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	05/08/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. COMPLAINT#: 2794629 Based on interview, review of medical records and other pertinent facility documents on 4/29/26, it was determined that the facility failed to monitor a resident's weight upon admission, and then weekly for 4 weeks in accordance with facility protocols and professional standards of practice. This deficient practice was identified for 1 of 3 residents (Resident #7) reviewed and was evidenced by the following:Resident #7 was not at the facility at the time of the survey. A closed record review was conducted. A review of the admission Record revealed that Resident #7 was admitted to the facility with diagnoses that included but were not limited to: hemiplegia and hemiparesis following cerebral infarction, aphasia, and congestive heart failure. According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 1/13/26, Resident #7 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating the resident's cognition was severely impaired. Further review of the MDS revealed that a weight of 126 pounds was entered on 1/13/26 for the resident. A review of Resident #7's Nursing Comprehensive Assessment, dated 1/6/26, did not include a weight for the resident. A review of Resident #7's electronic medical record revealed weights for the resident as follows:-1/13/26 = 126.4 [pounds]-1/29/26 = 124.0 [pounds] A review of Resident #7's Progress Notes (PN) for January 2026 revealed a nutrition note dated 1/13/26 at 11:33 AM, that indicated the resident's admission weight was obtained for the resident on, .1/13 = 126.4# height 67 inches BMI = 19.8. There were no additional weights documented in the resident's medical record. An interview was conducted on 4/29/26 at 1:06 PM with Licensed Practical Nurse (LPN #2) who stated that a resident's weight was to be obtained within twenty-four hours of admission, and then weekly for four weeks. She further stated that if a resident refused to be weighed that this should be documented by the nurse and reported to the Dietitian. In the presence of the surveyor, LPN #2 reviewed weights for Resident #7 and stated that the resident was missing an admission weight and a weekly weight [1/20/26]. She stated that if the resident refused, that should have been documented in a nursing note, and it should have been reported to the Dietitian. An interview was conducted on 4/29/26 at 2:10 PM with the Dietitian who stated that resident's weight is usually taken within twenty-four hours of admission, and weekly for four weeks, unless otherwise ordered. She further stated that obtaining resident weights were important to monitor whether a resident was gaining and/or losing weight. She stated that a list of residents needing their weights to be checked is kept on each unit so that staff were aware to check the weights and to document them. The Dietitian stated that staff were to inform her if any resident refused to be weighed, so that she could follow-up. In the presence of the surveyor the Dietitian reviewed Resident #7's Face Sheet which indicated their admission date, along with her PN which showed the weights were not in the medical record. The Dietician confirmed that there was no weight documented for Resident #7's initial twenty-four hours of admission and none for the week of 1/20/26. The Dietitian stated that she was not sure if the weights had been obtained, but that if they had they should have been documented. A joint interview was conducted on 4/29/26 at 4:37 PM with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The DON stated that an admission weight was important to obtain because it established a baseline for the residents. She further stated that weekly weights reflected the resident's nutritional status which could affect (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their health status. The DON stated that an admission weight should have been obtained and documented and that weekly weights should have been obtained for the first four weeks of the Resident #7's stay, including the week of 1/20/26. She stated that she was not sure why these were not recorded for the resident because if the resident refused, this should have been documented. A review of the facility's undated Weight Assessment and Intervention policy revealed that weights should be obtained by staff at the time of admission and then weekly for four weeks. N.J.A.C. 8:39-27.1(a)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. Complaint #: 2993624 Based on interviews, medical record reviews, and review of other pertinent facility documents on 04/29/2026, it was determined that the facility failed to ensure a nurse (Licensed Practical Nurse #1) identified a resident prior to administering medication to the resident. Resident #2 was given methadone by mouth that was prescribed for another resident (Resident #1).On 12/25/2025, LPN #1 administered 110 milligrams (MG) of methadone (opioid medication used for addiction treatment and pain management) liquid by mouth to Resident #2. The medication was prescribed for Resident #1. LPN #1 realized the error and immediately administered Narcan to Resident #2. Narcan is a medication designed to reverse opioid overdose rapidly. Resident #2 was sent by ambulance to the hospital Emergency Department (ED) for evaluation and was admitted . The facility self-corrected and put themselves back in compliance to prevent serious harm from occurring or recurring on 12/31/2025 when house-wide education of licensed nurses was completed.The IJ was Past Non-Compliance (PNC). This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed for medication administration.The evidence was as follows:A review of the facility policy titled Medication Administration with a reviewed/revised date of 10/20/2025 revealed under Policy that medications were administered by licensed nurses, or other authorized staff, as ordered by the physician and in accordance with professional standard of practice. Under Policy Explanation and Compliance Guidelines the facility policy revealed 10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentationA review of the facility policy titled Medication Errors with a reviewed/revised date of 10/01/2025 revealed under Policy that it was the policy of the facility to provide protection for the health, welfare, and rights of each resident by ensuring residents received care and services safely in an environment that was free of significant medication errors. Under Definitions the facility policy revealed that a significant medication error was one that caused a resident discomfort or jeopardized their health and safety. Under Policy Explanation and Compliance Guidelines the facility policy revealed, 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders. [.] c. In accordance with accepted standards and principles which apply to professionals providing services.According to the admission Record (AR), Resident #1 was admitted to the facility with diagnoses including but not limited to chronic multifocal osteomyelitis (lesions, inflammation and pain in the bones), left femur; opioid dependence, uncomplicated; and acquired absence of the left leg above the knee (surgical or traumatic removal of the leg). A review of Resident #1's Order Summary Report (OSR) which contained active, completed, and discontinued orders revealed a physician order (PO) for methadone HCl (hydrochloride) oral solution 10 MG/5 ML (milligrams/milliliters), give 55 ML by mouth in the morning. The Medication Administration Record (MAR) for Resident #1 was reviewed for December 2025. The MAR revealed that on 12/25/2025 the code 7 was entered by LPN #1 for Resident #1's 9:00AM dose of 55 ML of methadone HCl oral solution 10 MG/5 ML. Further review of the MAR revealed that the code 7 meant Other/See Nurse Notes. Progress Notes (PN) for Resident #1 were reviewed. A medication administration note written by LPN #1 and dated 12/25/2025 at 8:50 AM revealed that Resident #1's 9:00 AM dose of 55 ML of methadone HCl oral solution 10 MG/5 ML was not available. According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses including but not limited to traumatic subdural hemorrhage (collection of blood leaking between the dura mater, the outermost membrane surrounding the brain and spinal cord, and the brain's surface) and without loss of consciousness, subsequent encounter; and unspecified dementia (loss of cognitive functions including thinking, remembering, and reasoning which interferes with daily life and activities), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. According to the comprehensive Minimum Data Set, an assessment tool dated 12/08/2025, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident's cognition was moderately (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	impaired. A review of Resident #2's OSR which contained active, completed, and discontinued orders revealed no POs for methadone HCl oral solution or any other opioid medications. The PNs for Resident #2 were reviewed. A PN written by LPN #1 on 12/25/2026 at 12:03 PM revealed that Resident #2 received methadone 110 mg at 10:00 AM and showed no signs of distress. The PN further revealed that Narcan was administered, and the resident was sent to the ED for evaluation. A facility incident report (IR) titled Med error: (wrong resident) dated 12/25/2026 at 10:00 AM was reviewed. The facility IR revealed that the resident involved was Resident #2 and the location was Resident #2's room. The IR revealed under Incident Description that the nurse asked Resident #2 if they were Resident #1 and Resident #2 stated yes, then Resident #1 requested their methadone. An Incident/Accident Staff/Resident/Witness Statement (IASRWS) form signed by LPN #1, with Resident #2's name and an incident date of 12/25/2025 on top was reviewed. The IASRWS revealed Resident #2 received 110 mg of methadone at 10:00 AM. The IASRWS further revealed that the resident showed no signs of distress, the resident received Narcan, the physician was notified, and the resident was sent to the ED. A hospital physician note (HPN) dated 12/25/2025 at 2:24 PM, was reviewed. The HPN revealed that Resident #2 was admitted to the ED on 12/25/2025 at 11:14 AM due to inappropriate medication administration. The HPN revealed that the resident was very sleepy in the ED. The surveyor attempted to contact LPN #1 for an interview but was unsuccessful. An interview was conducted with the Director of Nursing (DON) on 04/29/2026 at 2:51 PM. The DON confirmed that on 12/25/2025 Resident #2 was administered a dose of methadone that was ordered for Resident #1. The DON stated that the expectation was for medications to be administered according to physician orders and the six rights of medication administration. The DON stated that the expectation was that residents were identified by their identification bracelets and by their photo in the electronic medical record. The DON stated that if this was done, the medication error would not have occurred. The DON further stated that administering methadone to the wrong resident could result in lethargy, changes in mental status, changes in level of consciousness, and respiratory depression which could result in serious harm. A review of the facility document titled Licensed Practical Nurse Job Description revealed under Major Duties and Responsibilities that the LPN prepares and administers medications as per physicians' orders and observes adverse effects as indicated. The facility submitted an acceptable removal plan (RP) on 05/07/2026 at 4:27 PM, indicating the action the facility took to prevent serious harm from occurring or recurring. The RP included:On 12/25/2025, the facility administered Narcan to Resident #2 and sent them to the ED.On 12/25/2025, other residents on LPN #1's assignment were evaluated, and no concerns were identified.On 12/25/2025, LPN #1 was removed from the assignment and blocked from returning to the facility.On 12/25/2025, house-wide education of licensed nurses on medication administration and medication errors was initiated and completed on 12/29/2025. The facility submitted an action plan on 05/08/2026 indicating further actions the facility took to prevent serious harm from occurring or recurring. The action plan included:On 12/25/2025, house-wide education of licensed nurses on name band identification was initiated and completed on 12/29/2025.On 12/25/2025, house-wide audits of name identification bands were initiated and continued weekly for 4 weeks, then monthly for two months.On 12/25/2025, house-wide education on methadone administration was initiated and completed on 12/31/2025. This IJ is Past Non-Compliance. The surveyor verified the implementation of the removal plan on site on 05/08/2026 and determined that there is sufficient evidence that the facility corrected the noncompliance on 12/31/2025 and is in substantial compliance at the time of the current survey for the specific regulatory requirement for F760. NJAC 8:39-29.2 (d)