

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Wall LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 and interview, it was determined that the facility failed to maintain the food preparation, storage area, kitchen equipment and food transport equipment in a clean and sanitary manner, and ensure staff had access to clean hand washing facilities and covered all facial hair appropriately to prevent contamination from foreign substances and limit the potential for food borne illness. This deficient practice effected all residents who resided at the facility and was evidenced by the following: On 07/29/2025 at 8:48 AM, in the presence of the Food Service Director (FSD) the surveyor conducted an initial tour of the kitchen and additional food storage areas and observed the following: The white ceiling tiles throughout the entire kitchen had various spatter type debris and stained areas. The surveyor asked the FSD when the tiles were last cleaned and the FSD stated, I do not know when. The walk in refrigerator contained produce and other perishable food items that were stored on visibly soiled racks (3 plastic type and 1 metal rack) with blackened embedded debris and greenish mold-like patterned stain. The FSD confirmed the racks were not clean and that they needed to be cleaned. The surveyor asked about a cleaning schedule and the FSD stated there was no cleaning schedule for the kitchen. The interior of the walk in contained debris scattered food debris and crumbs underneath the food racks and also black debris affixed to the walls by the interior fans and on the light fixture. The food preparation area that had a sink had visible debris, various colored stains were affixed to the white pipes below the sink, on the wall and floor below the sink, and a creamer was on the floor. Spices were stored on top of the metal shelf over the sink, a red powder was also on the surface, and a large container of basil with a best by January 3, 2024 was stamped on the exterior of the container, when asked if it was expired, the FSD threw it out and stated, I'll get rid of that, when in doubt throw it out. The dry storage room contained a rack that held canned foods with visible debris on the rack, and under the rack there was various crumb and flood type debris, against the the wall on the floor throughout the entire store room. There were splatters on the walls, the FSD stated, looks like they are not going under the racks. The surveyor observed the temperature in the kitchen and storage area felt very warm, when asked the FSD regarding the temperature and if there was a thermometer in the store room. The FSD stated that the air conditioner in the kitchen has not been functioning for two months, and when asked what the food storage temperature should be, the FSD stated should be around 60 degrees Fahrenheit (F). The surveyor and the FSD used thermometers to check the air temperature of the storage room with the surveyor's thermometer reading 76 F and 77 F for the FSD. A box of thickener, was labeled on the outside of the box, Store in a cool dry place. A black cart inside of the dry storage room that had canned tomatoes on it was soiled with debris. A meatal rack that contained take out style containers was visibly soiled throughout with various debris. The cold cut and chilled salad refrigerator that had a top that opened and contained various food items including tuna salad and egg salad and sliced produce was soiled on top of all of the food lids with crumbs and splatters and soiled on the inside of the cover facing the food and crumbs and embedded debris was surrounding the containers of food. Hand washing sink had black embedded substance in the drain and observed a staff wash their hands in the sink and proceeded to pick up the lid of the large garbage can with their bare, freshly washed hands. When asked why she (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	used that garbage can, she stated there was no other can to use. The surveyor observed the lidded garbage can was the only garbage can in the area of the hand washing sink. Two bins, located on a lower metal shelf were labeled as bread crumbs and flour and an unprotected scoop with flour and other crumbs was on top of each container. The surveyor asked if the scoops should be stored in that manner and the FSD stated, they should be covered. Three meal carts were located next to the tray line area and staff was setting up meal trays with resident lunch tickets. All three meal carts had various crumb and other debris inside of the cart and on the exterior of the carts. The area that held the food for meal service, contained various food and crumb debris on the shelves, debris was on the floor, and surrounding the adjacent microwave which was on the top. Both metal tray line shelves were visibly soiled and stained underneath both shelves. A metal 3- tiered cart in the cooks area, was soiled with various debris. The blue can opener insert was removed by the FSD and revealed copious amounts of a thick in appearance black grease like substance. The can opener blade appeared visibly worn. The knife rack affixed to the wall had debris on top by the knives. There were two visibly chipped insulated tray lid covers on clean rack with the tray lids. The three day emergency supply of food was stored in a closet on a resident unit. The closet was not air conditioned and the temperature was 80 degrees F. On 07/30/2025 at 10:56 AM, the surveyor conducted a follow- up kitchen observation and the underside of the shelves that covered the food on the tray line remained embedded with debris and showed the FSD who acknowledged the debris. During the meal service another cook was slicing kielbasa on a board over the food preparation sink, the cook did not have all of his facial hair covered. The surveyor asked the FSD for policies related to sanitation and food storage and the facility provided one policy, Established: February 16, 2024, that revealed the following: Dry Food Policy, The kitchen will receive, inspect and put away dry foods in a timely fashion ensuring quality of products and packaging. NJAC 8:39-17.2(g)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, interview and document review it was determined that the facility failed to ensure a comprehensive Quality Assurance Performance Improvement (QAPI) program self-identified areas for improvement which included to ensure all staff were knowledgeable and a consistent abuse process was in place to ensure residents were protected from abuse, investigations were initiated and appropriate staff participated in the investigations per their Job Description. This deficient practice affected all residents who resided in the facility and was evidenced by the following: On 08/06/2025 8:42 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, about the facility QAPI program. The LNHA informed the surveyor that he was responsible for the QAPI process. The surveyor asked how the facility determined areas of focus for the QAPI program. The LNHA stated the facility identified areas to focus on based off reportable events, self-identified issues surveys that were conducted, audits and discrepancies that were found. The surveyor then asked the LNHA to list the current QAP plans, and the LNHA reviewed the QAPI book and stated the following were the current QAPI plans: 1. New regulation regarding consent. 2. Medications not removed from units/medication carts upon discharge. 3. Code status on medical record. 4. Review of state survey results. 5. Funeral Home Listing. 6. Deep cleaning of resident rooms. 7. Agency employees should have all trainings. 8. Minimum Data Set completion. 9. Medicaid pending residents' paperwork. 10. Activity director room visits. 11. Accurate weights. 12. Call bell response. 13. Medication administration related to a methadone overdose. 14. Tray accuracy. 15. Physician history and physical within 48 hours. 16. Daily count for the automated pharmacy dispensing system. 17. Timely medication administration. The surveyor asked the LNHA were there any QAPI's related to the facility immediately identifying allegations of abuse, investigating the allegations and reporting as required to the Department of Health related to the two following allegations of abuse identified during the survey: 1. On 7/29/25 at 9:01 AM, during the initial tour of the facility, Resident #110 informed the surveyor that the Certified Nurse Aide (CNA #1 CNA #2) rough handled them during care (7/28/25), they pressed on their incision line, they pushed them and would not stop even when they were screaming. Resident #110 stated that they reported the incident to their representative (RR #1) who informed the facility on 7/28/25. Resident #110 added, I had a shattered femur, and it hurts. 2. On 7/29/2025 at 9:01 AM, during the initial tour of the facility, the surveyor interviewed Resident #110 who was alert and oriented. Resident #110 stated CNA #1 and CNA #2 rough handled them during care, they pressed very hard on their incision line and hurt them, they pushed them around and would not stop the care when they screamed. Resident #110 stated that they reported the incident to their representative (RR #1) and their representative had made the facility aware of what happened on Monday 7/28/25. Resident #110 added, I had a shattered femur and it hurts. On 7/29/25 at 11:30 AM, UM #1 confirmed that Resident #110's representative informed her on 7/28/25, Monday morning, that the CNA's assigned to their care were not gentle. When asked to elaborate regarding what not gentle meant? The UM stated she was informed that the CNAs took three hours to answer the call light and they were not nice during care. UM #1 confirmed to the surveyor that Resident #110's family made her aware about Resident #110 needed gentle caring. The surveyor asked UM #1 if she interviewed the resident regarding the concerns and she stated, No, and confirmed she did not initiate an investigation. On 08/06/2025 9:01 AM, the LNHA stated there were no QAPI's related to abuse prior to the survey. The surveyor asked if the Social Worker's job description that indicated the Social Worker was supposed to be involved in the abuse investigation process, and was not part of the process was identified for a QAPI area. The LNHA stated, we are reviewing the job description- the policies are made at corporate. The surveyor asked if resident grievances were reviewed to determine any trends or areas for improvement? The LNHA stated the facility was not reviewing grievances as part of the QAPI process. The Quality Assurance Performance Improvement (QAPI) Program Plan, Reviewed 5/2023 revealed: Purpose: The QAPI plan outlines the five core elements of the QAPI program (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Decisions are made that promote excellence in quality of care, quality of life, resident choice, person directed care and resident transitions. Focus areas include all systems, processes and outcomes that affect resident and family satisfaction, the quality of care and services provided, and the quality of life for persons living and working in our organization, as well as visitors to our facility. Scope: .The organization partners with residents, their family, and/or advocates to achieve person-centered individualized goals and to provide care that respects autonomy, preferences, and choices. When the need is identified, corrective action plans or performance improvement projects are implemented to improve processes, systems outcomes, and satisfaction. Performance Improvement Project (PIP) identification: The QAPI team reviews data and input from quality improvement activities and looks for potential areas of improvement prior to charting a PIP team. The QAPI team monitors and analyzes data, and reviews feedback and input from residents, staff, families, volunteers, providers, and stakeholders to identify areas to improve the quality of life and quality of care and services for the residents living and staying in our facility. Factors considered include high-risk, high-volume, or problem-prone areas that affect health outcomes, quality of care and services, resident satisfaction, and areas that affect staff performance and satisfaction. The Quality Assurance and Performance Improvement QAPI Policy, Date Implemented: 9/1/24 revealed:3. b. The facility draws data from multiple sources, including input from all staff, residents, families, and others as appropriate .may include .iii. grievance logs. NJAC 8:39-33.2(c) 12		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) within 2 hours, an allegation of abuse for 2 of 4 residents reviewed for abuse, (Resident #110 and #109), and the deficient practice was evidenced by the following: A. On 7/29/25 at 9:01 AM, during the initial tour of the facility, Resident #110 informed the surveyor that Certified Nurse Aides (CNA #1) and (CNA #2) rough handled them during care, they pressed on their incision line, they pushed them and would not stop although they were screaming. Resident #110 stated that they reported the incident to RR #1 who had made the facility aware of what happened on Monday 7/28/25. Resident #110 informed the surveyor, I had a shattered femur, and it hurts. On 7/29/25 at 11:30 AM, the surveyor conducted an interview with the Licensed Practical Nurse Unit Manager (UM #1), on the unit where Resident #110 resided. The surveyor inquired if she had received any resident concerns regarding the care that staff provided. UM #1 confirmed that Resident #110's representative (RR #1) informed her on Monday, 7/28/25, in the morning, that the CNA's assigned to their care were not gentle to Resident #110. When asked to elaborate regarding what does not gentle entail, the UM stated she was informed that the CNAs took three hours to answer the call light, and they were not nice during care. The surveyor inquired to UM #1 if she had interviewed Resident #110 after she had spoken to RR #1. UM #1 stated, No. UM #1 was asked if she documented the interview with RR #1 and she confirmed that she had no documentation, it was verbal. On 7/30/25 the surveyor requested any investigation, including any grievance for the above incidents. The Licensed Nursing Home Administrator (LNHA) informed the survey team that he did not have any grievance nor reportable for Resident #110. The surveyor reviewed the 24 hours reports, 7/27/25, 7/28/25, 7/29/25, there were no entries regarding the concerns with care. A review of the medical record for Resident #110 revealed, the admission Record face sheet (an admission summary) revealed that Resident #110 was admitted to the facility with diagnoses which included but were not limited to, unspecified fracture of the right femur, muscle weakness, other abnormalities of gait and mobility and pain due to internal orthopedic prosthetic devices, implants and grafts. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 7/29/25, revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. Further review of the MDS, revealed the resident required extensive assistance with activities of daily living and mobility. On 7/30/25 the surveyor requested any investigation, including any grievance for the above incidents. The Licensed Nursing Home Administrator (LNHA) informed the survey team that he did not have any grievance nor reportable for Resident #110. On 8/1/25 at 10:05 AM, the LNHA provided a Reportable Event Record (RER) dated 7/30/25, reflected statements from the UM #1 that Resident #110's RR discussed with her on 7/28/25 the concerns with care. A handwritten statement from Resident #110 indicated the following: I was treated roughly by two aides in the middle of the night. They pushed me, they pressed on my incision line, When I said you are hurting me, they did not stop. They also made me wait to answer the call bell. B. On 7/29/25 at 9:10 AM, in the presence of the surveyor and UM #1, Resident #109 was visibly upset, crying, and reported to UM #1 that the CNAs were not nice. Resident #109 went on to state, CNA #1 refused to change me, she called me crazy and threatened to move me to the crazy girl room, where I could not be heard, CNA #1 closed the door, and I continued to scream. On 7/31/25 at 9:40 AM, the surveyor then asked UM #1 how she addressed the concerns voiced by Resident #109 on 7/29/25. The UM #1 replied, Resident #109 was confused I did not follow up. The surveyor then asked, the UM #1 if a confused resident could have some concerns with the care received and UM #1 did not respond. A statement from the resident who is awake, alert, oriented was not obtained until 8/4/25. The resident's statement obtained by the Social Worker dated 8/4/25 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included the following: Resident stated that [they] yelled at the Aide (Certified Nurse Aide) because aide closed the door. Aide then yelled back, If you don't stop, you'll go to crazy room. Resident stated she responded, I'm not crazy. Aide then moved resident from room [ROOM NUMBER] to 211A and closed the door. Resident stated she continued to scream for help. Resident #109 reported when the aide returned, several minutes later, the aide picked up [their] head and stared at [them]. Resident #109 asked What are you doing?, and the aide did not answer. Resident #109 stated [they] heard another aide say, cut [them] some slack, [they just lost [their] brother, and then heard the Aide say, good. She described the Aide as a female in her late 40's-50's with short red hair and was heavy set. Resident #109 stated the aides would be mean and ignore [them] when [he/she] was still in room [ROOM NUMBER]. A review of the admission Record face sheet (an admission summary) revealed the resident was admitted with diagnoses which included acute respiratory failure with hypoxia, cervical disc disorder with myelopathy, unspecified cervical region. muscle weakness, malignant neoplasm of upper lobe, pain due to internal orthopedic prosthetic devices, implants, and grafts. A review of the admission Minimum Data Set (MDS), an assessment tool dated 7/31/25, revealed Resident #109 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. On 7/31/25 at 9:40 AM, the surveyor interviewed UM #1 and inquired if Resident #109 had a history of being accusatory toward staff or ever reported any issues with care. UM #1 informed the surveyor that Resident #109 usually was very quiet but at times they would refuse care. The surveyor then asked UM #1 how she addressed the concerns that Resident #109 voiced on 7/29/25. The UM #1 replied, Resident #109 was confused I did not follow up. The surveyor then asked, the UM #1 if a confused resident could have some concerns with care, the UM did not reply. The incident was not documented nor reported to the DOH. During an interview on 7/31/25 at 10:38 AM, the Licensed Nursing Home Administrator (LNHA) stated that the above concern was not reported to the New Jersey Department of Health NJDOH. When inquired if these concerns failed under the abuse category, the LNHA stated, it could be verbal abuse. On 8/6/25 during the exit conference held with the facility, the facility reported the allegation of abuse for Resident #10 on 8/3/25 to the DOH (more than 5 days later). A review of the facility's Abuse, Neglect, and Exploitation policy provided to the survey team on 7/29/25 at 11:00 AM, dated 9/1/2024, included: to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . Abuse means the willful infliction of injury, unreasonable confinement, intimidation . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental abuse. It includes verbal abuse, sexual abuse, physical abuse . Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or other but has not been investigated and, if verified, could be an indication of noncompliance with the Federal requirements related to . neglect or abuse . Policy Explanation and Compliance Guidelines: The facility will develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect . Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation . Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. The facility will have written procedures that include Reporting of all alleged violating to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury required. The Administrator will follow up with the government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. NJAC 8:39-9.4(f)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to initiate an investigation for an allegation of abuse and prevent further potential abuse, after two cognitively intact residents made allegations of abuse. The deficient practice occurred for 2 of 4 residents reviewed for abuse (Resident #109 and Resident 110) and was evidenced by the following: The evidence was as follows: A. On 7/29/25 at 9:01 AM, during the initial tour of the facility, Resident #110 informed the surveyor that Certified Nurse Aides (CNA #1) and (CNA #2) rough handled them during care, they pressed on their incision line, they pushed them and would not stop although they were screaming. Resident #110 stated that they reported the incident to RR #1 who had made the facility aware of what happened on Monday 7/28/25. Resident #110 informed the surveyor, I had a shattered femur, and it hurts. On 7/29/25 at 11:30 AM, the surveyor conducted an interview with the Licensed Practical Nurse Unit Manager (UM #1), on the unit where Resident #110 resided. The surveyor inquired if she had received any resident concerns regarding the care that staff provided. UM #1 confirmed that Resident #110's representative (RR #1) informed her on Monday, 7/28/25, in the morning, that the CNA's assigned to their care were not gentle to Resident #110. When asked to elaborate regarding what does not gentle entail, the UM stated she was informed that the CNAs took three hours to answer the call light, and they were not nice during care. The surveyor inquired to UM #1 if she had interviewed Resident #110 after she had spoken to RR #1. UM #1 stated, No. UM #1 was asked if she documented the interview with RR #1 and she confirmed that she had no documentation, it was verbal. On 7/29/25 at 1:15 PM, the surveyor reviewed the electronic medical record for Resident #110, including the Progress Notes, and there was no documentation regarding the concerns that UM #1 confirmed were reported to her by RR #1, and no documentation regarding a follow-up assessment, or any interaction with Resident #110 after UM #1 spoke with RR #1, and it was reported the staff took three hours to provide care and were not nice to Resident #110. A review of the admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to, unspecified fracture of the right femur, muscle weakness, other abnormalities of gait and mobility and pain due to internal orthopedic prosthetic devices, implants and grafts. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 7/29/25, revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. Further review of the MDS, revealed the resident required extensive assistance with activities of daily living and mobility. A review of the individual comprehensive care plan (ICCP) included a Focus area for Activity of Daily Living (ADL), self-care performance deficit related to activity intolerance, limited mobility, limited range of motion, musculoskeletal impairment, dated 7/22/25. The goal included, will improve current level of function in through the review date, Initiated 7/22/25. Interventions included: Use extra caution when doing ADL, Initiated 7/31/25. The resident was totally dependent on two staff for repositioning and turning in bed, Initiated 7/23/25. On 7/30/25 at 9:30 AM, the surveyor, along with UM #1, reviewed the CNA #1 and CNA #2's assignment sheet for 7/26/25, 7/27/25, 7/28/25, for the 3:00 PM -11:00 PM, and 11:00 PM -7:00 AM shift. The assignment sheet confirmed that both CNA #1 and CNA #2 worked over the weekend and provided care to Resident #110. The surveyor then inquired to UM #1 what the current resident census was for the unit and she stated that 18 residents were on the unit, and for the 11:00 PM-7:00 AM shift, there was only one CNA assigned to care for 18 residents. On 7/30/25 at 10:15 AM, the surveyor conducted an interview with the (Social Worker) SW #1 and inquired if there were any grievances that were filed, or any current investigations in progress for the 2 East unit. The LSW stated that she will provide the grievance binder and was not aware of any recent concerns regarding the 2 East Unit. On 7/31/25 at 9:23 AM, the surveyor conducted a second interview with the UM #1 and she again confirmed RR #1 reported the concerns on 7/28/25, during the morning shift. UM #1 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then stated, she discussed the concerns with the 11:00 PM- 7:00 AM nursing supervisor, the Social Worker and the Licensed Nursing Home Administrator (LNHA) on 7/29/25. UM #1 stated, at that time, she was not instructed to collect statements or start an investigation. On 07/31/2025 at 10:38 AM, a surveyor, in the presence of the survey team, interviewed the LNHA regarding the abuse policy. The LNHA stated that he was the Compliance Officer and was responsible for all allegations of abuse. The LNHA stated that the Social Worker (SW) was the grievance officer. When asked to differentiate regarding their respective role, the LNHA stated that he was responsible to report all allegations of abuse and the SW was responsible to address grievances. The surveyor asked the LNHA to identify the procedures to identify all type of abuse and how staff were trained to identify abuse and whom to report abuse. The LNHA stated that the facility educated all staff on the abuse policy and the facility had written policies to identify all types of abuse, verbal, physical, sexual, and psychosocial abuse. The surveyor asked the LNHA to elaborate on the process that should occur after a resident reports an allegation of abuse, specifically rough handling during care. The LNHA stated that first, the incident would be reported according to the abuse policy. The facility would start an investigation, the facility would identify the staff and notify the Abuse Coordinator which is the LNHA. On 8/1/25 at 9:28 AM, the surveyor requested any accidents, incidents, grievances, or reportable events for Resident #110. On 8/1/25 at 12:30 PM, the LNHA informed the surveyor that he did not have any grievances or Reportable Events (a mandatory reporting document for an allegation of abuse) for Resident #110. On 8/1/25 at 12:45 PM, the surveyor interviewed the LNHA, in the presence of the survey team, and asked who was responsible to oversee all investigations and report all allegations of abuse. The LNHA stated that he was responsible to report all allegations of abuse. The surveyor asked if this allegation was investigated (5 days after the allegation of potential abuse was received by UM #1) and reported, the LNHA stated, No On 8/1/2025 at 12:55 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team regarding the concerns with care reported by Resident #110. The DON stated that if a resident reported any concerns with care, and she stated she would start a grievance, she would inform the Social Worker (SW) and then start an investigation. The DON informed the survey team that the LNHA oversaw the investigations. The DON informed the survey team that she was not aware that Resident #110 documented a statement. On 8/1/25 at 1:15 PM, the surveyor inquired again to the LNHA, in the presence of the survey team, if Resident #110's stated concerns would fall under the abuse category. The LNHA stated that it could be verbal abuse. The LNHA stated when the incident was reported it was not considered as an abuse case. The surveyor inquired to the LNHA what the process was, if there was an allegation of abuse. The LNHA stated that an incident report should have been completed, statements from all staff involved should have been collected and any staff involved should be removed from the assignment pending the investigation. The surveyor then asked the LNHA if the resident provided a statement regarding the incident. The LNHA stated, the resident was not asked to document a statement at that time, but he would have asked the resident to provide a statement. On 8/1/25 at 2:30 PM, the LNHA provided the following documents:-Incident report dated 7/30/25 timed 5:11 PM (two days after the allegation was reported to UM #1). The following was documented: Nursing Description: Resident informed the Assistant Administrator that two of the overnight aides [CNAs] were not gentle while providing care.-A statement dated 7/30/25 from UM #1 indicated the following: [RR #1] advised me on 7/28/25 that Resident #110 indicated that the surgical site is sensitive while being repositioned to provide incontinence care and requested that the staff be careful while providing care. I provided verbal reminders to staff present to be mindful to surgical site while providing care. -A statement from CNA #2 dated 7/31/25 indicated the following: On several nights I took care of Resident #110. There were no concerns brought to my attention while providing care. When changing the resident, the resident stated to be careful with my hip, resident turned with a little assistance, and I gently cleaned them I will be mindful to be extra gentle going forward. -A statement written by the Assistant Administrator dated 7/30/25 at 10:45 AM, revealed the following: I walked into the room to check on (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she receive any grievance regarding Resident #109. SW #2 further stated that Resident #109 was very credible, she will talk back and added, Resident #109 was awake, alert and oriented. On 8/1/25 at 10:30 AM, the surveyor reviewed Resident #109's medical record. A review of the admission Record face sheet (an admission summary) revealed the resident was admitted with diagnoses which included acute respiratory failure with hypoxia, cervical disc disorder with myelopathy, unspecified cervical region. muscle weakness, malignant neoplasm of upper lobe, pain due to internal orthopedic prosthetic devices, implants, and grafts. A review of the admission Minimum Data Set (MDS), an assessment tool dated 7/31/25, revealed Resident # 109 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the Individual Comprehensive Care Plan (ICCP) included a focus area dated initiated 7/17/25, for Activities of Daily Living (ADL) self-care performance policy related to Activity intolerance, Disease process, fatigue, limited mobility. The Goal included that Resident #109 will improve current level of functioning through the review date. Initiated 7/17/25. Interventions included, Report any change to the nurse. Provide a sponge bath when a full bath or shower cannot be tolerated. Initiated 7/17/25. The resident is totally dependent on one staff for repositioning and turning in bed. Initiated 7/17/25. On 08/4/2025 at 10:42 AM, the surveyor conducted an interview with SW #2, she revealed that she did not talk to the resident specifically about any care concerns as she was informed there were concerns being handled by the LNHA. The SW stated the concerns with Resident #109 were not reported to her. SW #1 stated that she did not have any knowledge of the issue regarding Resident #109. On 8/4/25 at 11:15 AM, following the surveyor's inquiry regarding any concerns or grievances received by Resident #109, SW #2 then visited Resident #109 and informed the survey team that she documented a grievance from Resident #109 on 08/4/25. SW #2 provided the survey team with the copy of the Facility Grievance Form which revealed: Resident Name (Resident #109) Date of Concern: 7/28/25. Person reporting the problem: LSW. Department involved: Nursing. Complete Description of the problem: The document revealed: Resident #109, Date of Concern: 7/28/25, Complete Description of the Problem: Resident stated that [they] yelled at the Aide (Certified Nurse Aide) because aide closed the door. Aide then yelled back, If you don't stop, you'll go to crazy room. Resident stated she responded, I'm not crazy. Aide then moved resident from room [ROOM NUMBER] to 211A and closed the door. Resident stated she continued to scream for help. Resident #109 reported when the aide returned, several minutes later, the aide picked up [their] head and stared at [them]. Resident #109 asked What are you doing?, and the Aide did not answer. Resident #109 stated [they] heard another Aide say, cut [them] some slack, [they just lost [their] brother, and then heard the Aide say, good. She described the Aide as a female in her late 40's-50's with short red hair and was heavy set. Resident #109 stated the aides would be mean and ignore [them] when [he/she] was still in room [ROOM NUMBER]. On 08/04/2025 at 2:30 PM, the surveyor interviewed SW #2 and informed SW #2 of the concerns Resident #109 shared with the surveyor, the SW #2 then met with the resident regarding the concerns and documented a grievance that was provided to the LNHA and DON. The document revealed: Resident #109, Date of Concern: 7/28/25, Complete Description of the Problem: Resident stated that [they] yelled at the Aide (Certified Nurse Aide) because aide closed the door. Aide then yelled back, If you don't stop, you'll go to crazy room. Resident stated she responded, I'm not crazy. Aide then moved resident from room [ROOM NUMBER] to 211A and closed the door. Resident stated she continued to scream for help. Resident #109 reported when the aide returned, several minutes later, the aide picked up [their] head and stared at [them]. Resident #109 asked What are you doing?, and the Aide did not answer. Resident #109 stated [they] heard another Aide say, cut [them] some slack, [they just lost [their] brother, and then heard the Aide say, good. She described the Aide as a female in her late 40's-50's with short red hair and was heavy set. Resident #109 stated the aides would be mean and ignore [them] when she was still in room [ROOM NUMBER]. On 08/05/2025 at 9:30 AM, the survey team interviewed SW #1 and SW #2. The surveyor asked SW #1 what her role was with resident abuse and the investigation process when an allegation of abuse was received. SW #1 (continued on next page)		

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Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation . 5. Alleged Violation: A situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigation . 6. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedures for reporting/response as described below: 7. Protection: The facility will protect residents from harm during an investigation. Procedure for Response and Reporting Allegations of abuse/Neglect/Exploitation: .When reports of abuse/neglect/exploitation occur, the following procedure will be initiated: 1. The Licensed Nurse will: a. Respond to the needs of the resident and protect him/her from further incident, b. Remove the accused employee from resident care areas, c. Notify the Administrator or designee, d. Notify the attending physician, resident's family/legal representative, and Medical Director, e. Monitor and document the resident's condition, including response to medical treatment or nursing interventions, f. Document actions taken in the medical record, g. Complete an incident report as indicated, h. Revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result an incident of abuse. 2. The Administered or designee will: a. Notify the appropriate agencies, immediately . b. Obtain statements from direct care staff, c. Suspend the accused employee pending completion of the investigation . f. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate if any corrective actions taken, if the allegations were verified. A review of the Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy, Date Implemented: 9/1/24. Identification: B. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes . verbal abuse, . physical abuse, and mental abuse . iv. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation . 5. Alleged Violation: A situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigation . 6. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedures for reporting/response as described below: 7. Protection: The facility will protect residents from harm during an investigation. Procedure for Response and Reporting Allegations of abuse/Neglect/Exploitation: .When reports of abuse/neglect/exploitation occur, the following procedure will be initiated:1. The Licensed Nurse will: a. Respond to the needs of the resident and protect him/her from further incident, b. Remove the accused employee from resident care areas, c. Notify the Administrator or designee, d. Notify the attending physician, resident's family/legal representative, and Medical Director, e. Monitor and document the resident's condition, including response to medical treatment or nursing interventions, f. Document actions taken in the medical record, g. Complete an incident report as indicated, h. Revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result an incident of abuse. 2. The Administered or designee will: a. Notify the appropriate agencies, immediately . b. Obtain statements from direct care staff, c. Suspend the accused employee pending completion of the investigation . f. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate if any corrective (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	actions taken, if the allegations were verified. A review of the UM #1's job description indicated the following: Reports any allegation of abuse, neglect, misappropriation of property, exploitation, or mistreatment of residents to supervisor, /Administrator/Abuse Coordinator. Protects residents from abuse and cooperates with all investigations. NJAC 8:39-4.1(a)(5)(12)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C#: NJ166356 (397035), NJ173415 (397032)Based on observations, interviews, a review of the medical record, and other pertinent facility documents on 7/29/2025 through 8/6/2025, it was determined that the facility failed to provide documented evidence of care provided to residents (Resident #95, #97, #101, and Resident #125). The facility also failed to follow the Certified Nursing Assistant's job description, and its policies titled, Activities of Daily Living (ADLs), and Documentation in Medical Record for 4 of 4 residents (Resident #95, # 97, #101, and Resident #125) reviewed for ADLs and was evidenced by the following: Complaint # NJ168103(397036), # NJ183496 (397046), #NJ166356 (397035), and #NJ 173415 (397032) 1. Surveyor #1 reviewed the closed medical records for Resident #101. A review of the admission Record, an admission summary, revealed Resident #101 had diagnoses which included, but were not limited to, anemia, muscle weakness, difficulty in walking, and need for assistance with personal care. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/26/25, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS revealed the resident needed supervision or touching assistance with shower/bathing and required partial/moderate assistance for a shower transfer. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 2/18/25, that Resident #101 had an ADL self-care performance deficit related to fatigue, shortness of breath, muscle weakness and dysphagia (difficulty swallowing). Further review of the ICCP did not have an intervention that reflected to provide showers to Resident #101 as per facility protocol or as per unit shower schedule. A review of the Shower Schedule for 2 [NAME] reflected Resident #101 was scheduled twice for a shower between 7 AM & 3 PM shift. A review of the Order Summary Report did not reflect a physician order for shower twice a week as per unit shower schedule. A review of the February 2025 Documentation Survey Report v2 (DSR; also known as Certified Nurse Aide (CNA) ADL sheet) reflected that Resident #101 received a shower/bath on the following dates: 2/2/25 00:28 AM2/3/25 00:27 AM2/4/25 00:30 AM2/6/25 01:47 AM2/7/25 00:44 AM 2/7/25 02:59 PM2/8/25 00:04 AM2/11/25 01:41 PM2/13/25 00:27 AM2/15/25 01:37 AM Surveyor #1 observed the February 2025 ADL sheet with 8 blank spaces (gaps) for day shift. The ADL sheet did not reflect if Resident #101 received additional showers after 2/15/25 until 2/28/25. On 8/6/25 at 8:55 AM, Surveyor #1 interviewed CNA #1 regarding residents shower schedule.CNA #1 stated that all residents were scheduled for showers twice a week. CNA #1 stated if my resident was scheduled for shower and the shower in the room was clogged or not in good standing, I would report it to my Unit Manager (UM) to put a request in for the maintenance and would use the central shower (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room until maintenance could fix the shower in the room. On 8/6/25 at 9:18 AM, Surveyor #1 interviewed CNA #2 who stated if my resident's shower was broken, I would inform the Unit Clerk (UC) to request maintenance to fix resident's shower. CNA #2 further stated she would take her resident to the shower in the hallway to provide them with a shower. CNA #2 further stated, if the resident refused then she would document that the resident refused and would inform the nurse. Surveyor #1 reviewed the February 2025 Resident #101's ADLs sheet documentation with CNA #2. CNA #2 stated, you cannot prove if the resident had showers by looking at the ADL sheet due to the blank space (gaps). CNA #2 further stated, we usually do not give showers at night shift unless the resident requested a shower at night. On 8/6/25 at 9:50 AM, Surveyor #1 interviewed the UM who stated if a resident's shower was broken, we would send a request to maintenance department electronically. UM further stated until the resident's shower was fixed, the resident would get shower in the community shower. On 8/6/25 at 10:28 AM, in the presence of the survey team, the UM stated, we do not provide showers at night shift (11 PM- 7 AM shift). Surveyor #1 reviewed the February 2025 ADL sheet for Resident #101 with the UM regarding gaps and inquired if Resident #101 received shower after 2/15/25 and the UM stated, if there is no documentation that means resident did not receive shower. The surveyor #1 reviewed the closed medical records for Resident #97. A review of the AR revealed Resident #97 had diagnoses which included but were not limited to: muscle weakness and difficulty in walking. A review of the comprehensive MDS dated [DATE], indicated the resident had a BIMS score of 15 out of 15, which indicated the Resident #97's cognition was intact. Further review of the MDS revealed that the resident was frequently incontinent of bowel and needed extensive assistance from staff after toilet use and for personal hygiene. A review of the resident's ICCP included a focus area, dated 12/19/23, that resident had an ADL self-care performance deficit related to. Further review of the ICCP reflected an intervention included but were not limited to that resident required extensive assist by two (2) staff for toileting. A review of Resident #97's DSR v2 (CNA ADL sheet) for September 2023, reflected blank spaces indicating the ADL tasks for toilet use and bowel documentations were not completed on the following dates: Toilet use assist for day shift on 9/5/2023, 9/10/2023, 9/11/2023, 9/12/2023, 9/13/2023, 9/15/2023, 9/16/2023, 9/17/2023, 9/18/2023, 9/22/2023, 9/23/2023, 9/24/2023, 9/25/2023, 9/26/2023, 9/27/2023, 9/29/2023, and 9/30/2023. Toilet use assist for night shift on 9/7/2023, 9/8/2023, 9/10/2023, 9/12/2023, 9/13/2023, 9/15/2023, 9/22/2023, 9/25/2023, 9/26/2023, 9/27/2023, and 9/30/2023. Bowel documentation for day shift on 9/5/2023, 9/10/2023, 9/11/2023, 9/12/2023, 9/13/2023, 9/15/2023, 9/16/2023, 9/17/2023, 9/18/2023, 9/22/2023, 9/23/2023, 9/24/2023, 9/25/2023, 9/26/2023, 9/27/2023, 9/29/2023, and 9/30/2023. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Wall LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Meridian Trail Wall, NJ 07719	
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bowel documentation for night shift on 9/7/2023, 9/8/2023, 9/10/2023, 9/12/2023, 9/13/2023, 9/15/2023, 9/22/2023, 9/25/2023, 9/26/2023, 9/27/2023, and 9/30/2023. Surveyor #1 observed the February 2025 ADL sheet with 8 blank spaces (gaps) for day shift. The ADL sheet did not reflect if Resident #101 received additional showers after 2/15/25 until 2/28/25. On 8/6/25 at 8:47 AM, Surveyor #1 interviewed CNA #1, who stated we would document all ADL care that we provided in Plan of Care (POCs) once at the end of our shift and next shift would documents separately at the end of their shift. CNA #1 further stated documentation was very important, so the nurses and the supervisor knew that we provided care to the resident. The CNA stated if we do not document POCs then they (nurses and the supervisors) would not know what we did for the resident. On 8/6/25 at 9:05 AM, Surveyor #1 interviewed CNA #2, who stated that she used the computer to document her POCs at the end of her shift. CNA #2 stated if you did not document POCs then the next shift CNA would not know what was done for the resident during the shift. CNA #2 further stated documentation was important because it kept everybody (nurses and supervisor) informed about what type of care was provided. In the presence of CNA #2, Surveyor #1 reviewed Resident #97's DSR v2 (ADL sheet) with spaces (gaps) and CNA #2 stated, somebody did not do it as there should not be any gaps. CNA #2 further stated normally if we did not fill out our POCs then the Unit Manager (UM) or Nurse Supervisor (NS) would call and ask us why it was not completed and remind us to complete it on the next day. day. On 8/6/25 at 9:33 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN #2), who stated the CNAs documented their resident's ADL care in POCs. LPN #1 stated if she observed a gap on the ADL sheet, that would be a problem, and she would report it to her supervisor. On 8/6/25 at 9:45 AM, Surveyor #1 interviewed the UM who stated POCs for ADL care should be documented every shift because we need to know if the resident had a bowel movement, how much did they eat, what other tasks were completed for the day. In the presence of UM, Surveyor #1 reviewed Resident #97's DSR v2 (ADL sheet) with spaces (gaps) and UM stated, looks like POCs were not done. The UM confirmed the gaps on ADL sheet and stated, it did not look good and further stated, if you did not document that means it was not done. On 8/6/25 at 12:21 PM, Surveyor #1 interviewed the Assistant Director of Nursing (ADON) who stated, documentation was very important because you are taking credit and showing the care that you provided to the resident. The ADON further stated, If you did not document, it was not done. On 8/6/25 at 3:12 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). Surveyor #1 discussed the above-mentioned concerns. No additional information was provided by the facility management, and the facility did not refute findings. A review of the facility provided policy, Resident Showers, dated 9/2024, included but was not limited to; Policy: It is the practice of this facility to assist residents with bathing to maintain proper hygiene . Under Policy Explanation and Compliance Guidelines: 1. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. A review of the facility provided policy, Activities of Daily Living (ADLs), dated 9/2024, included: Care and services will be provided for the following activities of daily living: 1. Bathing, dressing.3. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Toileting; Under Policy Explanation and Compliance Guidelines: 2. A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 2. Review of the Electronic Medical Record (EMR) was as follows: According to the admission Record (AR), Resident #95 had diagnoses which included but were not limited to difficulty.Walking, Unsteadiness on Feet, and Acquired Absence of Right Leg Below Knee. A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of Care, dated 4/16/2024, Resident #95 had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. The MDS also showed Resident #95 needed assistance with Activities of Daily Living (ADLs). A review of the Care Plan under Focus, Resident #95 was care planned for Activities of Daily Living (ADL) self-care performance deficit related to (r/t) muscle weakness, difficulty walking, unsteadiness on feet, right below the Knee Amputation (BKA). Resident #95's interventions included but were not limited to: needed limited assistance of one with bed mobility, extensive assist of one with dressing, limited assistance with personal hygiene, extensive assist of two for toilet use, and transfer. A review of Resident #95's Documentation Survey Report Version (v2), a form utilized for documentation of ADLs care by the Certified Nursing Assistants (CNAs) for April 2024, showed blank spaces indicating the tasks were not completed as follows: Bladder documentation on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/24, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/24, 4/28/2024, and 4/30/2024 on the night shift. Bowel Documentation on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. Chair/Bed-to-Chair on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. Eating set up supervision on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Complete Care at Wall LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Meridian Trail Wall, NJ 07719	
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lower body dressing on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. Lying to sitting on side of bed on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. Oral Hygiene set up on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. Personal Hygiene assist on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. Sit to Stand assist on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. Toilet Transfer assist on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. Toilet Hygiene on 4/11/2024, 4/12/2024, 4/13/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/27/2024, and 4/28/2024 on the day shift. On 4/21/2024 on the evening shift. On 4/10/2024, 4/11/2024, 4/12/2024, 4/14/2024, 4/16/2024, 4/17/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/25/2024, 4/27/2024, and 4/28/2024, and 4/30/2024 on the night shift. 3. According to the admission Record (AR), Resident #125 had diagnoses which included but were not limited to Unilateral Primary Osteoarthritis, Left Knee, and Presence of Left Artificial Knee Joint. A review of the MDS dated [DATE] Resident #125 had a BIMS score of 15/15, which indicated the resident was cognitively intact. The MDS also showed Resident #3 needed total assistance with ADLs. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Care Plan under Focus, Resident #125 was care planned for Activities of Daily Living (ADL) self-care performance deficit related to (r/t) Activity Intolerance, Impaired Balance, Limited Mobility, Limited Range of Motion (ROM), Musculoskeletal Impairment, and Pain to Left Knee. A review of Resident #125's Documentation Survey Report Version (v2) for July 2023 showed blank spaces indicating the tasks were not completed as follows: Personal Hygiene on 7/25/23, 7/26/23, 7/30/23, and 7/31/23 on the 7 AM - 7 PM shift. On 7/29/23 and 7/30/23 7 PM &ndash; 7 AM shift. Toilet Use on 7/25/23, 7/26/23, 7/30/23, and 7/31/23 on the 7 AM - 7 PM shift. Bladder Documentation on 7/25/23, 7/26/23, 7/30/23, and 7/31/23 on the 7 AM - 7 PM shift. Bowel Documentation on 7/25/23, 7/26/23, 7/30/23, and 7/31/23 on the 7 AM - 7 PM shift. Oral Care on 7/25/23, 7/26/23, 7/30/23, and 7/31/23 on the 7 AM - 7 PM shift. On 7/29/23 and 7/30/23 on the 7 PM &ndash; 7 AM shift. During an interview on 8/4/2025 at 12:50 PM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) confirmed the blanks (spaces) on Resident #95 and Resident #125's ADL flow sheets and could not confirm if the ADLs were completed. The ADON stated there should be no blanks on the ADL flow sheets because it was important information related to residents' plan of care to assist with identifying any issues that needed to be followed up on. The ADON further stated that the expectation was for the assigned CNA to complete the ADL flow sheet for that shift, and the nursing leadership were responsible for ensuring ADL flow sheet documentation were completed. During interview on 8/4/25 at 2:39 PM, the Director of Nursing (DON) confirmed the blanks on Resident # 95 and Resident #125's ADL flow sheets. The Surveyor #2 asked the DON what the blank spaces meant. The DON stated, If it was not documented, it does not necessarily mean the care was not provided. The DON stated that there should be no blanks (spaces) on the ADL flow sheets because it was pertinent resident records used clinically to decipher if resident moved their bowel, ate, had diarrhea, so they can intervene clinically. The DON further stated that the CNAs should have filled out the ADL flow sheets, and the unit managers and supervisors should have checked to ensure that the ADL flow sheets were completed. The Surveyor #2 further asked the DON if there were any proof anywhere that showed the tasks were completed, and she was unable to provide any proof. During an interview on 8/6/2025 at 8:58 AM, the Surveyor #2 asked the Licensed Practical Nurse (LPN #1) what the blanks (spaces) meant. LPN #1 stated, if it was not documented, it did not happen. LPN #1 stated that even if the resident ate, had bowel movement (BM), a code should have been used to acknowledge that the resident was checked. There should have been some documentation to show that they checked. I t was important to document because it was a standard of care. It was unacceptable that the ADL flow sheets had blanks (spaces). During an interview on 8/6/2025 at 1:40 PM, the Surveyor asked the CNA #3 what the blanks (spaces) meant. CNA #3 stated, the residents did not get the care. CNA #3 further stated that CNAs should have done the care and documented that it was done to let everyone know what was current with the resident and to update the nursing staff on any skin issues. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/25 at 1:51 PM, Surveyor #2 asked the LPN/UM (Unit Manager) what the blanks (spaces) meant. LPN/UM stated, If it was blank, it was not done. She further stated that the CNA should have documented or at least told the nurse to show that the task was finished. A review of the Residents' medical records showed no further evidence that the tasks mentioned above were completed. At the time of the survey, the facility could not provide evidence that the aforementioned tasks were completed. A review of the Certified Nurse Assistant's Job Description under Major Duties and Responsibilities, revealed the following included but were not limited to: . Perform duties as assigned. Assists residents with or performs activities of daily living for resident in accordance with care plans and established policies and procedures. Assists nursing staff in carrying out toileting program activities. Completes flow sheet daily to indicate that the specified task was done. Review of the facility's policy titled Activities of Daily Living (ADLs) with date implemented on 9/1/2024 revealed under Policy: Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care; 2. Transfer and ambulation; 3. Toileting. Review of the facility's policy titled Documentation in Medical Record dated 10/1/2024 revealed under Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Under Policy Explanation and Compliance Guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with the state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. N.J.A.C.: 8:39-27.1(a)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and document review it was determined that the facility failed to consistently implement identified nutritional interventions for a resident, including providing timely assistance with meals, for a resident who was identified as having severe fat and muscle wasting and had increased nutritional needs. This deficient practice occurred for 1 of 4 residents reviewed for nutrition and for the dining task (Resident #49), and was evidenced by the following: Refer to F 803, F 804 On 07/30/2025 10:51 AM, the surveyor conducted a meal observation during the lunch meal tray service preparation in the kitchen. The surveyor observed the [NAME] use a green handled scoop to scoop Super Mashed Potatoes. At that time, upon interview, the [NAME] confirmed he did not utilize recipes for the super mashed potatoes, or super cereal, or puree white lasagna. During interviews conducted with the Food Service Consultant (FSC) and Food Service Director (FSD) it was confirmed that there should be a recipe for each item and the facility was serving a smaller portion (3 1/4 ounce green scoop) instead of the 1/2 cup portion size required for the super mashed potatoes, which affected the nutritional adequacy of the food. During the observation, the surveyor and the FSD, in the presence of the FSC, tasted the puree lasagna which was observed as thick, pasty and was bland, and the super mashed potato tasted like thickener powder. The FSD tasted the items and confirmed the thickener taste. On 07/30/25 at 12:30 PM the surveyor observed Resident #49, who appeared very thin in appearance and was in their room in bed. The meal tray was next to Resident #49, while the resident was in bed. The meal tray had three scoops of white and one scoop of a green, shiny, gelatinous looking spinach scoop on plate. The meal ticket listed super mashed potato with gravy= 1/2 cup, mashed potato= 1 1/2 cup, puree baked fish- 3 oz, and puree spinach =1/ 2 cup. Magic cup was listed= 1, Apple Juice= 4 ounces, Lactose Free Milk= 8 ounces. There was no Magic Cup on the tray although it was listed and a 4-ounce chocolate ice cream, 8 oz Lactose Free Milk, and 4-ounce Apple Juice all unopened on the tray. There was one spoon inside of one of the scoops and the other items were not touched. The surveyor asked Resident #49 if the food was good and the resident shook their head no. A review of Resident #49's electronic medical record revealed: The admission Record (an admission summary) revealed Resident #49 had diagnoses that included, but were not limited to; Dysphagia, oropharyngeal phase, need for assistance with personal care, Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side (paralysis from stroke). The Diet orders revealed: Puree texture, Think liquids consistency, feed assist. A Progress Note Signed by the Dietitian on 7/21/25 at 11:58 AM, Nursing has requested magic cup for patient bid (twice daily) will provide at lunch and dinner daily. Supplement provided 290 calories and 9 grams of protein per serving. A review of Resident #49's weights revealed 7/14/25- 87 pounds; 7/15/25-78.2 pounds, and on 7/29/25- 74.9 pounds which reflected a 12-pound 13% weight loss in less than one month. A review of the Care Plan for Resident #49 revealed a Focus, Initiated 7/15/25, for Nutrition which included: Cue to Severe Malnutrition based on low body mass index and severe fat and muscle wasting. Resident has increased nutrient needs secondary to impaired skin integrity (wounds) and was on a diuretic which can impact weights and was also at risk for dehydration. The following Goals Initiated 7/15/25 included: Resident will gain 1-2 pounds per week tared a Body Mass Index of >22, Wound Healing, Resident Meal intake will be > 50%. Interventions included: Feed at mealtimes., Offer Menu alternates/selective menus/always available menu, provide supplements as ordered .Magic Cup at lunch and dinner daily. On 07/30/2025 at 1:33 PM, the surveyor interviewed the Dietitian, who stated that she was in a clinical role and would help residents with meal selections, meet with family and attend care conferences, however, she stated she did not have interaction and oversight for the menu, or the kitchen as there was another Dietitian responsible for that and the menu was from a company. The surveyor asked about the supplements and the Dietitian stated she would order super mashed potatoes, and she ordered it mostly for calories. When asked was the kitchen supposed to use a recipe, she stated yes, so the resident received the proper calories and protein. When asked if they should (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receive the proper portion size, she stated, yes, because if you give less, they don't get the calories. The Dietitian stated that would be a problem if the portion size for super mashed potatoes was not correct, and she stated that she used the super mashed potatoes to specifically increase the calories provided. On 08/04/25 at 12:33 PM, the surveyor went to visit Resident #49 at the lunch meal and the door was closed and asked the Assistant Director of Nursing (ADON) to accompany the surveyor into the room. The ADON opened the door, an unsampled resident was in the other bed watching television and the lunch tray was opened and eaten next to them. Resident # 49 was in bed with the meal tray next the bed on the tray table and was untouched. The ADON lifted the lid and asked the resident if they would like the ice cream and the resident stated, yes. The surveyor observed again, there was no magic cup on the tray, vanilla ice cream was provided on the tray and none of the beverages or food was eaten The ADON then exited the room. The surveyor then asked the unsampled resident when the meal came and the resident stated about an hour prior. The surveyor exited the room and approached the ADON from behind when she was speaking with a Certified Nurse Aide (CNA #6) who was inside another resident room providing care. The ADON stated to CNA #6, why was Resident #49 not fed her lunch meal, and CNA #6 stated she had other work to do and the ADON instructed CNA #6 to feed Resident #45. The surveyor observed CNA #6 enter Resident #49's room, lifted the bed and stood over the resident and proceeded to feed the resident ice cream. The surveyor then reviewed a Nutrition Note, authored by the Dietitian and dated 8/4/25 at 12:06 PM, which revealed: . fed by staff, needs increased encouragement . providing Magic Cup twice per day and super mashed potatoes twice per day .Current weight 72.3 pounds . severe malnutrition .On 08/04/25 at 12:42 PM, the surveyor interviewed the ADON about the observations related to Resident #49 and asked what were the expectations for staff to assist a resident who was unable to feed themselves. The ADON stated, in a timely manner, The surveyor asked if a CNA needed help to finish their work, what should have been done. The ADON stated CNA #6 should have told someone they needed help with feeding a resident. On 08/06/25 at 9:25 AM, the surveyor conducted a follow-up interview with the Dietitian and informed her of the surveyor's observations regarding Resident #49. The surveyor asked what the expectations were for the facility staff to assist the residents with their meals? The Dietitian stated the staff should know which residents need help with meals and stated, Resident #49 required total assistance with all meals and the resident should have ice cream and magic cup because the family shared that that resident loves ice cream. The surveyor asked the dietitian if resident #49 needed the nutritional supplements and she stated Resident #49 had a low Body Mass Index and the resident had severe malnutrition, with severe muscle wasting and needs the supplements. On 8/6/25 at 10:06 AM, the surveyor interviewed the Food Service Director regarding when the meals were brought to the floor that Resident #49 resided on, and confirmed that it was at 12:00PM. The surveyor's observations confirmed the meal sat for over 1/2 hour prior to being offered to the resident. NJAC 8:36-17.4(a)(1)(d)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #s NJ 168330, NJ 168408, NJ 179527Based on observation, interview, and record review, it was determined that the facility failed to ensure all residents received their pain medication in a timely manner and in accordance with a physician order. This deficient practice was identified for 3 of 3 closed resident records reviewed for pain (Resident #94, Resident #96 and Resident #103) and was evidenced by the following: The surveyor reviewed the closed medical record for Resident #94,#96 and Resident # 103.A review of the admission Record face sheet (an admission summary) reflected that Resident #94 was admitted to the facility on [DATE] and had diagnoses which included but were not limited to, pain due to internal orthopedic prosthetic devices, implants and grafts, subsequent encounter, difficulty in walking, aftercare following joint replacement surgery.A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 10/13/23, reflected that the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating an intact cognition. The assessment for pain indicated that the resident was on pain management medication and the resident had frequent pain.A review of the resident's individualized, comprehensive care plan reflected a focus area for acute pain related to right total hip arthroplasty. Initiated 10/11/23. The goal indicated that the resident will not have discomfort related to side effects of analgesia through the review date. Initiated 10/11/23. Resident will verbalize adequate relief or ability to cope with incompletely relieved pain through the review date. Initiated 10/11/23. Interventions included:Anticipate the resident's need for pain and respond immediately to any complaint of pain. Initiated 10/11/23.Identify and record previous pain history and management of that pain and impact on function.Monitor, record, report to nurse any signs and symptoms of non-verbal pain. resident complaints of pain or requests for pain treatment A review of the Physician's Orders sheet (POS) for October 2023 reflected a physician's order (PO) dated 10/04/23 timed 1:51PM, for Tylenol 650 milligrams (ml) an (analgesic) to be administered every 6 hours as needed for breakthrough pain. A review of the Medication administration record (MAR) revealed that the resident did not receive Tylenol on 10/4/23.Resident #94 had an order for Oxycodone (an opioid pain medication used to treat moderate to severe pain) ordered 10/04/23 at 1: 23 PM. The nurse confirmed and transcribed the order at 1:51 PM on 10/04/23. The resident did not receive the medication until 8:32 PM. Almost 7 hours later when the (7:00 PM- 7:00 AM) reported to work. On 7/31/25 12:45 PM, the surveyor discussed the concerns with the Director of Nursing (DON). The DON reviewed the POS and the MAR with the surveyor, she confirmed that the medication was not administered in a timely manner. The Nurse no longer employed by the facility and could not be interviewed. The DON stated she could not comment on the issue as she was not working for the facility at that time. B. Resident #96 was admitted to the facility on [DATE] with diagnoses which included but were not limited to, encounter for surgical aftercare following surgery on the digestive system, rheumatoid arthritis and difficulty in walking.A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 10/20/24, reflected that the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicative of intact cognition. The Care Area Assessment was triggered for pain.A review of the Physician's Orders sheet (POS) for October 2024 reflected a physician's order (PO) dated 10/14/24 timed 6:52 PM, for Tylenol 650 milligrams (mg) an (analgesic) to be administered every 6 hours as needed for mild pain (1-3) Do not exceed 3,000 mg in 24 hours.Another order dated 10/14/24 timed 7:21 PM, was to administer Oxycodone 5 mg every four hours as needed for moderate pain (4-6). A review of the MAR showed that pain medication was not administered. There was no documentation in the medical record that Resident #96 was assessed for pain.Resident #96 also had an order for Oxycodone 10 mg every four hours for severe pain (7-10) dated 10/14/25 timed 7:22 PM. A review of the MAR failed to indicate that pain assessment was conducted, and the physician order was carried (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out. A review of the Medication administration record (MAR) for October revealed that Resident #96 received the first dose of Oxycodone 5 mg on 10/16/24 at 7:38 PM.C. Resident #103 was admitted to the facility on [DATE], with diagnoses which included but were not limited to, encounter for orthopedic aftercare, muscle weakness, difficulty in walking and spinal stenosis. Resident #103 was admitted for rehabilitation after surgery.The Complainant reported the following: Nurse [name redacted] would not give resident Percocet at 9:00 AM. Not sure of date. Caller reported meds [Percocet] was routine at 9:00 AM, but the nurse reported it was only as needed. Resident did not receive Percocet until 10:30 AM. No negative outcome. A review of the resident's admission assessment dated [DATE], reflected that the resident received a BIMS score of 13, indicative of intact cognition. Normal score 15.A Review of the POS dated 9/24/23 at 3:15 PM, revealed an order for Oxycodone-Acetaminophen oral tablet 10-325 milligram, give 1 tablet by mouth every four hours as needed for pain.A review of the September's MAR reflected that Resident #103 received the first dose of Oxycodone with acetaminophen at 10:08 PM. 7 hours later. The next dose of oxycodone was administered 12 hours later at 10:14 AM.Another physician order dated 9/25/23 at 1:56 PM, revealed an order for Percocet 10-325 mg, give 1 tablet orally one time a day for back pain for 7 days. The medication was scheduled to be administered daily at 9:00 AM. Percocet was signed as being administered on 9/26/23 at 9:00 AM. There was no documentation that the physician was called and informed that the resident requested the daily dose of Percocet on 9/25/23 after it was ordered at 1:56 PM. The facility failed to document that the physician was called and asked if Percocet could be administered at 1:56 PM on 9/25/23 after it was ordered and scheduled the Percocet for 9:00 AM the next day. The resident did not receive the Percocet until 9/26/23 at 9:00 AM. On 7/31/25 at 2:15 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) on the unit regarding the process to administer pain medication. The LPN informed the surveyor that pain medication should be administered as ordered by the physician. If the resident did not get relief within 30 minutes, the nurse would contact the physician or reported to the nursing supervisor for guidance.On 8/4/25 at 1:25 PM, the surveyor shared again the above concerns with the Director of Nursing. The DON revealed that the nurses required and received in-service education on pain management. A review of the facility's Pain Management policy dated 9/1/24 and last revised 3/6/25, indicated the following:The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.Policy Explanation and Compliance Guidelines.The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain.Pain AssessmentThe facility will use a pain management tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain.Pain Management and TreatmentBased upon the evaluation, the facility in collaboration with the attending physician/prescriber, and other health care professionals and the resident and /or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission.NJAC 8:39-27.1(a)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to; a.) clarify physician's order to monitor bruit (a whooshing or swishing sound that can be heard over an artery) and thrill (a vibrating or buzzing sensation that can be felt over an artery, often caused by a turbulent blood flow as well) to right arm at Permacath (is a durable and flexible catheter / medical device that is inserted into a large vein in the body for long term dialysis) site; b.) facility staff were trained and received competencies in Hemodialysis (HD; a treatment that removes wastes and extra fluid from your blood when your own kidneys have failed). This deficient practice was identified for 1 of 1 resident reviewed for dialysis (Resident #13), and was evidenced by the following: On 7/29/25 at 8:47 AM, during an initial tour, the surveyor observed Resident #13 sitting in their wheelchair. Resident #13 informed the surveyor that they were scheduled for HD later that day. Resident #13 further stated that there scheduled HD days are Tuesdays, Thursdays and Saturdays. The surveyor reviewed the Electronic Medical records for Resident #13. A review of the admission Record, an admission summary, revealed that Resident #13 was admitted with diagnoses which included but were not limited to; End Stage Renal Disease (ESRD; condition when the kidneys permanently fail to work), hypertension (high blood pressure) and muscle weakness. A review of the admission Minimum Data Set (MDS) a tool used to facilitate care, dated 6/20/25, included a Brief Interview for Mental Status (BIMS) of 15 out of 15 which indicated Resident #13 was cognitively intact. The MDS further documented that Resident #13 had been admitted with being on hemodialysis. A review of the Individual Comprehensive Care Plan (ICCP) included a focus area dated 6/13/25, that resident needs dialysis (HD) Tuesday, Thursday, and Saturday chair time 3:30 PM, pick up time 2:40 PM. Goals included that resident would not have signs and symptoms of complications from dialysis through the review date. Interventions included encourage resident to go for the scheduled dialysis appointments. Further review of the care plan reflected a focus area dated 6/16/25 that resident had End stage renal disease with interventions which included but were not limited to monitor for signs and symptoms of infection. A review of the Order Summary Report (OSR) reflected that Resident #13 had an active physician order (PO): Monitor bruit and thrill to right arm permacath every shift dated 6/13/25. The corresponding physician order was transcribed into the June 2025 through July 2025 electronic Treatment Administration Record (eTAR). Further review of the June - July 2025 eTARs for Resident #13 revealed that nurses signed and reflected a checkmark which means that they checked Resident #13's permacath site for bruit and thrill three times a shift from 6/13/25 until the surveyor's inquiry. The surveyor observed 52 entries in June and 89 entries in July 2025 eTARs. On 7/31/25 at 9:40 AM, the surveyor interviewed the Registered Nurse (RN), who stated the nurses would fill out dialysis report sheet (communication between the facility and the dialysis center) with all the information about what medications residents had taken prior to leaving the facility for HD, resident's date of birth, allergies if resident had any and physician orders. The RN further stated that Resident #13 had right chest wall (RCW) permacath and she would assess for bruit and thrill, signs and symptoms of infection and pain at the site. The RN stated she would document all these findings in her nursing notes. The RN accompanied the surveyor to Resident #13's room to demonstrate how she would assess for Bruit and thrill. The RN performed hand hygiene and donned gloves and then she placed her stethoscope at the resident's RCW permacath site to listen for bruit and afterwards placed her fingertips to palpate (to examine by touch) for thrill as she explained. On 7/31/25 at 9:58 AM, the surveyor interviewed the Unit Manager (UM), who stated the nurses would fill out HD communication book prior to resident leave the facility for their HD session. The UM stated the nurses would check resident's HD site dressing for any bleeding or signs and symptoms of infection, auscultate (listening to an internal sound of the body) for bruit and thrill for HD resident. The UM further stated if the resident had AV fistula (a connection that a surgeon makes between an artery and a vein to make it possible to receive hemodialysis) then we could auscultate it for bruit. The UM (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	further stated/confirmed Resident #13 had RCW permacath for HD, bruit and thrill could not be assessed or monitored. On 8/6/25 at 12:05 PM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated she was responsible for providing education to nursing staff. The ADON stated/confirmed if the resident had an AV fistula or graft, then we would check for bruit and thrill and if the resident had permacath then we monitor for signs and symptoms of infection at the site. The ADON further stated if there was an order to monitor for bruit and thrill at permacath site then she would clarify the order with the physician. The ADON acknowledged that the nurses who were assigned to Resident #13 should have clarified the order and not carried out because bruit and thrill could not be assessed at permacath site. The surveyor requested for HD competencies for RN #1 and the ADON stated, we do not have competencies for HD. On 8/6/25 at 1:43 PM, the surveyor interviewed the Director of Nursing (DON), who stated we assess AV fistula for bruit and thrill and there was no bruit and thrill on permacath. The DON stated the nurses should have contacted the physician to correct or discontinue that order. On 8/6/25 at 3:12 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON. The surveyor presented above mentioned concerns with the administration. In the presence of the survey team, the DON confirmed that they did not have HD competencies for the nurses. A review of the facility policy titled Hemodialysis dated 12/24 included under Policy: This facility will provide the necessary care and treatment, consistent with professional standards of practice. and psychosocial needs of residents receiving hemodialysis. NJAC 8:39 - 27.1(a)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review it was determined that the facility failed to ensure the social workers were incorporated into the abuse process and provided medically related social services to residents who alleged physical and verbal abuse by staff to ensure residents maintained their highest physical, mental and psychosocial well-being. This deficient practice was identified for 2 of 2 residents reviewed for abuse (Resident #109 and Resident #110) and was evidenced by the following: On 7/29/2025 at 9:01 AM, during the initial tour of the facility (on the same resident unit that Resident #109 resided-2 East), the surveyor interviewed Resident #110 who was alert and oriented. Resident #110 stated CNA #1 and CNA #2 rough handled them during care, they pressed very hard on their incision line and hurt them, they pushed them around and would not stop the care when they screamed. Resident #110 stated that they reported the incident to their representative (RR #1) and their representative had made the facility aware of what happened on Monday 7/28/25. Resident #110 added, I had a shattered femur and it hurts. On 7/29/25 at 11:30 AM, UM #1 confirmed that Resident #110's representative informed her on 7/28/25, Monday morning, that the CNA's assigned to their care were not gentle. When asked to elaborate regarding what not gentle meant? The UM stated she was informed that the CNAs took three hours to answer the call light and they were not nice during care. UM #1 confirmed to the surveyor that Resident #110's family made her aware about Resident #110 needed gentle caring. The surveyor asked UM #1 if she interviewed the resident regarding the concerns and she stated, No, and confirmed she did not initiate an investigation. On 7/29/25, at 9:10 AM during the initial tour of the facility, the surveyor interviewed Resident #109 who was alert and oriented and who was visibly upset and was crying. The surveyor immediately escorted Unit Manager #1 (UM #1) to Resident #109's room, and the resident stated a Certified Nurse Aide (CNA #1) called them crazy last night. Resident #109 exclaimed, I'm not crazy! UM #1 did not report the allegation of verbal abuse to the Administrator and did not initiate an investigation. CNA #1 continued to care for residents on 7/28/25 and on 7/29/25. On 7/30/25 at 10:15 AM, the surveyor conducted an interview with the Social Worker (SW #1) and inquired if there was a grievance binder/ or any current investigations in progress for the 2 East unit. The SW stated that she would provide the grievance binder and was not aware of any recent concerns regarding the 2 East Unit. The surveyor reviewed the grievance binder and there was no grievance regarding the concerns with care raised by Resident #110's representative, or for Resident #109. On 07/31/2025 at 10:37 AM, the surveyor interviewed the LNHA in the presence of the survey team and asked who was responsible to ensure the abuse process was followed when an allegation of abuse was received. The LNHA stated he was the Compliance Officer and he was responsible for the abuse process, and stated when abuse was reported it was to be reported to him. The LNHA stated that the Social Worker (SW) was responsible for the grievance process and not the abuse process. The surveyor requested the grievance policy at that time. On 07/31/2025 at 10:45 AM, the LNHA provided the grievance policy to the survey team. The LNHA stated, if a grievance related to an abuse allegation was brought to the SW it would be transferred to the Abuse Coordinator which is the LNHA. The LNHA clarified, when it comes to reporting abuse, it goes to the LNHA. On 07/31/25 at 11:08 AM, the survey team further interviewed the LNHA regarding what the facility is supposed to do when allegation of abuse was made. The LNHA stated that when an allegation of abuse was made, the staff should be notifying the Abuse Coordinator and all staff have his phone number to always call him as needed. The LNHA stated if something was reported to him, that he would conduct the investigation. When asked if taking any statements was part of the investigative process the LNHA stated, I might ask for statements if that is what is needed. A surveyor asked the LNHA regarding the incident that Resident #110 reported to UM #1 and UM#1 had confirmed she had been made aware that RR #1 informed her on 7/28/25 of the (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns regarding the staff. The LNHA stated that what was reported to the LNHA was not an allegation of bad care because RR #1 told UM #1 that Resident #110 needed extra gentle care. When asked what that meant, the LNHA stated, I am aware that is not what the resident was saying and declined to comment further. A review of the Resident and Family Grievances Policy at that time, Date Implemented 9/1/24 revealed: Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Policy Explanation and Compliance Guidelines: 1. The Social Worker has been designated as the Grievance Official . Procedure: i. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. i. Take any immediate actions needed to prevent further violations of any resident right. ii. Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation or resident property immediately to the administrator and follow procedures for those allegations. On 08/01/2025 at 12:55 PM, the surveyor interviewed the DON, in the presence of the survey team, regarding Resident #110's allegations. The DON stated that if a resident reported any concerns with care, she would start a grievance, then inform the SW who would start an investigation and the incident would be reported to the Department of Health. On 08/04/2025 at 1:40 PM, the facility provided the employment file for the Director of Social Services (SW #1) which revealed a Social Services Director Job Description signed by the facility and SW #1 on 10/1/24. The Major Duties and Responsibilities included: The Social Services Director is responsible for overseeing the development, implementation, supervision and ongoing evaluation of the social Services Department designed to meet and assist residents in attaining and maintaining their highest practicable well-being. This includes identifying the need for medically related social services and ensuring that these services are provided in accordance with State and Federal regulations; . The Director will also advocate for residents and assist them in assertion of their rights within the facility. When there is an allegation of suspected abuse, neglect or exploitation, the Social Services Director will report to the Administrator and appropriate state agency, as well as lead a thorough investigation into the allegation. Additional Assigned Tasks: Reports any allegations of abuse, neglect, misappropriation of property, exploitation, or mistreatment of residents to supervisor/Administrator/Abuse Coordinator. Protects residents from abuse and cooperates with all investigations. On 08/04/2025 at 2:30 PM, the surveyor interviewed SW #2 regarding any investigation regarding the allegations of rough handling by Resident #110. SW #1 stated that she was not made aware of the issues as the concerns for Resident #110 as that was being followed by the LNHA. SW #2 then stated after the surveyor asked about Resident #109 and informed the SW #2 of the concerns Resident #109 shared, that on 8/4/25 SW #2 met with the resident regarding the concerns and documented a grievance that was provided to the LNHA and DON. The document revealed: Resident #110, Date of Concern: 7/28/25, Complete Description of the Problem: Resident stated that [they] yelled at the Aide (Certified Nurse Aide) because aide closed the door. Aide then yelled back, If you don't stop, you'll go to crazy room. Resident stated she responded, I'm not crazy. Aide then moved resident from room [ROOM NUMBER] to 211A and closed the door. Resident stated she continued to scream for help. Resident #109 reported when the aide returned, several minutes later, the aide picked up [their] head and stared at [them]. Resident #109 asked What are you doing?, and the Aide did not answer. Resident #109 stated [they] heard another Aide say, cut [them] some slack, [they just lost [their] brother, and then heard the Aide say, good. She described the Aide as a female in her late 40's-50's with short red hair and was heavy set. Resident #109 stated the aides would be mean and ignore [them] when she was still in room [ROOM NUMBER]. On 08/05/2025 at 9:30 AM, the survey team interviewed SW #1 and SW #2. The surveyor asked SW #1 what her role was with resident abuse and the investigation process when an allegation of abuse was received. The surveyor reviewed the job description for SW #1 and SW #1 stated that upon hire, she was informed by the LNHA that he was responsible for all of the abuse investigations, any grievances and any abuse (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allegations. The surveyor then asked what the documented Grievance for Resident #109 indicated an allegation of? SW #2 stated I would say psychosocial abuse as the staff terrorized resident #109 when they were holding the resident's face and staring into their eyes. Both SW #1 and #2 confirmed they were not made aware of Resident #110's allegations of abuse. On 08/05/2025 at 10:52 AM, the survey team interviewed both social workers regarding the Quality Assurance (QAPI) process and if abuse allegations were part of the QAPI process? SW #1 stated it was not discussed and she will complete a Grievance if it comes to her and she stated statements would be documented and collected. On 08/05/2025 at 11:11 AM, the surveyor, in the presence of the survey team interviewed the LNHA and read the Grievance provided by SW #2 on 8/4/25, that documented by SW #2 and dated 8/4/25 regarding the allegation from Resident #109 to the LNHA. The surveyor asked if that was an allegation of abuse, and the LNHA stated yes. On 08/05/2025 at 2:22 PM, the survey team conducted a follow-up interview with SW #2 regarding Resident #109's allegations that SW #2 documented on the Grievance form dated 8/4/25. SW #2 stated that she only asked Resident #109 about what happened because of the surveyor asked SW #2 about the allegation that was made. The SW #2 stated she provided the Grievance to the LNHA, and she had been informed the LNHA was handling the investigation and did not ask SW #2 to discuss the allegation or any concerns with Resident #109 and she made daily rounds and visited Resident #109 on 7/31/25 and 8/1/25 which she confirmed were not related to the abuse allegations as she only became aware of how Resident #109 felt after the surveyor inquiry as she was told the Abuse Officer was handling everything related to the investigation. On 08/05/2025 11:01 AM, in the presence of the survey team, the surveyor interviewed the LNHA regarding SW #1 Job Description and showed him the Job Description and the surveyor asked the LNHA the Social Workers role in the abuse process and he stated, I don't know. The surveyor then read Resident #109's Grievance to the LNHA, and picked up [their] head, stared . and asked if that allegation was abuse, and the LNHA stated, yes. The surveyor then read the part of the Social Workers Job Description related to the Social Worker leads a thorough investigation into an allegation of abuse and asked is there a reason the Social Workers were not involved in the abuse investigations for Resident #109 and Resident #110? The LNHA stated, I don't have an answer for this and the surveyor asked the LNHA if he was aware that the abuse investigations were part of the Social Workers Job Description, and he stated, No. On 8/6/25 at 3:54 PM, the survey team met with the LNHA and DON for the exit conference and no additional information was provided. NJAC 8:39-39.4(i); 4.1(5); 27.1(a)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and document review it was determined that the facility failed to ensure recipes were followed for therapeutic food supplements, and proper portions were provided to residents who required the items to improve nutritional intake and were served modified diets. The deficient practice was evidenced for 2 of 2 resident (Resident #7 and Resident #49) meal trays observed, for 1 of 1 resident reviewed for nutrition (Resident # 49) and was evidenced by the following: Refer to F804 On 07/30/2025 at 10:35 AM, a surveyor conducted a Resident Council meeting with 5 residents and all 5 residents stated they felt the portions of the meals were too small. 07/30/2025 10:51 AM, the surveyor conducted a meal observation during the lunch meal tray service preparation in the kitchen. The posted menu was Cheddar Baked Tilapia or Cheese Lasagna with [NAME] Sauce, Seasoned Spinach, Potato Wedges, and Butterscotch Pudding. The surveyor observed the Food Service Director (FSD) and the Food Service Consultant (FSC) in the kitchen. The surveyor observed the [NAME] scoop up Super Mashed Potatoes, Mashed Potatoes and Puree Spinach with a green handled scoop. The surveyor observed a meal ticket for Resident #7 while the meal was being plated. The meal ticket revealed a No Added Salt Ground diet with the following items: Puree Cheese Lasagna with [NAME] Sauce, 1- SVG [Serving]; Mashed Potatoes, 1/2 Cup; and Seasoned Spinach, 1/2 Cup. The surveyor watched the cook use the green handled scoop for the puree Cheese Lasagna with [NAME] Sauce, Mashed Potatoes and Spinach. The surveyor asked the [NAME] if he used a recipe for the lasagna and he stated it was a homemade recipe. The surveyor asked how the [NAME] would know what 1 serving of the puree lasagna would be and he showed the surveyor the green scoop and stated, generally, this is what I give. The surveyor asked the [NAME] what the portion size of the green scoop and he stated, 3 1/4- ounces. The surveyor asked what scoop size was used for the super mashed potatoes and for the mashed potatoes and the [NAME] confirmed it was the same 3-1/4-ounce scoop. The surveyor asked the cook if he had recipes for the puree white lasagna and the super mashed potato. The [NAME] stated, he added milk and butter to instant mashed potato and that there was no recipe for the super mashed potato and that was what the Dietitian told him to do. The surveyor then asked about the super cereal (a nutritional supplement that is made in house with oatmeal) and he stated there was no recipe for the super cereal also and he would add brown sugar and milk to the oatmeal. The surveyor then asked if they had a recipe for the puree lasagna and white sauce and the [NAME] stated, there was no recipe and he put the lasagna in the blender and added thickener to it. The surveyor asked the FSD if there was a recipe for the item that was served and he looked for a recipe and the surveyor asked it was important to have a recipe and he stated, yes. The FSC stated there should be a recipe for the item in the kitchen, and he was unable to locate a recipe. The FSC stated the item that was supposed to be served was a regular lasagna (noodles flat with cheese layered inside) and not supposed to be a lasagna roll up. The FSC presented a recipe that he stated was supposed to be utilized for the white lasagna. When asked the FSC if not using proper portions or following menus could affect the nutritional content of the food, he stated of course it would. The surveyor asked for a puree lasagna and the recipe for the super mashed potato and the FSC stated there was no recipe for the puree white lasagna. The FSC then showed the surveyor super mashed potato recipe which listed Water, Heavy Cream, Margarine, Instant Potato base and Chicken Base. The surveyor asked what the serving size was and the FSC stated it is supposed to be on there, it is 1/2 Cup. The FSC stated if the correct scoop size is not utilized it affects the nutritional content of the food served. The surveyor informed the FSD and FSC of the observations of the staff using the 3 1/4-ounce scoop for the puree lasagna, mashed potato and super mashed potato. The surveyor asked how often the super mashed potato was served to the residents and the FSD stated every day. On 07/30/25 at 12:30 PM the surveyor visited Resident #49. The meal tray was next to Resident #49 and there were three scoops of white and one scoop of green. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The meal ticket listed super mashed potato, mashed potato, puree fish and puree spinach- all 1/ 2 cup servings. There was one spoon inside of unidentified white item and no other items. The surveyor asked Resident #49 if the food was good and the resident shook their head no. On 07/30/2025 at 1:33 PM, the surveyor interviewed the Dietitian, who stated that she was in a clinical role and would help residents with meal selections, meet with family and attend care conferences, however, she stated she did not have interaction and oversight for the menu, or the kitchen as there was another Dietitian responsible for that and the menu was from a company. The surveyor asked about the supplements and the Dietitian stated she would order super mashed potatoes, and she ordered it mostly for calories. When asked was the kitchen supposed to use a recipe, she stated yes, so the resident received the proper calories and protein. When asked if they should receive the proper portion size, she stated, yes, because if you give less, they don't get the calories. The Dietitian stated that would be a problem if the portion size for super mashed potatoes was not correct, and she stated that she used the super mashed potatoes to specifically increase the calories provided. NJAC 8:39-17.4(e)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Complaint NJ #176091, NJ #179258Based on observation, interview and document review it was determined that the facility failed to ensure the menus were followed and standardized recipes were consistently utilized to ensure resident meals were consistently palatable and consistent portion sizes were served to ensure nutritional adequacy of the meals served. The deficient practice was identified for 5 of 5 residents (Resident #39, Resident #63, Resident # 79, Resident # 85 and Resident #116) who attended a resident council meeting and was evidenced by the following:On 07/30/2025 at 10:35 AM, a surveyor conducted a Resident Council meeting with five residents with the following meal concerns: -5 of 5 residents stated the portions that were served were too small. -5 of 5 residents stated the food items would not always match them menu including soup and the taste would be salty.-5 of 5 residents stated they would select a weeks' worth of menus and still not receive the items that they selected.-3 of 5 residents stated they did not receive the item on the menu, as if the kitchen did not prepare enough items and stated a packaged cookie would be substituted for a homemade cookie.On 07/30/2025 10:51 AM the surveyor observed the lunch meal service in the kitchen and the posted menu was: Cheese Lasagna with [NAME] Sauce, orCheddar Baked TilapiaPotato WedgesSeasoned SpinachButterscotch Pudding On 07/30/25 at 10:54 AM, the Food Service Director (FSD), [NAME] and Food Service Consultant (FSC) were present in the kitchen. The FSC stated his company provided the menus for the kitchen and assisted with oversight of the kitchen. The surveyor observed the cook had a pan of what appeared to be rolled lasagna noodles with cheese inside, and the cook was observed plating up the item, pouring a cream sauce on it and handing it to dietary staff for resident meal trays. When asked the cook what the item was and if he use a recipe, he stated it was a home made recipe and he confirmed it was not a layered lasagna. The surveyor asked the FSD if there was a recipe for the item that was served and he looked for a recipe and the surveyor asked it was important to have a recipe and he stated, yes. The FSC stated there should be a recipe for the item in the kitchen, and he was unable to locate a recipe. The FSC stated the item that was supposed to be served was a regular lasagna (noodles flat with cheese layered inside) and not supposed to be a lasagna roll up. The FSC presented a recipe that he stated was supposed to be utilized for the white lasagna. When asked the FSC if not using proper portions or following menus could affect the nutritional content of the food, he stated of course it would. The surveyor reviewed the recipe and the recipe did not document the amount that should be prepared for quantity food production and to ensure enough portions were available and the serving size listed on the Regular Menu tickets revealed 1 portion. On 07/30/25 11:56 AM, the surveyor observed puree items, the cook confirmed the items were puree lasagna super mashed potato and mashed potato. The surveyor observed the puree item appeared glazed and thick as if too much thickener was in the item and asked to have a scoop of the puree lasagna and puree super mashed potato. The surveyor asked the cook if he used a recipe for the puree lasagna, or super mashed potato and he stated no. The cook stated that he would puree the lasagna and add thickener, he stated he would add milk and butter to the super mashed potatoes. The surveyor's sample was taken to the FSD office and with the FSD and FSC present, the surveyor tasted the puree lasagna which was thick and pasty and was bland, the super mashed potato tasted like thickener powder. The FSD tasted the items and confirmed the thickener taste. The FSC confirmed that the cook should be using recipes. NJAC 8:39-17.2(b); 17.4(a)(2)(3)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and interview on 8/5/2025 and 8/6/2025 in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that all portions of the resident call system were functioning in accordance with 483.90(g) Resident Call System. This deficient practice had the potential to affect all 33 residents and was evidenced by the following: An observation by surveyor #2 on 8/5/2025 at approximately 10:35 AM revealed that the call system computer monitor on 2 [NAME] was not turned ON. An observation by surveyor #1 on 8/6/2025 at 8:00 AM in the presence of the Maintenance Director (MD), revealed the call system computer monitor was not turned ON. In an interview at 8:02 AM, the MD confirmed the observation. The Assistant Administrator, Regional Director of Maintenance and Maintenance Director were notified of the deficient practice during the Life Safety Code exit conference on 8/6/2025 at 3:30 PM. NJAC 8:39-31.2(e), 31.8(c)9		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review it was determined that the facility to ensure that a room transfer was appropriate and ensure the resident and resident representative were notified of the room change. This deficient practice occurred for 1 of 1 residents reviewed for 1 of 2 residents reviewed for abuse (Resident #109) and was evidenced by the following: Complaint # NJ168408Based on interview and document review it was determined that the facility to ensure that a room transfer was appropriate and ensure the resident and resident representative were notified of the room change. This deficient practice occurred for 1 of 2 residents reviewed for abuse (Resident #109) and was evidenced by the following: On 7/29/25, during the initial tour of the facility, the surveyor interviewed Resident #109 who was alert and oriented and who was visibly upset and was crying. The surveyor immediately escorted Unit Manager #1 (UM #1) to Resident #109's room, and the resident stated a Certified Nurse Aide (CNA #1) called them crazy last night. Resident #109 exclaimed, I'm not crazy! On 08/04/2025 at 2:30 PM, the surveyor interviewed the Social Workers (SW #1 and SW #2) regarding any investigation regarding the allegations of rough handling by Resident #110. SW #1 stated that she was not made aware of the issues as the concerns for Resident #110 as that was being followed by the Licensed Nursing Home Administrator (LNHA.) SW #2 then stated after the surveyor asked about Resident #109 and informed SW #2 of the concerns Resident #109 shared, that on 8/4/25 SW #2 met with the resident regarding the concerns and documented a grievance that was provided to the LNHA and DON. The document revealed: Resident #110, Date of Concern: 7/28/25, Complete Description of the Problem: Resident stated that [they] yelled at the Aide (Certified Nurse Aide) because aide closed the door. Aide then yelled back, If you don't stop, you'll go to crazy room. Resident stated she responded, I'm not crazy. Aide then moved resident from room [ROOM NUMBER] to 211A and closed the door. Resident stated she continued to scream for help. Resident #109 reported when the aide returned, several minutes later, the aide picked up [their] head and stared at [them]. Resident #109 asked What are you doing?, and the Aide did not answer. Resident #109 stated [they] heard another Aide say, cut [them] some slack, [they just lost [their] brother, and then heard the Aide say, good. She described the Aide as a female in her late 40's-50's with short red hair and was heavy set. Resident #109 stated the aides would be mean and ignore [them] when [he/she] was still in room [ROOM NUMBER]. On 08/05/2025 at 9:30 AM, the survey team interviewed SW #1 and SW #2. The surveyor asked what the documented Grievance for Resident #109 indicated an allegation of? SW #2 stated I would say psychosocial abuse as the staff terrorized resident #109 when they were holding the resident's face and staring into their eyes. Both SW #1 and #2 confirmed they were not made aware of Resident #110's allegations of abuse. On 08/05/2025 at 12:25 PM, the survey team interviewed SW #1 about the room change for Resident #109 and what was the process for changing resident rooms. SW #1 stated, she did not know there was a room change, the room change evaluation should have been completed before the room change had even occurred. SW #1 stated the process was: 1. Complete a room change evaluation, 2. Complete the room change form, and 3. Notify the family. SW #1 and SW #2 stated neither were informed of the room change and provided the Change of Room Policy and a Census List for Resident #109 that indicated the resident was moved on 7/28/25 at 22:46 [10:46 PM]. SW #1 stated the facility could make a room change for an emergency, however an evaluation still needed to be completed by the social worker to determine appropriateness of the room change and to ensure no abuse had occurred. SW #1 stated the Social Worker must be involved in the room change process regardless of if it was an emergency, related to isolation precautions, resident request or a safety need. Both Social Workers explained that Resident #109 was screaming and they needed to find out what was happening at that time and investigate the issue to see what was going on with the resident. On 08/05/2025 1:19 PM, the survey team met with the LNHA and (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) and asked what the process for resident room changes was. The LNHA stated if the resident requested a room change, and if the resident was alert and oriented the DON would call the family and let them know. The surveyor asked if there was any documentation for a room change and the LNHA stated it would be documented in the electronic medical record and DON stated, it is documented somewhere. The surveyor aske if there was a policy and the LNHA stated, yes, if it was due to safety, I would move them and let the family know. The LNHA stated the nursing supervisor would make the determination. The DON stated based on the shift-to-shift report from the nursing supervisor, Resident #109 was moved. The surveyor asked if the Social Worker supposed to be involved in the move? The DON stated, they do a form, and the surveyor asked was there any follow-up from nursing or administration to determine if the room change was appropriate? The surveyor asked the DON and LNHA if they are notified of room changes and the DON stated, I wasn't here and they don't need to call her if the resident was disruptive. The surveyor asked if she was aware of Resident #109's statement that the staff threatened the resident they would go to the crazy room. The DON stated she was not aware of Resident #109's statement and provided Resident #109's statement for review. The DON stated there was no documentation in the progress notes regarding the room change that occurred on 7/28/25 at 10:46 PM. On 08/05/25 at 2:22 PM, the survey team interviewed SW #2 regarding the statement obtained from Resident #109 on 8/4/25 and if SW #2 asked Resident #109 anything further about the room change. SW #2 stated that she provided the Grievance to the LNHA and she was informed that the LNHA was handling the investigation as the Abuse Officer, and the LNHA never directed her to participate in the investigation into the abuse or the room change. SW #2 stated she visited the resident for her general room rounds on 7/31/25 and 8/1/25 and did not ask about the incident prior to 8/4/25 when the surveyor brought it to her attention. SW #2 would have completed a room change evaluation if she was made aware of the room change, and the social worker was unaware if the RR was informed of the room change because the Abuse Officer was handling the investigation. On 8/5/25 at 3:20 PM, the surveyor in the presence of the survey team conducted a telephone interview with Resident #109's Resident Representative (RR). The surveyor asked the RR if the facility had informed them of Resident #109's room change? The RR stated the facility never told them, Resident #109 told the RR that they put them in the bad [gender redacted] room, the psychiatric room. The Change of Room or Roommate policy Date Implemented: 9/1/24, Policy: It is the policy of this facility to conduct changes to room and/or roommate assignments when considered necessary and/or when requested by the resident or resident representative. Policy explanation and compliance guidelines: 3. Requests for changes in room or roommate should be communicated to the Social Service Designee. 4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason (s) why the move or change is required. 6. A. Informing the resident and family as soon as possible of the room or roommate change. B. involving the resident in the decision and selection of a room or roommate when possible. C. allowing the resident to ask questions about the move. D. Showing the resident where the room is located. E. Introducing the resident to his/her new roommate and sharing information about the new roommate while maintaining confidentiality regarding medical information in order to help the resident become acquainted. F. Introducing the resident to the employees who will be providing care. g. Explaining to the resident why the change is necessary; reassuring the resident his/her personal possessions will be safeguarded. NJAC 8:39-4.1(a)13		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews on 8/5/2025 in the presence of the Assistant Administrator (Assist. Admin), Regional Director of Maintenance (RDM) and Maintenance Director (MD), it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as possible, in accordance with 483.25(d)(1). This deficient practice had the potential to affect all residents, staff and visitors within unit 2 East and was evidenced by the following: An observation at approximately 11:06 AM revealed the vinyl plank floor of room [ROOM NUMBER] A and B was bubbled and lifted from its substrate. In an interview at approximately 11:08 AM, the unsampled B side resident stated, isn't that awful, someone could trip on the floor. In an interview at the time of observation the Assist. Admin., RDM, and MD, confirmed the findings. The RDM stated, yes, we have to get this taken care of. The Assist. Admin., RDM and MD were notified of the deficient practice during the Life Safety Code exit conference on 8/6/25 at 3:30 PM. NJAC 8:39-31.2(e)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Wall LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Complaint #NJ174026 (397043)Based on observation, interview, and record review it was determined the facility failed to follow a physician's order for an insulin medication and acceptable professional standards of practice for 1 of 3 residents reviewed (Resident #115). This deficient practice is 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 casefinding, 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 casefinding; 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. On 7/31/2025 at 12:31 PM, the surveyor reviewed the electronic medical records (EMR) of Resident #115. A review of the admission Record (a summary of important information about the resident) revealed that Resident #115 had diagnoses that included but were not limited to, type 2 diabetes mellitus (DM2). A review of the comprehensive Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated 4/22/2024, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #115 scored a 15 out of 15, which indicated the resident was cognitively intact. A review of the Order Summary Report (OSR) revealed a physician's order date of 4/6/2024 for Humulin R U-500 Kwik Pen Subcutaneous Solution Pen-injector 500 UNIT/ML (Insulin Regular (Human)), Inject 15 unit subcutaneously before meals related to Type 2 Diabetes Mellitus. The order was scheduled to be administered at 11:30 AM. A review of the April 2024 Medication Administration Record (MAR) revealed the following for the Humulin R U-500 injection insulin entry: The order entry specified, .Inject 15 unit subcutaneously before meals related to Type 2 Diabetes Mellitus On 4/6/2024 at 10:56 AM, it was documented that the nurse gave Resident #115 Lispro insulin. A review of Incident Report dated 4/6/2024 at 5:52 PM revealed, Lispro administered by primary nurse . with no orders in place. A review of the progress note dated 4/6/2024 at 6:49 revealed, Lispro 15U was administered . A review of Disciplinary Action Form under Safety Violation for Unsafe practice, revealed, . gave insulin Lispro to the pt. Pt is not on insulin Lispro. On 7/31/2025 at 11:56 AM, the surveyor interviewed the Director of Nursing (DON) about Resident #115's insulin order. The DON stated that the nurse gave Resident #115 Lispro 15 U which was house stocked. When surveyor asked the DON what the expectation was, the DON stated, the nurse should have followed the doctor's order. On 8/1/2025 at 11:55 AM, surveyor attempted to reach the assigned nurse via telephone regarding Resident #115's insulin and was unsuccessful. On 8/1/2025 at 11:58 AM, surveyor attempted to reach the nursing supervisor via telephone regarding Resident #115's insulin and was unsuccessful. On 8/4/25 at 12:50 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) about Resident #115's insulin, the ADON stated, the Lispro should not have been given to the resident. The expectation was for the nurse to follow the doctor's order and Medication Administration Policy to identify the correct resident, correct medication, correct time, and correct dosage. It was important for the resident to receive the right medication because it was prescribed by the physician and resident was a diabetic. On 8/6/25 at 2:48 PM, during interview with the survey team, the Medical Director stated that if the nurse gave a wrong medication, it was a medication error. A review of the facility provided policy titled, Medication Administration, with an Implemented date of 9/1/2024, under Policy Explanation and Compliance Guidelines revealed: 10. Ensure that the six rights of medication administration are (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed: . b. Right drug. 11. Review Medication Administration Record (MAR) to identify medication to be administered. A review of the facility provided policy titled, Medication Errors with an implemented date of 9/1/24, under Policy Explanation and Compliance Guidelines revealed: 1. The facility shall ensure medications will be administered as follows: a. According to the Physician's orders. NJAC 8:39-11.2 (b); 29.2(d)		