STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Venetian Care & Rehabilitation Center, The	275 John T O'Leary Boulevard South Amboy, NJ 08879

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of facility policies, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to establish and maintain an infection prevention and control program (IPCP) for recording incidents of infections identified under the facility's IPCP, surveillance, tracking and trending, and the corrective actions taken by the facility. The facility further failed to ensure staff wore the proper personal protective equipment (PPE) when providing care to one (Resident (R)3) out of one reviewed for proper PPE being donned (put on) out of a total sample of 35 residents. This had the potential for an increase in infections for all the residents of the facility. Findings include: Review of a document titled, Centers for Disease Control (CDC) . National Healthcare Safety Network (NHSN) . Long Term Care Facility Component Tracking Infections in Long-Term Care Facilities ., dated 01/25, indicated . Surveillance is defined as the ongoing systematic collection, analysis, interpretation, and dissemination of data. A facility infection prevention and control (IPC) program should use surveillance to identify infections and monitor performance of practices to reduce infection risks among residents, staff, and visitors. Information collected during surveillance activities can be used to develop and track prevention priorities for the facility. When conducting surveillance, facilities should use clearly defined surveillance definitions that are collected in a consistent way. This method ensures accurate and comparable data regardless of who is performing surveillance. The NHSN LTCF modules provide standard surveillance definitions, allowing participating facilities to consistently apply well defined data elements to ensure accurate, reproducible, and comparable data. Review of a facility policy titled Infection Prevention and Control Policy and Procedure Manual dated 04/25 indicated . The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and/or QAPI committee may be involved in interpretation of the data. Surveillance includes a review of any or all of the following information to help identify possible indicators of infections.Laboratory records.Skin care sheets.Infection control rounds or interviews.Verbal reports from staff.Infection documentation records.Temperature logs.Pharmacy records.Antibiotic review.and Transfer log/summaries. 1.During an interview on 09/11/25 at 9:01 AM, the Infection Preventionist (IP) 1 and IP2 (who was an IP from a sister facility) provided tracking from 04/25 through 07/25. A request was made for a full year of surveillance data during this interview. During an interview on 09/11/2025 at 9:18 AM the Administrator stated they did not have access to any other surveillance data since the previous company took the tracking and trending data. 2. Review of R7's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] and had a diagnosis of acute osteomyelitis given on 08/13/25. Review of R7's EMR under the Orders tab revealed a physician's order, dated 09/09/25, for contact isolation related to ESBL [extended-spectrum beta-lactamase, refers to enzymes produced by bacteria that make them resistant to many commonly used antibiotics] of wound. Review of R7's Care Plan, dated 08/14/25, revealed, I am on [intravenous] therapy (cefiderocol) [an antibiotic] for osteomyelitis until 9/9/25. I.V. (micafungin) [antifungal medication] for candida until 9/10/25. An addition to the Care Plan, dated 09/09/25, revealed, I have an active/colonized multidrug resistant organism r/t [related (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to] ESBL in wound. The approaches included, Isolation precautions per policy. During an observation on 09/10/25 at 9:39 AM outside of R7's room, a sign that documented, Contact Precautions was in place at the doorway and directed staff to sanitize hands, don (put on) a gown and gloves prior to entering the room, remove the gown and gloves prior to room exit, and to sanitize hands at room exit. There was a bin with available personal protective equipment (PPE) at the door. R7's room door and privacy curtain were open, and LPN7 was observed inside the room administering medications, taking the resident's vitals including blood pressure, and touching the resident's overbed table. LPN7 was not wearing a gown or gloves. Upon exiting the room, LPN7 did not sanitize her hands. At this time, LPN7 stated R7 had an open wound, so she required a gown and gloves for high-contact care only. She stated she did not have to don any PPE when administering medications or providing care that was not considered a high contact activity. When asked about the Contact Precautions sign on the door, LPN7 stated she was not sure why that was there, as she thought PPE was only required during high-contact activities and added she would need to check with the LPN/Unit Manager (LPN/UM). LPN7 confirmed she did not wear a gown or gloves while in R7's room administering medications and monitoring vitals. During an interview on 09/10/25 at 9:51 AM, the LPN/UM stated R7 was on contact precautions due to osteomyelitis and a fungal infection in her wound. He stated staff were to wear a gown and gloves any time they entered the room. Review of the policy titled, Isolation - Categories of Transmission-Based Precautions, dated September 2022, revealed, Contact Precautions . Staff and visitors wear gloves. when entering the room . Gloves are removed and hand hygiene performed before leaving the room . Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room. NJAC 8:39-19.4

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure five of five residents (Resident (R) 116, R21, R114, R121, and R26) out of 35 sampled residents had an accurate Minimum Data Set (MDS) assessment. Failure to code the MDS correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the residents.Findings include: Review of the RAI manual, dated 10/2024 and located at Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual | CMS, revealed .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. 1.Review of R116 electronic medical record (EMR) titled admission Record located under the Profile tab indicated that the resident was admitted to the facility on [DATE]. Review of R116's EMR titled quarterly MDS located under the MDS tab with an Assessment Reference Date (ARD) of 06/19/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of five out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident was at risk for the development of pressure ulcers, had no current pressure ulcers, and identified that the resident had a pressure reducing device for her wheelchair. During an observation conducted on 09/09/25 11:09 AM R116 was sitting in a transportation wheelchair, and the wheelchair seat was covered with a towel. There was no preventative pressure reducing cushion on the resident's wheelchair. During an observation conducted on 09/09/25 at 2:40 PM the Occupational Therapist (OT) verified R116 sat on a towel, and this was not appropriate for a resident who was at risk for the development of pressure ulcers. During an interview with the Regional Director of Case Management (RDCM) and MDS Coordinator (MDSC) on 09/10/25 at 2:26 PM confirmed R116 did not have pressure ulcer prevention measures on the resident's wheelchair. Both stated the MDS was incorrect. 2.Review of R21's EMR titled admission Record located under the Profile tab indicated that the resident was admitted to the facility on [DATE]. Review of R21's EMR titled annual MDS located under the MDS tab with an ARD of 08/21/25 indicated the resident had a BIMS score of 14 out of 15 which revealed the resident was cognitively intact. The assessment indicated that the resident was offered a pneumococcal vaccine, but he declined. Review of R21's EMR titled Immun (Immunization) tab failed to contain evidence that the resident received a pneumococcal vaccine. During an interview on 09/10/25 at 2:26 PM with the RDCM and the MDSC, both confirmed the resident did not have evidence of being offered the pneumococcal vaccine. Both stated the MDS was incorrect. 3.Review of R114's EMR titled admission Record located under the Profile tab indicated that the resident was admitted to the facility on [DATE]. Review of R114's EMR titled Immunization located under the Immun tab dated 04/06/22 indicated the resident was administered Pneumovax Dose 2 [PPSV23]. Review of R114's EMR titled annual MDS located under the MDS tab with an ARD of 07/04/25 indicated the resident had a BIMS score of three out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident was up to date with the pneumococcal vaccine. During an interview on 09/10/25 at 2:26 PM, the RDCM and the MDSC confirmed there was no evidence that R114 was offered the pneumococcal vaccine. Both stated the MDS was incorrect. 4.Review of R121's EMR titled admission Record located under the Profile tab indicatedthe resident was admitted to the facility on [DATE]. Review of R121's EMR titled annual MDS located under the MDS tab with an ARD of 01/16/25 indicated the resident had a BIMS score of four out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident was offered and declined the pneumococcal vaccine. Review of R121's EMR titled Immunization located (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	under the Immun tab failed to contain evidence that the resident and/or his representative was provided the opportunity to be vaccinated with the pneumococcal vaccine. During an on 09/10/25 at 2:26 PM interview with the RDCM and MDSC both confirmed there was no evidence that R121 was offered and declined the pneumococcal vaccine. Both stated the MDS was incorrect. 5.Review of R26's EMR titled admission Record located under the Profile tab indicatedthe resident was admitted to the facility on [DATE]. Review of R26's EMR titled annual MDS located under the MDS tab with an ARD of 05/07/25 indicated the resident had a BIMS score of 14 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident was offered and declined the pneumococcal vaccine. Review of R121's titled Immunization located under the Immun tab indicated the facility did not offer the resident a pneumococcal vaccination. During an interview 09/10/25 at 2:26 PM, with the RDCM and MDSC confirmed that R121 did not have evidence of being offered the pneumococcal vaccine. Both stated the MDS was incorrect. NJAC 8:39- 33.2(d)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer four of five residents (Resident (R) 21, R26, R114, and R121) reviewed for flu/pneumonia vaccinations out of 35 sample residents and/or their representatives the opportunity for the residents to be vaccinated in accordance with nationally recognized standards. This practice had the potential to increase the risk for this resident to contract pneumonia.Findings include: Review from the CDC website titled PCV20 or PCV21 Vaccination for Adults 65 Years or Older dated 09/11/24 indicated .Adults [AGE] years of age or older have the option to receive supplemental PCV20 or PCV21 (not both) if they previously completed the pneumococcal vaccine series with both PCV13 and PPSV23 and meet the following criteria.Previously received one dose of PCV13 (but not PCV15, PCV20, or PCV21) at any age, and .Previously received all recommended doses of PPSV23 (including 1 dose of PPSV23 at or after [AGE] years of age). The determination to administer PCV20 or PCV21 is based on a shared clinical decision-making (SCDM) process between a patient and their health care provider. SCDM recommendations are optional and informed by the characteristics, values, and preferences of the patient, and the clinical discretion of the health care provider. Review of the facility policy titled Pneumococcal Vaccine dated 10/23 indicated All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series within 30-days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. 1. Review of R21's electronic medical records (EMR) titled admission Record located underthe Profile tab indicated the resident was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of his admission. Review of R21's EMR titled Immun (Immunization) tab failed to contain evidence that the resident received a pneumococcal vaccine. During an interview on 09/10/2025 at 2:26 PM the Regional Director of Case Management (RDCM) and the MDS Coordinator (MDSC) both confirmed that R21 did not have evidence of being offered a pneumococcal vaccine per CDC recommendations. 2. Review of R26's EMR titled admission Record located under the Profile tab indicatedthe resident was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of his admission. Review of R26's EMR titled Immunizations located under the Immun tab failed to indicate the resident was offered a pneumococcal vaccine. Review of a document for R26 provided by the facility titled Patient Immunizations Administered Report dated 11/09/21 indicated the resident received Pneumo Poly [PPSV23]. During an interview conducted on 09/10/2025 at 2:26 PM the RDCM and the MDSC both confirmed the resident should have been offered a second pneumococcal vaccine per CDC recommendations a year later and this was not done. 3. Review of R114's EMR titled admission Record located under the Profile tab indicatedthe resident was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of his admission. Review of R114's EMR titled Immunization located under the Immun tab dated 04/06/22 indicated the resident was administered Pneumovax Dose 2 [PPSV23]. During an interview conducted on 09/10/25 at 2:26 PM the RDCM and the MSDC both confirmed R114 did not have evidence of being offered a second pneumococcal vaccination per CDC recommendations. 4. Review of R121's EMR titled admission Record located under the Profile tab indicatedthe resident was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of his admission. Review of R121's titled Immunization located under the Immun tab indicated the facility did not offer the resident a pneumococcal vaccination. Review of a document for R121 provided by the facility titled Patient Immunizations Administered Report failed to address if the resident was offered a pneumococcal vaccine. During an interview conducted on 09/10/25 at 2:26 PM the RDCM and MDSC both confirmed R121 did not receive a pneumococcal vaccine per CDC recommendations. During an interview on (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/10/25 at 8:27 AM, Infection Preventionist (IP) 2, who was the IP for a sister facility stated if a resident had the PCV13 and the PPSV23, the resident would be technically up to date and then five years later to be offered the PCV20 or PCV21. IP2 stated the physician can order whatever their preference was, and the facility would then supply the vaccination to the resident. IP2 stated the goal was to provide the resident with the opportunity to be vaccinated. NJAC 8:39-19.4

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to ensure one resident (R 116) out of one reviewed for accommodations of needs, out of a survey sample of 35, was provided and assessed for an appropriate wheelchair. This had the potential for R116 not to be able to propel herself and have to wait for staff assistance.Findings include: Review of a facility policy titled Resident Mobility and Range of Motion dated 04/20 indicated .Interventions may include therapies, the provision of necessary equipment.based on professional standards of practice consistent with state laws and practice acts. Review of R116's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of dementia. Review of R116's EMR titled quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 06/19/25 indicated the resident had a Brief Interview of Mental Status (BIMS) score of five out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had no impairments of her upper or lower extremities. The assessment indicated the resident required partial to moderate assistance with activities of daily living. Review of R116's EMR titled Care Plan located under the Care Plan tab dated 07/30/25 revealed the resident had decreased safety awareness, endurance, and dynamic balance. One of the interventions included Occupational Therapy (OT) to evaluate and treat. The OT treatment included therapeutic activities and wheelchair management. Review of a document for R116 provided by the facility titled Occupational TherapyOT Evaluation & Plan of Treatment dated 07/30/25 indicated the therapeutic goal included that the resident would complete all functional transfers from the wheelchair, toilet, and bed. There was no further assessment which addressed the use of a transportation wheelchair (for individuals who have no upper body strength) or for a standard wheelchair (an individual can self-propel). During an observation on 09/09/25 at 11:09 AM, R116 was sitting in a transportation wheelchair. The resident's bi-lateral legs were placed on legs rests attached to the transportation wheelchair. The resident was participating in activities. During an interview on 09/09/25 at 11:52 AM, Certified Nurse Aide (CNA) 1 stated that the transportation wheelchair must have been brought in by R116's family. During an interview on 09/09/25 at 12:17 PM the Director of Rehabilitation (DOR) stated that residents were assessed for the use of a standard wheelchair. The DOR stated normally residents were assessed for the use of a standard wheelchair and then measurements would be taken for the height, depth, width, and leg rests. The DOR stated he was unsure if R116 was able to propel herself due to her poor cognition. The DOR stated he would have tested R116 in a standard wheelchair prior to the use of a transportation wheelchair. A request was made for any wheelchair assessments for R116. During an interview on 09/09/25 at 2:07 PM, the DOR confirmed that the OT completed an evaluation for R116 but there was no evaluation for the use of which type of wheelchair the resident required. During an observation on 09/09/25 at 2:11 PM, R116 was observed sitting in her transportation wheelchair playing activities with the other residents. During an interview on 09/09/25 at 2:40 PM, the OT stated the therapy department typically did not place a resident into a transportation wheelchair since the resident could not be positioned properly in them. The OT and surveyor went to observe R116. The OT stated she was not aware of the resident being in a transportation wheelchair and confirmed that the resident would be dependent on staff for mobility. During an interview on 09/10/25 at 8:25 AM, CNA2 stated R116 always had a transportation wheelchair. During an interview on 09/11/25 at 11:34 AM, the Administrator stated that she believed that the family brought the transportation wheelchair for R116 and stated she believed that staff provided the family with risks verses benefits on the use of the transportation wheelchair. The Administrator stated she would verify if this information was in the medical records for the resident. No additional information was provided at the conclusion of this survey. NJAC 8:39-4.1(a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy review, the facility failed to ensure an open window was covered with a screen for one of 33 Initial Pool residents (Resident (R) 73) whose rooms were observed. This failure had potential to increase pest activity and risk of infection for R73.Findings include: Review of R73's admission Record, located under the Profile tab of the electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses including schizophrenia, dementia, and chronic kidney disease. Review of R73's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/15/25 and located under the MDS tab of the EMR, revealed he scored an eight out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. During an observation in R73's room on 09/08/25 at 10:07 AM, R73 was unable to answer most questions and was speaking nonsensically. His room had a heavy urine odor, feces smeared on the wall, the floor, and the mattress; dirty laundry and used incontinence briefs in bags on the floor of the room, and crumbs and debris on the floor. The window was open, and the screen of the window was resting against the wall of the resident's room. There were several flies and other flying insects in the room. During an observation from the hallway outside of R73's room on 09/10/25 at 2:17 PM and on 09/11/25 at 9:00 AM, the window was again observed open with the screen missing, resting against the wall in the room. There were several flying insects in the room. During an interview on 09/11/25 at 9:30 AM, the Maintenance Director (MD) stated the missing window screen had not been reported to him to address. The MD stated there was a system in place for the staff to create work orders for items that needed fixing, and the staff were expected to report any concerns. The MD stated if he was aware of the missing screen in R73's window, he would have addressed it right away. The MD stated R73 had habit of keeping his room dirty and a window screen was important for keeping flies out of his room. Review of the policy titled, Work Orders, Maintenance, dated August 2025, revealed, Maintenance work orders shall be completed in order to establish a priority of maintenance service. NJAC 8:39-4.1(a)NJAC 8:39-5.1(a)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure adequate monitoring for the use of psychotropic medications for two of five residents (Resident (R) 8 and R10) reviewed for unnecessary medications out of a total sample of 35 residents. For R8, behaviors were not identified for monitoring of medication effectiveness and failed to ensure ongoing assessment for adverse side effects of medication for R10. These failures had the potential to contribute to unnecessary psychotropic medication use and risk for adverse side effects of the medications.Findings include: 1.Review of R8's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including intellectual disabilities, depression, and psychosis. Review of R8's EMR under the Orders tab revealed a physician's order, dated 05/14/24, for aripiprazole [an antipsychotic medication] 7.5 milligrams (mg) at bedtime for psychosis. Review of R8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/25 and located under the MDS tab of the EMR, revealed she scored 12 out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R8 did not exhibit mood or behavioral symptoms. She received routine antipsychotic medication and gradual dose reduction (GDR) had not been attempted. Review of R8's Care Plan, dated 08/18/25 and located under the Care Plan tab of the EMR, revealed, The resident uses psychotropic medications [aripiprazole, an antipsychotic medication] r/t [related to] behavior management and the goal was, [R8] will reduce the use of psychoactive medication through the review date. The approaches included, Administer medications as ordered. Monitor/document for side effects and effectiveness. R8's Care Plan did not describe her target behaviors to monitor to determine effectiveness of the medication. Review of R8's MAR, dated August 2025 and located under the Orders tab of the EMR, revealed she received antipsychotic medication daily. The MAR documented behaviors were exhibited on 08/09/25, 08/10/25, 08/13/25, 08/15/25, 08/20/25, 08/21/25, 08/22/25, 08/23/25, 08/24/25, 08/27/25, 08/29/25, and 08/30/25. Review of R8's EMR under the Progress Notes tab revealed no corresponding notes to indicate the nature of the behavior, the severity, the non-pharmacological intervention, and the intervention's effectiveness. Review of R8's Medication Administration Record (MAR), dated September 2025 and located under the Orders tab of the EMR, revealed she received antipsychotic medication daily. The MAR documented behaviors were exhibited on 09/03/25, 09/06/25, 09/07/25, and 09/08/25. Review of R8's EMR under the Progress Notes tab revealed no corresponding notes to indicate the nature of the behavior, the severity, the non-pharmacological intervention, and the intervention's effectiveness. During an interview on 09/10/25 at 2:57 PM, Licensed Practical Nurse (LPN) 7 stated R8 did not exhibit any behavioral symptoms and was pretty quiet. During an interview on 09/10/25 at 3:12 PM, Recreation Aide (RecA) 1 stated R8 did not exhibit behavioral symptoms and was pleasant and cooperative. During an interview on 09/11/25 at 9:50 AM, the Long-Term Care Social Worker (LTCSW) stated R8's most recent psychiatrist report documented a dose reduction of the aripiprazole was not indicated as the resident was experiencing auditory hallucinations. The LTCSW stated it was important to monitor not only if a behavior occurred, but the specific behavior exhibited and any contributing factors to ensure adequate monitoring for effectiveness of the medication. The LTCSW also stated the specific behaviors, and individualized interventions should be included in the Care Plan. During an interview on 09/11/25 at 11:37 AM, the Director of Nursing (DON) stated a behavior tracking sheet should be completed to quantify the specific behaviors exhibited and interventions used; however, these sheets were not yet in place. The DON stated at minimum, a corresponding Progress Note describing the behavior should be entered. The DON stated it was important to track specific behaviors to determine if the medication could be trialed for a dose reduction. The DON also stated these specific behaviors (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be outlined in the Care Plan.Review of the facility's policy titled, Psychotropic Medication Use, dated February 2025, revealed, Residents receiving psychotropic medication are monitored and the response to treatment is documented. 2.Review of the admission Record located in the Profile tab of the EMR revealed R10 was admitted to the facility on [DATE] with diagnoses of intellectual disabilities, anxiety disorder, major depressive disorder, and obsessive-compulsive disorder. Review of the Evaluations tab in the EMR revealed an AIMS (abnormal involuntary movement scale assessment used to determine if there are any adverse side effects that develop when someone is taking an anti-psychotic medication) was completed on 08/15/24 with a score of zero. There was no evidence of any other AIMS being completed. There was no other evidence in the medical record that any monitoring for side effects was being completed. Review of the significant change MDS located in the MDS tab of the EMR with an ARD of 06/24/25 revealed R10 had a BIMS score of three out of 15 which indicated R10 was severely impaired in cognition and was administered an anti-psychotic medication during the seven-day observation period. Review of the Order Summary dated 07/25/25 revealed R10 had an Order for Risperdal [an anti-psychotic medication] 1 mg [milligram] every 12 hours for psychosis [a mental health condition characterized by a loss of contact with reality.] During an interview on 09/11/25 at 10:11 AM, the DON confirmed there was no other documentation to show there was any monitoring for any adverse side effects for the Risperdal for R10 and there had been a lack of monitoring overall for the use of an antipsychotic. NJAC 8:39-4.1(a)6NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. Building B. Wing	09/11/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure one resident (Resident (R)7) reviewed for a hospital transfer out of a total sample of 35 was provided with a written transfer notice. This failure has the potential to affect all residents by not having knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired.Findings include: Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed, R7 was admitted to the facility 07/28/24. Review of the Progress Notes located in the Progress Notes tab of the EMR revealed on 07/15/24, .Seen by MD [Medical Doctor]. Order rec'd [received] and carried out to send to [hospital name] for surgical wound debridement eval and treat. Review of the Progress Notes located in the Progress Notes tab of the EMR, revealed on 07/16/25, .Called ER [emergency room] Department for a status update. Patient was admitted . Admitting diagnosis Acute Osteomyelitis [bone infection] .Review of the EMR did not show documentation that R7 and/or her representative was provided with a written transfer notice regarding her transfer to the hospital, as required. During an interview on 09/10/25 at 11:36 AM, the Long-Term Care Social Worker (LTCSW) was asked if the transfer notice had been provided to R7, as it was not documented in the EMR. The LTCSW stated, We stopped doing them in May. I was not aware that we needed to keep doing them. NJAC 8:39-4.1(a)

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	315518	A. Building B. Wing	09/11/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR), Level II Determination recommendations were developed and implemented for one of four residents (Resident (R) 73) reviewed for PASARR out of a total sample of 35 residents. This failure had the potential to lead to continued or worsening behavioral symptoms without intervention.Findings include: Review of R73's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including schizophrenia, dementia, and chronic kidney disease. Review of R73's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/15/25 and located under the MDS tab of the EMR, revealed he scored eight out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R73 experienced delusions and exhibited behaviors of rejection of care daily. Review of R73's PASRR Level II Determination Notification, dated 05/09/25 and located in the Miscellaneous tab of the EMR, revealed the following recommendations were included: Formulate and implement a behavioral modification plan to address any behavioral disturbances and Develop a Crisis Intervention/Safety Plan with the client. Review of R73's Care Plan, located under the Care Plan tab of the EMR and dated 08/12/25, revealed, I meet the PASRR 2 Level of determination secondary to diagnosis of mental health disability . Recommendations as follows: Med [medication] monitoring, routine f/u [follow up] visits with psychiatrist and PCP [primary care physician], routine lab testing, develop crisis intervention plan for client. The approaches included: Case consultation . [and] Structured social activities, medication monitoring. Further review of R73's Care Plan revealed the focus, dated 05/23/25, [R73] has a diagnosis of schizophrenia. [R73] has a history of hallucinations and delusions . [R73] becomes agitated during care, shower, and hands on care and will yell at staff. The approaches included: Medications as ordered . Track behaviors . Validate resident's emotions . Approach in a calm, slow friendly manner . [and] Inform [R73] of care provided. Review of R73's EMR revealed there was no evidence of a behavior modification plan or a crisis intervention/safety plan. During an interview on 09/11/25 at 9:57 AM, the Long-Term Care Social Worker (LTCSW) stated she was in the process of making referrals to behavioral health facilities for R73, as his care could not be managed in the facility. She stated R73's behavior included all care including labs, weights, and medications as well as washing his linens in the toilet, washing his walls with toilet water, leaving soiled briefs and clothing on the floor, urinating on the floor, and refusing staff to enter his room. The LTCSW stated a behavior modification program and crisis intervention/safety plan were not created for R73 because he refused care. The LTCSW stated the PASARR Level II recommendations were typically sent to the unit manager for follow up and she was unsure why these recommendations were not followed through. During an interview on 09/11/25 at 11:29 AM, the Director of Nursing (DON) stated R73 had extreme behaviors related to schizophrenia, and the best way to manage his behavior was to leave him alone and re-approach at a later time when he can be reasoned with. The DON stated there was a certain way for staff to approach R73 to not set off his behaviors. The DON stated these approaches should be included in the Care Plan or in a behavior modification plan. The DON stated R73's behaviors were not appropriate for the nursing home and referrals were being made for mental health care. The DON was unaware the PASARR Level II recommendations were not implemented. Review of the policy titled, admission Criteria, dated March 2019, revealed, Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate . The state PASARR representative provides a copy of the report to the facility . The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. NJAC 8:39-40.3(d)

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	315518	A. Building B. Wing	09/11/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and interview, the facility failed to develop a person-centered comprehensive plan of care with measurable goals and plans for two of 35 sampled residents (Resident (R)116 and R56) reviewed for care plans. The failure had the potential for the residents to have unmet care needs.Findings include: Review of a facility policy titled Care Plans, Comprehensive Person-Centered dated 03/22 indicated .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 1.Review of R116's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R116's EMR titled admission Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 03/19/25 indicated the staff could not determine the resident's Brief Interview for Mental Status (BIMS). The assessment indicated the resident had no pressure ulcers, and was assessed and considered to be at risk for the development of pressure ulcers. Under the Care Area Assessment (CAA) revealed the resident triggered for the development of pressure ulcers and directed the staff to develop a care plan. Review of R116's EMR titled Care Plan located under the Care Plan tab failed to contain evidence that the clinical staff developed a pressure ulcer care plan. During an interview on 09/10/25 at 2:26 PM, the Director of Case Management and the MDS Coordinator (MDSC) stated if a resident triggers under the CAA the care plan should reflect this. During an interview on 09/10/25 at 3:25 PM the Regional Director of Case Management (RDCM) and the MDSC confirmed that a pressure ulcer care plan should have been developed for R116, and it was not. During an interview on 09/11/25 at 10:28 AM the Director of Nursing (DON) confirmed if R116 triggered under the CAA the care plan should have been developed. 2. Review of R56's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility 05/02/22 and had diagnoses including dementia, contracture, muscle weakness, and osteoarthritis. Review of R56's quarterly MDS, with an ARD of 07/20/25 and located under the MDS tab of the EMR, revealed she was rarely/never able to make herself understood and severely impaired cognition. R56 was always incontinent of bladder and frequently incontinent of bowel. She required substantial/maximum assistance with toileting hygiene and did not use the toilet. Review of R56's Care Plan, dated 06/27/25 and located under the Care Plan tab of the EMR, revealed she was dependent on staff for assistance with activities of daily living. The Care Plan did not address R56's incontinence or toileting hygiene needs. During an interview on 09/11/25 at 11:37 AM, the Director of Nursing (DON) stated a toileting/changing schedule was based on each individual; the facility did not have a protocol to apply to every resident. The DON stated the information on how often to check and change R56 should be included in her Care Plan. During an interview on 09/11/25 at 12:27 PM, the MDS Coordinator (MDSC) stated R56's incontinence and toileting hygiene needs should have been addressed in the Care Plan. NJAC 8:39-11.2(e) thru(i)

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	315518	A. Building B. Wing	09/11/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure one of five residents reviewed for unnecessary medications (Resident (R) 12) received antibiotic eye medication as ordered and failed to notify the physician of missed doses of the medication out of a total sample of 35 residents. This failure had the potential to delay healing or contribute to worsening infection and pain.Findings include: Review of R12's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] and had diagnoses including encephalopathy, sepsis, and dementia. Review of R12's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/03/25 and located in the MDS tab of the EMR, revealed she was rarely/never able to make herself understood and had severely impaired cognition. Review of R12's Electronic Medication Administration Record (eMAR), dated September 2025 and located under the Orders tab of the EMR, revealed a physician's order, dated 09/04/25, for tobramycin [antibiotic] ointment 0.3%, one application in the left eye three times a day for infection for seven days. The eMAR documented the eye ointment was applied twice on 09/04/25 and three times on 09/05/25, then was not administered at all on 09/06/25 or 09/07/25, then was administered three times daily on 09/08/25. On 09/06/25 and 09/07/25, Licensed Practical Nurse (LPN) 7 documented three times daily, drug/treatment not administered. Review of R12's EMR under the Progress Notes tab revealed the following corresponding notes:-An eMar Medication Administration Note dated 09/06/25 at 2:56 PM documented, Awaiting delivery. -An eMar Medication Administration Note dated 09/06/25 at 2:57 PM documented, Awaiting delivery. -An eMar Medication Administration Note dated 09/06/25 at 4:33 PM documented, Awaiting delivery. -An eMar Medication Administration Note dated 09/07/25 at 10:57 AM documented, Not available. -An eMar Medication Administration Note dated 09/07/25 at 3:30 PM documented, Not available. An eMar Medication Administration Note dated 09/07/25 at 6:15 PM documented, Not available. During an interview on 09/09/25 at 12:34 PM, LPN7 stated that over the weekend on 09/06/25 and 09/07/25, she was unable to find the tobramycin ointment for R12. She stated she looked for the medication but did not see it anywhere. LPN7 stated she did not alert the physician to the missed doses of medication nor contact the pharmacy to determine whether the medication had been delivered. She stated she should have called the physician as the medication was only ordered for seven days but she had already missed two days of application. During an interview on 09/11/25 at 11:35 AM, the Director of Nursing (DON) stated LPN7 should have contacted the pharmacy to check on the status of the medication and notified the physician of the missed doses. Review of the policy titled, Unavailable Medication, dated June 2021, revealed, In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: a. Contact the pharmacy regarding the unavailable medication. b. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication, explain the circumstances, report the date of expected availability, and provide the alternative medication(s) recommended by pharmacy.i. Obtain a new order and discontinue prior order, orii. Obtain a hold order for the unavailable medication. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document review, facility policy review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure pressure ulcer prevention measures were in place for two residents out of four reviewed (Resident (R) 116 and R3) for pressure ulcers out of a total sample of 35 residents. This had the potential for the residents to develop pressure ulcers and/or worsen current pressure ulcers.Findings include: Review of the RAI manual, dated 10/2024 and located at Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual | CMS, revealed .The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. Review of a facility policy titled Prevention of Pressure Injuries dated 04/20 indicated .The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors .Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice.For prevention measures associated with specific devices, consult current clinical practice guidelines. 1.Review of R116's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R116's EMR titled quarterly MDS located under the MDS tab with an assessment Reference Date (ARD) of 06/19/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of five out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident used a wheelchair for mobility, required partial to moderate assistance from staff for activities of daily living, and was considered to be at risk for the development of pressure ulcers and the facility had applied pressure reducing devices to her wheelchair. During an observation on 09/09/25 at 11:09 AM, R116 sat in a transportation wheelchair and under her was a white towel. At 2:11 AM, R116 sat in a transportation wheelchair and under her was a white towel. During an interview on 09/10/25 at 8:03 AM, the Assistant Director of Nursing (ADON) stated if a resident was at risk for the development of pressure ulcers, the physician would order baseline bloodwork, and Registered Dietician (RD) would assess the resident to ensure the resident ate adequately. The ADON stated R116's goal was to continue to assist her with walking and involved in activities. ADON stated all the transportation wheelchairs should have a gel cushion. During an interview on 09/09/2025 at 2:40 PM, the Occupational Therapist (OT) stated that therapy did not like the use of a transportation wheelchairs since the wheelchair was difficult to reposition a resident in. During this interview, the OT observed the resident and confirmed the resident was not on a gel cushion and would recommend a Roho cushion due to the resident being at risk for the development of pressure ulcers. The OT also confirmed that the resident sat on a white towel during this interview. During an interview on 09/10/2025 at 8:25 AM, Certified Nurse Aide (CNA) 2 stated that R116 never had a Roho cushion to be placed on the resident's wheelchair. CNA2 stated she was unsure who placed the resident on a towel. During an interview on 09/11/25 at 10:09 AM, the MDSC stated R116's the resident had a Roho cushion but R116's family member would place the cushion behind the resident's back instead of underneath her. 2. Review of R3's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] and had diagnoses including metabolic encephalopathy, protein-calorie malnutrition, peripheral vascular (continued on next page)

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	315518	A. Building B. Wing	09/11/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease, and dementia. Review of R3's significant change of condition MDS, with an ARD of 07/23/25 and located under the MDS tab of the EMR, revealed she was rarely/never able to make herself understood and had severely impaired cognition. R3 was at risk for development of pressure ulcers and had one stage III pressure ulcer. Review of R3's Care Plan, located under the Care Plan tab of the EMR and dated 07/28/25, revealed, The resident has pressure ulcer to her right heel r/t [related to] history of pressure ulcers. The approaches included: Follow facility policies/ protocols for the prevention and treatment of skin breakdown. The Care Plan did not include the specific interventions to use for prevention. Review of R3's Progress Note by the wound care physician, dated 07/21/25 and located under the Miscellaneous tab of the EMR, revealed, Patient has a new right heel pressure injury. Possibly from immobility. She has hx [history] of DM-uncontrolled, PVD, impaired mobility, and incontinence all which increases [sic] wound incidence and further inhibit optimal wound healing. Reviewed with staff the importance of offloading, dressing changes, nutrition optimization, and strict glycemic control . Offload heels per Facility Protocol - Heel booties. Review of R3's EMR under the Orders tab revealed no order for use of heel booties to offload pressure. During observations on 09/10/25 at 8:45 AM, 10:07 AM, 11:38 AM, 1:16 PM, 2:11 PM, and 2:24 PM, and 2:42 R3 was seated in her reclining wheelchair in the day room. She had her heels directly on a pillow and was not wearing heel booties. During an interview on 09/10/25 at 2:11 PM, CNA5 confirmed R3 was not wearing heel booties. She stated she thought she only wore booties while in bed. During an interview on 09/10/25 at 2:42 PM, LPN7 stated R3 should be wearing heel booties every day, in and out of bed as she spent her time out of bed in a reclining wheelchair. LPN7 stated she had a pressure ulcer on her heel, and the booties were important to offload pressure for wound healing and prevention of further breakdown. LPN7 confirmed R3 did not have heel booties on. LPN7 stated she was unable to find a physician's order for use of the heel booties. During an interview on 09/11/25 at 11:44 AM, the DON stated R3 should have the heel booties on at all times while in bed and while out of bed in her reclining wheelchair. The DON stated the booties should be included in the physician orders and Care Plan.Review of the policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated March 2014, revealed, The physician will help identify medical interventions related to wound management. Review of the policy titled, Prevention of Pressure Injuries, dated April 2020, revealed, Review the resident's Care Plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. NJAC 8:39-27.1(a)

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	315518	A. Building B. Wing	09/11/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, record review, and facility policy review, the facility failed to ensure interventions were in place for one of one resident (Resident (R) 56) out of two residents reviewed for range of motion (ROM) out of a total sample of 35 residents. This had the potential for the residents contracture to worsen. Findings include: Review of R56's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility 05/02/22 and had diagnoses including dementia, contracture, muscle weakness, and osteoarthritis. Review of R56's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/20/25 and located under the MDS tab of the EMR, revealed she was rarely/never able to make herself understood and severely impaired cognition. R56 did not have limited ROM. Review of R56's Care Plan, dated 06/27/25 and located under the Care Plan tab of the EMR, revealed she was dependent on staff for assistance with activities of daily living. The Care Plan did not address R56'shand contracture or interventions to manage it. Review of R56's EMR under the Orders tab revealed a physician's order, dated 09/18/24, for Gauze roll to be applied to [left] hand daily. Skin checks and hand hygiene at AM/PM.Review of R56's Care Plan, located under the Care Plan tab of the EMR and dated 08/18/25, revealed, Continue to do range of motion exercises and Keep skin clean and dry. The Care Plan did not address the use of a gauze roll in the left hand. Review of R56's Treatment Administration Record (TAR), dated September 2025 and located under the Orders tab of the EMR, revealed the order to apply a gauze roll to the left hand was signed as completed daily. During an observation on 09/08/25 at 10:31 AM, R56 was seated in her reclining wheelchair in the sensory group without a gauze roll in her left hand. Her left hand was in her lap and was balled into a fist. R56 was not seen to use her left arm/hand. During an observation on 09/09/25 at 8:51 AM, R56 was seated in her reclining wheelchair at the breakfast table. Her left hand was in her lap and there was no gauze roll in the hand. Her left hand remained in a fist. During observations on 09/10/25 at 10:56 AM and 2:48 PM, R56 was seated in her reclining wheelchair in the sensory group. She did not have a gauze roll in her left hand, which was in a fist on her lap. w/c to sensory group after changing in room. During an observation and concurrent interview on 09/10/25 at 3:08 PM, Licensed Practical Nurse (LPN) 7 confirmed R56 did not have a gauze roll in her left hand, and she needed to have it to protect her skin due to contracture. LPN7 did not know why the gauze roll was not applied but was documented on the TAR as completed. LPN7 placed a gauze roll in R56's left hand and stated it was a challenge to get it in the hand. During an interview on 09/11/25 at 11:37 AM, the Director of Nursing (DON) stated he had no explanation for the gauze roll not being applied as ordered and signed as completed on the TAR. The DON stated the gauze roll should be applied to R56's left hand daily. Review of the policy titled, Resident Mobility and Range of Motion, dated July 2017, revealed Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility . As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility, including . skin integrity issues . The care plan will be developed by the interdisciplinary team based on comprehensive assessment. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315518	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Venetian Care & Rehabilitation Center, The	275 John T O'Leary Boulevard South Amboy, NJ 08879

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and facility policy review, the facility failed to provide respiratory care per standards of practice for one of two sampled residents (Resident (R)142) reviewed for respiratory care out of a total sample of 35 residents. Specifically, the facility failed to ensure respiratory equipment (Ambu-bag) was accessible. The failure had the potential for the resident to have respiratory issues and unmet care needs.Findings include: Review of a facility policy titled Tracheostomy Care dated 06/25/25 failed to address the importance of an Ambu-bag to be stored by a resident, who has a trach, at bedside. Review of R142's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R142's EMR titled Care Plan located under the Care Plan tab dated 09/06/25 indicated the resident had a tracheostomy related to respiratory failure and that the resident required emergency equipment at the bedside which included an Ambu-bag. Review of R142's EMR titled admission Minimum Data Set (MDS) located under the MDS tab dated 09/12/25 was in progress and data could not be collected. During an observation and interview on 09/09/25 at 6:05 AM, Registered Nurse Supervisor (RNS) entered R142's room and proceeded to show the emergency medical equipment which was at the bedside of the resident. RNS confirmed there was no Ambu-bag at the resident's bedside. RNS stated it was important for an Ambu-bag to be at the bedside if the resident was unable to breathe on his own and required manual assistance with the Ambu-bag. During an interview on 09/11/25 at 10:09 AM, the Director of Nursing (DON) stated he was unsure why the Ambu-bag was not at the bedside of R142 but it was critical for the clinical staff to have access to the Ambu-bag if the resident was unable to breathe on his own. NJAC 8:39-5.1(a)NJAC 8:39-27.1(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure the physician responded to the consultant pharmacist medication reviews for one resident (Resident (R7) out of five reviewed for unnecessary medications in a total sample of 35 residents. This failure placed the resident at risk of receiving unnecessary medications.Findings include: Review of the facility policy titled, Medication Regimen Reviews (MRR), dated July 2025, revealed, .A licensed pharmacist reviews the medication regiment of each resident at least monthly.The purpose of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.Upon receiving the MRR, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them.If the physician does not provide a timely or adequate response, or the consultant pharmacist identified that no action has been taken, he/she contacts the medical director or the administrator. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R7 was originally admitted to the facility on [DATE] and was readmitted after a hospital stay on 08/13/25 with diagnoses that included hypotension (low blood pressure), atrial fibrillation (an irregular heart rhythm), and a bone infection of the left ankle and foot. Review of an 05/12/25 Pharmacist Consultant Report provided by the Administrator revealed, This resident has an order for Midodrine [Midodrine is a medication used to treat a sudden drop in blood pressure when standing up.] q [every] 8 hours. Midodrine should not be dosed after 5 PM in order to minimize the potential for supine [laying on your back] hypertension [high blood pressure]. Please update MD [Medical Doctor] orders and MAR [Medication Administration Record] to indicate doses separated by at least 3 hours and the last dose of the day no later than 5 PM. There was no provided documentation or indication on the Pharmacy Consultant Report that R7's physician had responded to the request by the Pharmacist. Review of the June and July 2025 MARs located in the Orders tab of the EMR revealed R7 was restarted on Midodrine HCL [hydrocholoride] on 06/20/25. The medication was ordered at 2.5 mgs [milligrams] every eight hours. Hold for systolic [upper number on a blood pressure reading] greater than 130. The dosing times of the Midodrine were listed as 6:00 AM, 2:00 PM, and 10:00 PM. Review of the August 2025 MAR revealed R7 had an order for Midodrine HCL 2.5mgs q 8 hours. Hold for systolic greater than 120. Dated 08/13/25. Review of the 08/14/25 Pharmacy Consultant Report provided by the Administrator revealed, This resident has an order for Midodrine q 8 hours. Midodrine should not be dosed after 5 PM in order to minimize the potential for supine hypertension. Please update MD orders and MAR to indicate doses separated by at least 3 hours and the last dose of the day no later than 5 PM. There was no documentation on the Pharmacy Consultant Report indicating that the physician was notified of the pharmacist's recommendation or that the order had been changed on the MAR. Review of the September 2025 MAR revealed R7 was being administered Midodrine q 8 hours. The dosing times were listed as 6:00 AM, 2:00 PM, and 10:00 PM. During an interview on 09/11/25 at 10:14 AM, the Director of Nursing (DON) stated, The physician came in and ordered the Midodrine for two times daily, yesterday. The DON was asked how the physician knows about the pharmacy recommendations and when does he answers them. The DON stated, We send them to him electronically. He is not very good at electronics and did not return them to us timely. During an interview on 09/11/25 at 11:06 AM, the Pharmacist Consultant was asked if the physician had responded to her recommendations. The pharmacist stated, No. During a follow-up interview on 09/11/25 at 12:23 PM, the DON stated, We will usually put the pharmacy recommendation reports in the physician folder. Sometimes they don't check them. My expectation is they are reviewed in a timely manner. NJAC 8:39-29.3

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to ensure the medical record was complete and accurate for three residents (Residents (R)7, R64, and R70) out of total sample of 35 residents reviewed. This failure had the potential for the resident's health status not be accurate, complete, and possibly create unmet care needs.Findings include: Review of the facility policy titled, Charting and Documentation, dated July 2017 revealed, .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed that R7 was admitted to the facility with a diagnosis that included major depressive disorder. Review of the 04/22/25 Comprehensive Care Plan located in the Care Plan tab of the EMR revealed, I use anti-psychotic medication [a class of medications used to treat psychotic disorders, such as schizophrenia and bipolar disorder] r/t [related to] Psychosis [a mental health condition characterized by a loss of contact with reality]. Review of the EMR did not show documentation that R7 had a diagnosis of Psychosis or was being administered an anti-psychotic medication. During an interview on 09/10/25 at 10:28 AM, Unit Manager (UM) was asked if R7 was taking an anti-psychotic medication for psychosis, per the Care Plan. The UM stated, No, that was an error and should have been anti-anxiety instead of anti-psychotic and she did not have a diagnosis of Psychosis. 2. Review of the admission Record located in the Profile tab of the EMR revealed R64 was admitted to the facility on [DATE] with a diagnosis that included anoxic [without oxygen] brain injury. Review of the Order Summary located in the Orders tab of the EMR revealed, 10/24/25 Aspiration precautions.No water from the sink or foam cup at bedside. May drink bottled water. Review of the Order Summary located in the Orders tab of the EMR revealed, 06/26/25 NPO [nothing by mouth] diet, NPO texture, NPO consistency. Review of the 07/25/25 Nutrition Care Plan located in the Care Plan tab of the EMR revealed, R64 is at risk of malnutrition 2/2 [secondary to] anoxic brain injury.dependence on TF [tube feeding] regimen for total nutrition. Interventions included, but not limited to: Provide fluids as ordered: Currently on fluid restriction of 1600 ml [milliliters] Daily.Q8H [every eight hours]. Date initiated on 07/28/25. During an interview on 09/09/25 at 2:15 PM, the UM was shown the Order for bottled water and stated, This is an error. The dietician wrote that order and it is inaccurate as he is NPO. 3. Review of R70's EMR titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE].Review of R70's EMR titled physician Orders located under the Orders tab dated 08/19/25 indicated the resident was to receive insulin Lispro subcutaneous before meals and at bedtime by sliding scale as follows: if 150 - 200 = 0 units and to call the physician if the resident's blood sugar was less than 75; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units and to call the resident's physician if the resident's blood sugar was greater than 400; 401+ = 10 units.Review of R70's EMR titled admission Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident took insulin.Review of R70's EMR titled Medication Administration Record (MAR) located under the Orders tab for the month of 08/25 revealed the resident had a blood sugar result of 11111 on 08/24/25 and on 08/28/25 at 11:00 AM. Review of R70's EMR titled MAR located under the Orders tab for the month of 09/25 revealed the resident had blood sugar result of 11111 on 09/06/25.Review of R70's EMR titled nursing Progress Notes located under the Prog Note tab failed to contain corresponding documentation of the abnormal blood sugar results. During an interview on 09/10/25 at 8:16 AM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) confirmed the blood sugar entry for R70 was incorrect. During an interview on 09/10/25 at 8:17 PM Registered Nurse (RN) 1 confirmed the data entry error and stated she was unaware that there was a code for unapplicable since R70 did not require insulin. NJAC 8:39-4.1(a)NJAC 8:39-5.1(a)