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	07/22/2025

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 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, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness and, b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following:On 7/16/25 at 10:02 AM, in the presence of the Food Services Director (FSD), the surveyor observed the following:1. In the food preparation area, the surveyor observed red colored, sticky debris on the tubing of the juice dispenser and observed a spillage of clear liquid below the juice dispenser legging. 2. On oven number 1, the surveyor observed 5 of 12 oven knobs soiled with a white colored substance and 1 of 2 oven handles soiled with a white substance. On oven number 2, the surveyor also observed 7 of 11 oven knobs soiled with a thick brown colored substance.3. In the walk in freezer, the surveyor observed approximately 3 inches thick of ice build up on the brown box underneath the condenser unit and approximately 3 inches of ice build up on the floor next to the brown box, which was also located underneath the condenser unit.4. In the dry storage room, the surveyor observed two dry food storage containers containing rice and flour, both of the lids were opened to the air. The FSD stated that the containers lids should have been closed. On a shelf in the dry storage room, the surveyor observed a thermometer which read 78 degrees Fahrenheit (F) and the FSD stated that the dry storage room is always warm, and that she was aware that the temperature should be between 50 and 70 degrees F. 5. In the dry storage room, on a shelf with cans which were in rotation for use, the surveyor observed a number 10 sized can of sliced carrots with 4 separate 1 inch sized dents on the body of the can and 1 number 10 sized can of marinara with a 4 inch dent on the body of the can.A review of the policy titled Perishable Foods, dated 1/1/2027, revealed that all foods should be securely covered, dated and labeled. A review of the policy titled Dented Can, dated 1/1/2027, revealed that all dented cans should be placed on a designated shelf marked Dented Cans.A review of the policy titled CCS Food Storage Criteria, undated, which revealed hat dry food storage temperatures meet FDA or state standards (usually a maximum of 50 degrees F to 70 degrees F.)On 7/21/25 at 2:14 PM, the surveyor discussed the above concerns with the Administrator, Director of Nursing (DON) and Assistant DON.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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide pharmaceutical services in accordance with professional standards and ensure a.) removal of a discontinued antianxiety controlled drug (Clonazepam 0.5 milligrams half-tablet) from [DATE] until surveyor inquiry causing a medication error and accurate documentation on the declining inventory log for 1 of 6 medication carts inspected, b.) accurate documentation for the administration and removal of an antianxiety controlled drug (Alprazolam) for 1 of 6 medication carts inspected and c.) accurate documentation of medication administration and timely receipt of a medication (Lactulose [a medication that assists removal of ammonia from the body]) to prevent borrowing from another resident's supply for 1 of 5 residents observed during the medication administration. The evidence was as follows:1.) On [DATE] at 11:23 AM, the surveyor conducted a medication cart inspection for the active controlled drugs, in the presence of the Registered Nurse (RN #1) on the 4 [NAME] unit. At that time, the surveyor observed Resident #168's bingo card (a multidose card containing individually packaged medications) for Clonazepam 0.5 milligram (mg), half-tablet = 0.25 mg which had a remaining balance of 14 half-tablets. The surveyor then reviewed the matching Individual Patient Controlled Substance Administration Record (a declining inventory log) for Resident #168's Clonazepam 0.5 mg tablet half-tablet = 0.25 mg which reflected a remaining balance of 15 half-tablets. The declining inventory log had not corresponded with the remaining number of Clonazepam 0.5 mg half-tablets for Resident #168. On [DATE] at 11:36 AM, the surveyor continued the medication cart inspection, in the presence of the RN #1 on the 4 [NAME] unit. The surveyor observed Resident #173's bingo card of Clonazepam 1 mg tablets that had a remaining balance of 52 tablets. The surveyor then reviewed the declining inventory log for Resident #173's Clonazepam 1 mg tablets which reflected a remaining balance of 51 tablets. The declining inventory log was last signed by the administering nurse (RN #1) on [DATE] at 9:00 AM. The declining inventory log had not corresponded with the remaining number of Clonazepam 1 mg tablets for Resident #173. On [DATE] at 11:44 AM, the surveyor reviewed the facility's Record of Narcotic Use Drug Count and Syringe Count (a shift-to-shift count/sign in sheet, used to account for the controlled drugs and syringes within the medication cart) for [DATE], reflected that the inventory counts were performed on three shifts (7:00 AM, 3:00 PM and 11:00 PM), daily from [DATE] at 7:00 AM to [DATE] at 7:00 AM by two nurses, the outgoing shift and the incoming shift. RN #1 confirmed that the shift-to-shift count was conducted that morning her and another nurse and there were no discrepancies reported. RN #1 was unable to speak to the declining inventory log discrepancies for Resident's #168 and #173. A review of the Medication Review Report (MRR) for Resident #168 reflected a discontinued physician's order (PO) dated [DATE], for Clonazepam tablet 0.5mg, give 0.5 tablet by mouth two times a day related to anxiety disorder, give 0.5-tab total of 0.25 mg. A review of the [DATE], electronic medication administration record (eMAR) for Resident #168 reflected there was no active PO for Clonazepam. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MRR for Resident #173 reflected an active PO dated [DATE], for Clonazepam tablet 1 mg, give 1 mg by mouth every 12 hours for anxiety. A review of the [DATE], eMAR for Resident #173 reflected the last administration of the Clonazepam 1mg was on [DATE] at 9:00 AM given by RN #1. On [DATE] at 1:43 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON), the surveyor discussed the concern regarding the declining inventory log discrepancies for Resident's #168 and #173. On [DATE] at 10:51 AM, the survey team met with the LNHA, the DON, and the Assistant Director of Nursing (ADON). The ADON stated she had performed an investigation regarding the discrepancies and identified that there was a medication error. The ADON explained the discontinued Clonazepam 0.5 MG half-tablet labelled for Resident #168 was administered to Resident #173 and that RN #1 had signed the inventory control log for Clonazepam 1 mg tablets. The DON stated the primary physician was notified of the error. The ADON further stated that a medication incident report form was filed, and education was provided to RN #1 who committed the error. The DON stated that Resident #168's Clonazepam which was discontinued on [DATE] should have been removed from the active inventory to avoid a medication administration error. 2. On [DATE] at 11:44 AM, the surveyor conducted a medication cart inspection for the active controlled drugs, in the presence of the Licensed Practical Nurse (LPN #1) on the 4 East unit. On [DATE] at 11:59 AM, the surveyor observed Resident #152's bingo card for Alprazolam 0.25 mg which had a remaining balance of seven (7) tablets. The surveyor then compared the bingo card against the declining inventory log for Resident #152's Alprazolam 0.25 mg tablets which reflected a remaining balance of six (6) tablets. The declining inventory log was last signed by the administering nurse on [DATE] at 9:00 AM. The declining inventory log had not correlated with the remaining number of tablets for Alprazolam. On [DATE] at 12:14 PM, the surveyor interviewed LPN #1, who stated that the shift-to-shift count was conducted that morning without discrepancies. At that time, LPN #1 could not speak to the discrepancy for Resident #152's Alprazolam and was unable to speak to whether she had administered the 9 AM dose. LPN #1 added that she would let the DON know of the concern. A review of the [DATE] eMAR for Resident #152 reflected daily administration of the 9 AM Alprazolam 0.25mg from [DATE] to [DATE]. Further review of the declining inventory log had not reflected the removal of Alprazolam 0.25 mg on [DATE]. On [DATE] at 1:43 PM, the survey team met with the LNHA, and the DON. The surveyor discussed the discrepancy regarding Resident #152's Alprazolam inventory and eMAR documentation. On [DATE] at 10:51 AM, the survey team met with the LNHA, DON and ADON. The ADON stated that she had investigated the discrepancy for Alprazolam for Resident #152 and LPN #1 had pre-signed the declining inventory log without administering the medication to Resident #152 on [DATE]. In addition, the ADON explained that the nurse who signed the eMAR on [DATE] had not administered the Alprazolam. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided policy for Medication Storage updated on [DATE], reflected under purpose was to ensure all medications were stored safely, securely. and to maintain resident safety and medication safety. Controlled Substances discrepancies must be reported and investigated immediately. Disposal of Medications (expired or discontinued) must be disposed of according to federal and state regulations. A review of the Narcotic Control Management Policy, updated on [DATE], indicated that each dose must be documented on the Medication Administration Record and Controlled substance Log immediately after administration. A narcotic count be performed before and after each administration. REFER to F759 Example #2 3. On [DATE] at 9:07 AM, the surveyor observed LPN #2 preparing to administer nine (9) medications to Resident #212 which included Lactulose. LPN #2 stated that according to the eMAR, the resident had a PO for Lactulose 20 grams (GM) per 30 milliliters (ML) but was only able to pour 15 ML because that was left in the bottle. LPN #2 added that he had reordered the Lactulose solution for Resident #212 from the provider pharmacy and would have to check later with the Staffing Coordinator (SC) to see if the medication had been delivered to get more. LPN #2 explained that the SC was responsible for checking with the nurses to make sure medications were being reordered from the provider pharmacy. LPN #2 added that he would have to call the physician and let them know he gave 15 ML. The surveyor reviewed the electronic medical record for Resident #212. A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to, Type 2 Diabetes Mellitus (DM) (a diminished response to insulin causing inadequate control of glucose blood levels), schizophrenia, convulsions and neurosyphilis (a form of syphilis, a bacterial infection, that has spread to the central nervous system). A review of the most recent comprehensive quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [DATE], reflected the resident had a brief interview for mental status (BIMS) score of 13 out of 15, indicating that the resident had an intact cognition. A review of the resident's MRR reflected a PO with a start date of [DATE] for Lactulose Oral Solution 20 GM/30 ML Give 30 ML by mouth three times a day for ammonia level Give 30 ML = 20 GM. A review of the electronic progress notes (EPN) for Resident #212 revealed a medication administration note on [DATE] at 20:50 (9:50 PM) by LPN #2 which indicated awaiting supply for Lactulose solution. There were no notes on [DATE] regarding the physician being called for the administration of a 15 ML dose of Lactulose solution at the administration time of 9 AM. On [DATE] at 9:21 AM, the surveyor interviewed the DON who stated when a medication was not available then the nurses were to call the provider pharmacy to find out when the medication would be delivered and if necessary, there was another emergency pharmacy that they could call. The DON also stated that she had started as the DON approximately three months ago and had instituted a daily auto refill procedure that the SC oversaw to check with each unit to make sure refills were ordered. The DON explained that the nurses could reorder medication electronically but were required follow-up. The DON added that an in-service regarding the process was done in [DATE]. The DON (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also explained that the physician would need to be called and made aware if a medication was unable to be administered as ordered and there should be documentation. The DON then stated that she would have to check what had happened with the Lactulose solution for Resident #212. The DON also added that Lactulose solution was not a medication that was listed in the facility back up supply. On [DATE] at 10:52 AM, the surveyor interviewed RN #2, who stated that she was the medication nurse that day for Resident #212. RN #2, in the presence of the surveyor, reviewed the medication cart and was unable to locate Lactulose solution for Resident #212. RN #2 then checked the computer and stated that the Lactulose had been delivered but could not find it and would have to check. RN #2 acknowledged that she had signed for the 9 AM administration of Lactulose solution. RN #2 reviewed the medication cart again and removed a bottle labeled for an unsampled resident #1 for Lactulose 10 GM/15 ML. RN #2 stated that she had used that Lactulose solution to administer the dose to Resident #212. RN #2 added that she didn't have Resident #212's bottle of Lactulose and had to give the medication. On [DATE] at 12:59 PM, the surveyor interviewed the DON who stated that the nurses were not to use another resident's medication. A review of the unsampled resident's MRR revealed a PO dated [DATE] for Lactulose Oral Solution 10 GM/ML (Lactulose) Give 15 ML by mouth one time a day every other day for elevated ammonia levels. On [DATE] at 12:32 PM, the surveyor interviewed the Consultant Pharmacist (CP #1) via telephone who stated that she was not the specific CP #2 for the facility but could speak to any questions. CP #1 stated as per the facility contract, they do not perform medication administration observations for the facility and the nursing administrative staff was responsible for that. CP #1 stated that if a medication was not available, the nurses should check the back up supply first, then call the physician if they cannot administer the medication as ordered to make them aware and get follow up instructions. On [DATE] at 10:50 AM, the survey team met with the LNHA, DON and ADON. The DON stated that she was contacting RN #2 to inform her that the nurses were not to borrow medications from another resident. A review of the facility policy dated as reviewed [DATE] for Administering Medications provided by the DON reflected The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. In addition, If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. NJAC 8:39-11.2(b), 29.2 (a)(d), 29.4(g)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 3 (three) of the 7 residents (Residents #24, #88, and #140) reviewed for reasonable accommodations of needs/preferences.This deficient practice was evidenced by the following: 1. On 7/16/2025 at 10:50 AM, the surveyor observed Resident #24 in bed, awake. The surveyor observed that there was no available call light near the resident's bedside. The surveyor observed a call bell unit on the wall that had two outlets, one for each resident. The outlet on the side of Resident #24, did not have a call light cord connected to it. The surveyor asked the resident about the location of the call light and they stated that they were unsure of its location. On 7/17/2025 at 9:50 AM, the surveyor observed the resident inside the room; there was no physical call light available near the resident. When the surveyor interviewed the resident, the resident stated they did not know. On 7/17/2025 at 10:02 AM, the surveyor interviewed the Certified Nurse Assistant (CNA#1), who stated that the resident should have an available call light and was unaware that the resident did not have one. CNA#1 added that she would log in the maintenance book of the missing call light. On 7/21/25 at 12:13 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #24, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #24 was admitted with diagnoses that included but were not limited to unspecified dementia (loss of memory), other diseases classified elsewhere, and major depressive (feelings of sadness) disorder. A review of the recent quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care), which was dated 5/17/25, 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 severe impairment of cognition. Further review of the Q/MDS, as reflected in section GG, revealed that the resident required supervision for daily living activities. A review of the individual comprehensive care plan (ICCP) report initiated on 4/27/22 focused on the resident's risk of falls related to psychoactive drug use. Interventions included, but were not limited to, ensuring the call light was within the resident's reach and encouraging the resident to use the bell to call for assistance. 2. On 7/16/2025 at 11:04 AM, the surveyor observed Resident #88 asleep in bed. The resident's call light was observed wrapped around the resident's side rails. The call light was not connected to the outlet and was lying on the floor. On 7/17/2025 at 9:37 AM, the surveyor observed that the resident was awake and able to answer the surveyor's inquiries. The surveyor observed that Resident #88's call light was attached to the siderails but not connected to the outlet. The resident stated that they were unaware that the call bell was not connected to the outlet. The resident added they tried not to scream for help, but it takes 10-15 minutes for the staff to respond to their call. On 7/17/2025 at 10:00 AM, the surveyor interviewed CNA#2, who stated that the call light must be pulled out from the outlet but could not explain what had happened. She added that the call bell should be within the resident's reach and functioning correctly. The CNA#2 connected the call light to the outlet and noted that it was not functional. She stated she would tell the maintenance about it. On 7/21/25 at 9:54 AM, the surveyor reviewed the hybrid medical record of Resident #88, which revealed the following:A review of the AR reflected that Resident #88 was admitted with diagnoses that included, but were not limited to, hypertensive heart disease without heart failure, and major depressive disorder. A review of the most Q/MDS, dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 9 out of 15, indicating moderate cognitive impairment. Further review of Q/MDS, reflected in section GG, revealed that the resident depends on staff assistance for daily living activities. A review of the ICCP report initiated on 9/21/23 focused on the resident's risk for falls related to gait/balance problems and psychoactive drug use. Interventions included, but were not limited to, placing the call light within reach and encouraging the resident to (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use it. 3. On 7/16/2025 at 10:49 AM and on 7/17/25 at 9:40 AM, the surveyor observed Resident #140 in bed, awake, unable to answer the surveyor's inquiries. The surveyor observed the call light was located behind the cabinet which was located at least 3-4 feet away from the resident. On 7/17/2025 at 10:05 AM, the surveyor interviewed CNA#2, who stated that all residents should have a call light and that it should be within easy reach in case the resident needs assistance. CNA#2 took the call light from behind the cabinet and placed it on top of the resident's right hand. A review of the AR reflected that Resident #140 was admitted with diagnoses that included, but were not limited to, vascular dementia (loss of memory caused by brain damage). A review of the recent Q/MDS, dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 0 (zero) out of 15, indicating severe cognitive impairment. Further review of Q/MDS, reflected in section GG, revealed that the resident depends on staff assistance for daily living activities. A review of the ICCP report initiated on 9/21/23 focused on the resident's risk for falls related to blindness, gait/balance problems, psychoactive drug use, and seizure (abnormal activity in the brain) disorder. Interventions included, but were not limited to, placing the call light within the resident's reach. On 7/17/2025 at 10:05 AM, the surveyor interviewed CNA#2, who stated that all residents should have a call light and that it should be within easy reach in case the resident needs assistance. On 7/17/2025 at 10:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the call light should be placed within the resident's reach. On 7/17/2025 at 10:20 AM, the surveyor interviewed the maintenance staff, who stated that they usually conduct rounds in the morning from the 3rd to the 5th floor. The maintenance staff stated if the staff did not report it to the maintenance log book, they could not tell which room needed to be fixed. He added that he does not have time to check each room; instead, he relied on the information in the log book. On 7/22/2025 at 11:21 AM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant DON (ADON). The DON stated that the staff should ensure the call light was within the resident's reach, functioning correctly, and properly connected to the outlet. A review of the facility policy titled Call Light Answering, updated in March 2018, revealed under Procedure: 8. When providing care to residents, be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light. 10. Notify the maintenance department and enter defective call light location(s) in the maintenance log, if the facility has such a log. 11. Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand. NJAC 8:39-31.8(c)9

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician a.) signed and dated monthly physician orders and b.) wrote physician progress notes each month. The deficient practice was observed for 2 of 35 residents (Resident #53, #248) reviewed and occurred over a 3 month period. The evidence is as follows: 1.The surveyor reviewed the hybrid (electronic and paper) medical record for Resident #53 on 7/21/25, which revealed the primary medical doctor (PMD) had not signed monthly Medication Review Reports (MRR) for the prior 3 months. Additionally, the PMD had not documented monthly Physician Monthly Follow-Up Notes (PMFN) for the prior 3 months.The surveyor interviewed the Nurse Unit Manager (NUM) on 7/21/25 at 11:00 am. The NUM confirmed the medical record did not contain April, May, or June 2025 MRRs or PMFNs. She stated there was a stack of printed MRRs in the nursing office to be signed by the PMD. She stated the PMD would be in later that day to sign them.On 7/21/25 at 11:00 am the NUM provided the surveyor with MRRs for April, May, and June 2025 which had been signed by the PMD, but not dated. 2.The surveyor reviewed the hybrid medical record for Resident #248 on 7/21/25 at 11:30 am which revealed the PMD had not signed monthly MRRs for the prior 3 months. Additionally, the PMD had documented not documented monthly PMFN for the prior 3 months.The surveyor interviewed the Nurse Unit Manager (NUM) on 7/21/25 at 11:38 am. The NUM confirmed the medical record did not contain April, May, or June 2025 MRRs or PMFNs.The survey team interviewed the PMD on 7/21/2025 at 10:35 AM He stated he thought physician visits should be documented every 90 days. He stated he was catching up with his notes.The surveyor discussed the concerns with the Administrator and the Director of Nursing (DON) on 7/21/25 at 1:30 pm.The DON told the survey team on 7/22/25 that the PMD was educated on the facility policy and the regulation for documentation of monthly notes and signing of monthly physician orders. The surveyor reviewed the facility Physician Orders Policy, updated 5/2025. The policy indicated all care and treatment provided to residents will be based on timely physician orders which are clear, complete, dated, and signed according to regulatory timeframes.NJAC 8:39-11.2; 23.2

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation performed on 7/17/25, the surveyors observed four (4) nurses administer medications to five (5) residents. There were 32 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 6.25 %. This deficient practice was identified for one (1) of five (5) residents, (Resident #212), that were administered medications by one (1) of four (4) nurses. The deficient practices were evidenced as follows: 1.On 7/17/25 at 9:07 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) preparing to administer nine (9) medications to Resident #212 which included Humalog (Insulin Lispro) (a fast-acting insulin-a medication used to lower blood sugar). LPN #1 reviewed a paper that he had recorded Resident #212's blood sugar (BS) result of 156. He stated he had obtained the BS from the resident before they had eaten breakfast and according to the electronic medication administration record (EMAR) the resident had a physician's order (PO) for insulin coverage which indicated to administer two (2) units (U) based on the BS result of 156.On 7/17/25 at 9:22 AM, the surveyor observed LPN #1 administer subcutaneously (under the skin) two (2) U of Insulin Lispro to Resident #212. The surveyor observed that there were no meal trays on the unit. On 7/17/25 at 9:23 AM, the surveyor interviewed LPN #1 who stated that breakfast that day was around 8:10 AM to 8:30 AM and had taken the BS prior to the meal tray coming to the unit and had not wanted to disturb the resident while they were eating to administer the Insulin Lispro. LPN #1 acknowledged that according to the EMAR the PO had an administration time of 7:30 AM and indicated to be administered before a meal. (ERROR #1)The surveyor reviewed the electronic medical record for Resident #212.A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to, Type 2 Diabetes Mellitus (DM) (a diminished response to insulin causing inadequate control of glucose blood levels), schizophrenia, convulsions and neurosyphilis (a form of syphilis, a bacterial infection, that has spread to the central nervous system).A review of the most recent comprehensive quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 6/1/25, reflected the resident had a brief interview for mental status (BIMS) score of 13 out of 15, indicating that the resident had an intact cognition. A review of the resident's Medication Review Report (MRR) reflected a PO with a start date of 10/3/24 for HumaLog injection Solution 100 U/ML (milliliter) (Insulin Lispro) Inject as per sliding scale: if 0-150 = 0 U, 151-200 =2 U; 201-250 =4 U; 251-300 = 6U; 301-350 = 8 U; 351-400 =10 U, 401- 450 = 12 U Call MD (physician) if BS less than 60, greater than 450, subcutaneously before meals (AC) for DM. A review of the resident's individualized Care Plan Report had a focus area of Diabetes Mellitus with a revision date of 1/18/24 and interventions, which included but not limited to, Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness and Fasting Serum Blood Sugar as ordered by doctor.On 7/18/25 at 9:21 AM, the surveyor interviewed the Director of Nursing (DON) who stated that insulins should be administered before a meal. The DON added that she would expect the nurses to take a BS, then administer the insulin before a meal according to the BS results when there was a coverage PO.On 7/21/25 at 12:32 PM, the surveyor interviewed the Consultant Pharmacist (CP #1) via telephone who stated that she was not the specific CP #2 for the facility but could speak to any questions. CP #1 stated as per the facility contract, they do not perform medication administration observations for the facility and the nursing administrative staff was responsible for that. CP #1 also stated that she would expect the time of administration of insulins to depend on the mealtime and would have a PO indicating before a meal. In addition, the CP #1added fast-acting insulins should be administered 15 minutes before eating a meal. On 7/21/25 at 12:32PM, the surveyor was provided a Med-Pass Nursing Competency form for LPN #1 by the DON, dated 10/20/24, that was completed by the Supervisor/Registered Nurse (S/RN). The form indicated a checkmark for (continued on next page)

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	07/22/2025

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NO for Give AC (before a meal), PC (after a meal) and time specific meds on time and a comment of redirected. The DON explained that the S/RN performed a medication pass observation with LPN #1 and the NO meant LPN #1 had not administered on time either an AC, PC (after meals) or time specific med and was redirected meaning LPN #1was educated to follow the correct administration time. The DON added that she was unaware of any other follow-up with LPN #1. The DON stated that the CP #2 was not responsible for performing medication administration observations.On 7/22/25 at 10:50 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON and Assistant Director of Nursing (ADON). The DON stated LPN #1 was educated on administering Insulin Lispro before a meal and not to wait until the resident has eaten.A review of the facility policy dated as reviewed May 2024 for Administering Medications provided by the DON reflected Medications are administered in a safe and timely manner, and as prescribed. In addition, the policy interpretation and implementation included but not limited to; 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: enhancing optimal therapeutic effect of the medication. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). A review of the facility policy dated as September 2014 for Insulin Administration provided by the DON reflected for Preparation The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. In addition, the policy indicated that the onset of action (how quickly the insulin reaches the bloodstream and begins to lower blood glucose) for the rapid acting type of insulin was 10-15 minutes.The Patient Information for Humalog (insulin lispro) injection for subcutaneous use revealed Humalog is a rapid-acting insulin. Inject Humalog within 15 minutes before or right after eating a meal.The manufacturer specifications for Humalog (Insulin Lispro) revealed Humalog should be given within 15 minutes before a meal or immediately after a meal. REFER to F755 EXAMPLE #32.On 7/17/25 at 9:07 AM, the surveyor observed LPN #1 preparing to administer nine (9) medications to Resident #212 which included Lactulose (a medication used to lower ammonia levels in the blood) solution. LPN #1 stated that according to the EMAR, the resident had a PO for Lactulose 20 grams (GM) per 30 ML but was only able to pour 15 ML because that was all that was left in Resident #212's bottle. LPN #1 added that he had reordered the Lactulose solution for Resident #212 from the provider pharmacy and would have to check later with the Staffing Coordinator (SC) to see if the medication had been delivered to get more. LPN #1 explained that the SC was responsible for checking with the nurses to make sure medications were being reordered from the provider pharmacy. LPN #1 added that he would have to call the physician and let them know he gave 15 ML.On 7/17/25 at 9:20 AM, the surveyor observed LPN #1 administer 15 ML of Lactulose solution to Resident #212. Upon returning to the medication cart, the surveyor observed LPN #1 sign the EMAR for the PO Lactulose Oral Solution 20 GM/30 ML Give 30 ML by mouth three times a day for ammonia level Give 30 ML = 20 GM for the 9 AM administration time. (ERROR #2)The surveyor reviewed the electronic medical record for Resident #212.A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to, Type 2 Diabetes Mellitus schizophrenia, convulsions and neurosyphilis.A review of the most recent comprehensive quarterly MDS dated [DATE], reflected the resident had a BIMS score of 13 out of 15, indicating that the resident had an intact cognition. A review of the resident's MRR reflected a PO with a start date of 3/30/25 for Lactulose Oral Solution 20 GM/30 ML Give 30 ML by mouth three times a day for ammonia level Give 30 ML = 20 GM.A review of the electronic progress notes (EPN) for Resident #212 revealed a medication administration note on 7/17/25 at 20:50 (9:50 PM) by LPN #2 which indicated awaiting supply for Lactulose solution. There were no notes on 7/17/25 regarding the physician being called for the administration of a 15 ML dose of Lactulose solution at the administration time of 9 AM.On 7/18/25 at 9:21 AM, the surveyor interviewed the Director of Nursing (DON) who stated when (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a medication was not available, the nurses were to call the provider pharmacy to find out when the medication would be delivered and if necessary, there was another emergency pharmacy that they could call. The DON also stated that she had started as the DON approximately three months ago and had instituted a daily auto refill procedure that the SC oversaw to check with each unit to make sure refills were ordered. The DON explained that the nurses could reorder medication electronically but required follow-up. The DON added that an inservice regarding the process was done in May 2025. The DON also explained that the physician would need to be called and made aware if a medication was unable to be administered as ordered. The DON then stated that she would have to check what had happened with the Lactulose solution for Resident #212.The DON also added that Lactulose solution was not a medication that was listed in the facility back up supply.On 7/18/25 at 10:52 AM, the surveyor interviewed Registered Nurse (RN #1), who stated that she was the medication nurse that day for Resident #212. RN #1, in the presence of the surveyor, reviewed the medication cart and was unable to locate Lactulose solution for Resident #212. RN #1 then checked the computer and stated that the Lactulose had been delivered but could not find it and would have to check. On 7/18/25 at 12:59 PM, the surveyor interviewed the DON who stated that she had called the provider pharmacy earlier. The DON, in the presence of the surveyor, had the SC call the provider pharmacy. The SC stated that she was told the Lactulose was out on delivery. The DON stated that the provider pharmacy usually made three deliveries a day. Then, the SC stated that she was going to check if the Lactulose had been delivered to the wrong unit.On 7/18/25 at 1:21, the SC stated that she just came from the unit and the provider pharmacy delivery person was there making a delivery. The SC stated she checked the package and Resident #212's Lactulose solution was delivered.On 7/21/25 at 12:32 PM, the surveyor interviewed the Consultant Pharmacist (CP #1) via telephone who stated that she was not the specific CP #2 for the facility but could speak to any questions. CP #1 stated as per the facility contract, they do not perform medication administration observations for the facility and the nursing administrative staff was responsible for that. CP #1 stated that if a medication was not available the nurses should check the back up supply first, then call the physician if they cannot administer the medication as ordered to make them aware and get follow up instructions.On 7/22/25 at 11:15 AM, the surveyor was provided an inservice dated 7/21/25 for LPN #1. The DON stated that liquid medications had to be reordered when medication was running low and were not included in the daily auto refill report.A review of the facility policy dated as reviewed May 2024 for Administering Medications provided by the DON reflected The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. In addition, If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. NJAC 8:39-11.2(b), 29.2(a)(d)