STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315501	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Wall LLC	1725 Meridian Trail Wall, NJ 07719

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ184446 Based on interviews, medical records reviews, and review of other pertinent facility documentation on 03/24/2025, it was determined that the facility failed to protect a resident (Resident #2) from significant medication error and follow the physician's order when the Licensed Practical Nurse (LPN #2) administered an incorrect dose of Methadone and failed to follow its policy titled Medication Administration and follow the Licensed Practical Nurse Job Description. On 03/14/2025 at approximately 6:04 A.M., LPN #2 administered 105 MG [milligram] of liquid Methadone ordered for Resident #6 for opioid dependence to Resident #2 instead of the Methadone 10MG tablet ordered for the Resident for pain. Resident #2 was found by LPN #1 at approximately 8:15 A.M. to be lethargic and semi-responsive; the Resident was placed on oxygen at 2 liters via nasal cannula and received Narcan Nasal Liquid 4 MG/ ML via nostrils for possible drug overdose; 911 was called, and Emergency Medical Team (EMT) arrived. Resident #2 was transferred to a local hospital emergency room (ER) and admitted with a diagnosis of Methadone overdose. The facility's failure to prevent Resident #2 from a significant medication error placed Resident #2 and all other residents at risk for serious injury, harm, or death. The Immediate Jeopardy Past Non-Compliance began on 03/14/2025 and ended on 03/17/2025 after the facility re-educated all staff on its medication administration policy. This deficient practice was identified for 1 of 6 residents (Resident #2) reviewed for medication administration. There was sufficient evidence that the facility corrected the non-compliance and was in substantial compliance at the time of this Complaint Survey for the specific F760 regulatory requirements. The facility provided documented evidence of a Plan of Correction (POC) to the Surveyor, which included the following: - On 03/14/2025, the staff were trained on Opioid overdose management, which included: If a resident exhibits any of the following overdose symptoms, the facility will call 911, initiate basic life support, if indicated, and administer naloxone as per facility and manufacturer's instructions. - On 3/14/2025, the Narcotic shift count/control substances, which included Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 3/14/2025, how to administer Narcan/ identifying overdose initiated, which included responding to an overdose, checking for a response, lightly shaking the Resident, yelling their name, airway open, and rescue breathing if an overdose is witnessed, and recovery position: if the Resident is breathing but unresponsive, put them on their side to prevent choking if they vomit. - On 3/15/2025, the new Methadone process, which included one locked container, was ordered that will fit in the newly placed narcotic drawer. The clinic gives one countdown of 28 bottles each that contain areas for the residents to cosign for doses and where the bottles are to be kept for the next pick up. - On 3/14/2025, MD orders included ensuring that the six rights of medication administration were being followed: right Resident, right drug, right dose, right route, right time, and right documentation. - On 3/14/2025, Medication Administration/Rights of Medication, which included comparing medication source (bubble pack, vial .) with the MAR [medication administration record] to verify the Resident's name, medication name, form, dose, route, and time. Also, the MAR should be reviewed to identify the medication to be administered. On 03/24/2025, a review of Resident #2's Electronic Medical Record (EMR) was as follows: According to the admission Face Sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to Unspecified Pain, Hypertension (high blood pressure in the arterial wall), and Depression (loss of interest in activities for long periods of time). According to the Minimum Data Set (MDS), an assessment tool dated 02/06/2025, Resident #2 had a Brief Interview of Mental Status (BIMS) score of 11 out of 15, which indicated the Resident's cognition was moderately impaired. A review of Resident #2's Order Summary Report (OSR) Active Orders as of 01/29/2025 revealed the following Physician Orders (POs): Methadone HCl Oral Tablet 10 MG give 1 tablet by mouth every 8 hours for pain. According to the admission Face Sheet, Resident #6 was admitted to the facility with diagnoses which included but were not limited to Opioid Dependence (a chronic condition characterized by a compulsive and persistent pattern of opioid use that leads to significant negative consequences), Anemia (lower than normal amount of healthy red blood cells), and Muscle Weakness (reduced ability of muscle to contract and generate strength). According to the MDS dated [DATE], Resident #6 had a BIMS score of 15 out of 15, which indicated the Resident was cognitively intact. A review of Resident #6's OSR Active Orders as of 03/01/2025, revealed the following POs: Methadone HCl Oral Solution 10 MG/5ML give 105 MG by mouth one time daily for opioid dependence. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Facility Reportable Events Record (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents dated 03/14/2025, with an event date of 03/14/2025 and a time of event of 8:25 A.M. was reviewed. According to the FRE, On 3/14/2025, resident appeared lethargic. Assessed by staff. Narcan administered and patient transferred to ER [Emergency Department] for further evaluation. MD [Medical Doctor] and family notified. According to the facility's form titled Incident/Accident Staff/ resident/Witness Statement (IASRWS) dated 03/14/2025 at 06:05 A.M., completed by LPN #2, On 03/13/2025, I began my 11-7 (11:00 P.M. to 7: A.M) shift. I completed my rounds on my patients with the nurse I was relieving. We both completed the narcotic count, and it was correct. I started my medication pass. I administered Resident #2's morning medication at approximately 6:04 A.M. I mistakenly gave the liquid medication of Methadone instead of the tablet. I did not realize this until the facility notified me of the error. Upon completion of my shift, the patient (Resident #2) showed no signs or symptoms of respiratory distress or lethargy. According to the facility's form titled IASRWS dated 03/14/2025, with a Date and of 03/14/2025 at 07:15 A.M. , completed by LPN#1, I arrived at work at 7:00 A.M. The night shift nurse gave report, and we counted the narcs (narcotics) at 7:15 A.M. At 7:30 A.M. while doing my walking rounds with the supervisor, we saw Resident #2 in their room leaning against the bathroom door with their walker. I asked if Resident #2 needed help, and Resident #2 responded that he/she wanted to get back in bed. The supervisor and I assisted the Resident back into his/her bed. Resident #2 was alert and normal. I left the room, and the supervisor continued talking to Resident #2. I started my med pass at approximately 8:30 A.M. I went to give the patient (Resident #6) in room [Resident's room number] their scheduled Methadone and realized one bottle was missing. I immediately reported it to my supervisors. A review of Resident #2's Progress Notes (PNs) revealed the following notes completed by LPN#1: On 03/14/2025 at 9:51 A.M., patient (Resident #2) was seen in their room, leaning on his/her bathroom door and holding on to his/her walker. Resident #2 was alert and at his/her normal baseline, but Resident #2 needed help getting back into the bed. The supervisor and I assisted the Resident (Resident #2) back in bed. Approximately one hour later (the) patient (Resident #2) was observed sleeping but uneasy to arouse. The Nurse Practitioner in-house assessed (the) patient, (Resident #2) rapid response initiated. O2 (oxygen) @2L (liter) via nasal cannula applied, IV (intravenous) line inserted to (the) left forearm, Narcan (was) administered. EMTs arrived and transported (the) patient (Resident #2) to the local hospital (name of hospital listed). The patient's (Resident #2) daughter was notified. On 03/14/2025 at 3:12 P.M., . spoke to RN (Registered Nurse) in the ER at local hospital (name of hospital) patient (Resident #2) admitted with Accidental Methadone Overdose. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/24/2025 at 11:30 A.M., LPN #1 stated on 03/14/2025 at approximately 8:30 A.M., while doing medication pass, she realized a bottle of liquid Methadone 105 MG was missing from Resident #6 narcotic count. She stated that she immediately reported this to the supervisor, called the night shift nurse (LPN#2), and asked if she had given Resident #2 his/her Methadone in the morning. LPN #1 further stated, I asked her what she gave Resident #2, and she [LPN #2] told me she gave [Resident #2] the liquid Methadone in the narcotic drawer. I told her the liquid Methadone was not for [Resident #2]. I immediately alerted the Director of Nursing (DON), and we both went into Resident #2's room, who was sleeping in a deeper sleep than normal. We were able to wake the Resident up, take his/her vitals, and have the NP (Nurse Practitioner) come and assess Resident #2. Narcan intranasal was administered, oxygen was applied via nasal cannula, and an IV (intravenous) line was initiated; 911 was called, and the Resident (Resident #2) was transferred to the hospital for evaluation. During the same interview, LPN#1 said the medication administration process involves verifying the order before administering the medication to the Resident and paying close attention to the form in which the medication is ordered (liquid or tablet). She said it is important to follow the rights of medication administration, right medication, right dose, right form, tight time, right route, and right patient. During a telephone interview on 03/24/2025 at 1:26 P.M., LPN #2 stated on 03/14/2025, I started my morning medication pass at 5:00 A.M. I saw the methadone order for Resident #2, I picked up the liquid bottle of methadone instead of the methadone tablets as ordered. I went to the Resident's (Resident #2) room and administered the liquid Methadone instead of the tablet as ordered. When asked by the Surveyor if she identified Resident #2 prior to administering the Methadone, LPN #2 said, Yes, I identified the Resident (Resident #2) prior to administering the Methadone. I thought I looked at the bottle, I thought I picked up the right medication, [and] I thought I saw Resident #2's name on the bottle. I thought Resident #2's order said liquid, that's why I picked up the liquid Methadone. When asked by the Surveyor if the order was verified prior to administering the medication to Resident #2, LPN #2 said, No, I did not verify the order once I got the bottle from the narcotic draw. LPN #2 stated she thought she saw liquid Methadone as Resident #2's order; that's why she took the liquid from the narcotic drawer. When asked if the facility policy for medication administration was followed, LPN #2 said, no, the policy was not followed on 03/14/2025 when I administered the wrong medication to the resident. During the same interview, LPN #2 said, If the resident receives the wrong medication, it could result in death or serious injury. She further stated that I should have followed the rights of medication administration, right medication, right dose, right time, right form, right route, and right patient. LPN #2 stated she was made aware of the medication error via phone by LPN #1. During an interview on 03/24/2025 at 2:12 P.M., the DON said her expectation is for the nurse to follow the rights of medication administration, which includes the right medication, right dose, right form, right route, right time, and right patient. She said the nurse (LPN#2) should have followed the six rights of medication administration and followed the physician's order on 03/14/2025 during her morning medication pass. The DON further stated, The incident of Resident #2 receiving the wrong dose of Methadone (Methadone 105 MG) could lead to possible death. When asked if the facility policy for medication administration was followed, the DON said, no, the facility's policy for medication administration was not followed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility policy titled Medication Administration with a revised date of 09/2022 revealed the following: Under Policy included: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standards of practice, in a manner to prevent contamination or infection. Under Policy Explanation and Compliance Guidelines: included: 10. Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug. C. Right dose, D. Right route, E. Right time, F. Right documentation . A review of the facility's document titled Licensed Practical Nurse Job Description revealed the following: Under Major Duties and Responsibilities included: Prepares and administers medications as per physicians' orders and observes adverse effects as indicated. N.J.A.C.: 8.39-29.2 (d)