to staff. Law enforcement was not called, and R3 was not sent to the hospital for evaluation.Review of progress notes dated 10/02/2025 located on the Progress Notes tab of the Electronic Medical Record (EMR) revealed the following: On 10/01/2025: Resident was noted by social worker to have bruising on the left upper eyelid. Resident denied pain or visual changes. Full body assessment completed with no additional injuries noted. Resident was calm and resting in bed. Vital signs were stable. Physician notified; X-ray of left orbital area ordered. Family notified. X-ray completed; results pending.Follow-up note dated 10/03/2025 located on the Progress Notes tab of the EMR: Resident observed with bluish discoloration to the left periorbital area. Resident continued to deny pain, blurred vision, or headache. X-ray results negative for fracture or contusion. Resident monitored with no adverse findings. Resident noted to have declining mobility and coordination, requiring assistance with transfers. Resident was combative during morning care.R3 was care planned for combativeness and physical and verbal aggression toward staff. The MD ordered an X-ray, but R3 was not sent to the hospital for evaluation.During an interview on 04/09/26 at 1:27 PM, attending physician (MD) 1 stated that standard protocol typically warrants hospital transfer and possible CT imaging for such a peri-orbital injury. Nursing homes may attempt in-house monitoring with neuro checks; however, there are circumstances where hospital evaluation is required. MD1 stated they were not the one who handled the matter but would have sent R3 to the ER for evaluation and a possible CT scan due to the injury being in the head area. MD1 stated an X-ray may not have (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing & Rehabilitation Ctr	300 Broadway Newark, NJ 07104

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	picked up a deeper injury.During an interview with the DON on 04/09/26 at 6:04 PM, they confirmed that an X-ray was ordered for R3, but R3 was not sent to the ER, and law enforcement was not called.Review of the facility policy titled Reporting & Investigation Policy updated 03/2025 revealed the following: The purpose is to ensure that all alleged violations of resident rights, abuse, neglect, mistreatment, or other adverse incidents (reportable events) are promptly reported, thoroughly investigated, documented, and corrected in accordance with state and federal law . and All staff receive training upon hire and periodic refresher training on: recognition of abuse/neglect, resident rights, facility reporting requirements, how to complete incident reports, how to protect residents during investigation. The facility maintains records of training dates, attendees, and curriculum. NJAC 8:39-27.1(a)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315458	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vista Nursing & Rehabilitation Ctr	300 Broadway Newark, NJ 07104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review, interviews, and facility policy review, the facility failed to ensure a physician-ordered laboratory test was performed and failed to ensure results were reported to the ordering physician for one (1) of one (1) resident (R)2 reviewed.Findings include:The review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/08/26 revealed the following diagnoses: syncope and collapse, unspecified dementia, unspecified mental disorder, and Parkinson's disease without dyskinesia. The Brief Interview for Mental Status (BIMS) score was 3, indicating severe cognitive impairment.A review of the Orders tab in the Electronic Medical Record (EMR) showed a physician order dated 09/02/25 by MD 1 for Recheck test for Trichomonas in November 2025.However, the Results tab in the EMR revealed no documentation that the ordered laboratory test was performed, nor were any laboratory results reported to the ordering physician During an interview on 04/09/26 at 6:04 PM, the Director of Nursing (DON) confirmed that the ordered test was not performed and no results were reported to the ordering physician. A review of the facility's policy titled Carrying Out Physician's Orders, effective date 02/04/03, revised on 01/15/26, revealed its purpose is to Ensure physician's orders are carried out accurately and consistently to maintain compliance with regulatory standards and ensure patient safety. Key points include:1. All physician orders shall be carried out by the RN/LPN on duty. 6. All admission orders shall be checked by the RN/LPN of the incoming shifts and by the respective Unit Manager.NJAC 8:39-11.2(b)