STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315228	A. Building B. Wing	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Court House, LLC	144 Magnolia Drive Cape May Court House, NJ 08210

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 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. Complaint #: 2695513 Based on interviews, medical record review, and review of pertinent facility documents on 12/19/25 and 12/23/25, it was determined that the facility failed to adequately assess and implement measures to protect a resident (Resident #3) who was identified as a high risk for elopement on their initial admission nursing assessment. This deficient practice was identified for 1 of 3 residents (Resident #3) reviewed for elopement risk.This was evidenced as follows:Resident #3 was not at the facility at the time of the survey and a closed record review was conducted. According to the admission Record face sheet (an admission summary), Resident #3 was admitted to the facility with diagnoses which included but were not limited to: cognitive communication deficit, type II diabetes, metabolic encephalopathy (brain dysfunction from a chemical imbalance in the body), and acute kidney failure. A review of the Facility Reported Event (FRE) dated 12/14/25, revealed the following:At 2:30 AM on 12/14/25 while conducting rounds, a Certified Nursing Assistant (CNA #1) observed that Resident #3 was not in their room. A search of the building and grounds was conducted, a head count was completed, and the local police, family, and physician were notified. Resident #3 was contacted and was reportedly safe. It further indicated that Resident #3 stated having a personal matter to attend to and that they were, not aware of the procedure to go out of the policy on pass. Further review of the FRE indicated that Resident #3 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, meaning that the resident's cognition was intact. The FRE also indicated that Resident #3 did not have a care plan, nor interventions, developed to address elopement prior to the event incident. Further review of the FRE included a statement provided by CNA #1 which indicated that CNA #1 heard the resident on a phone call and later felt cold air and that when CNA #1 entered the resident's room, the window was open but the resident was not in the room. FRE stated that CNA#1 then notified the nurse. There were no timeframes provided on the FRE regarding the timeframes the resident left their room.A review of Resident #3's Nursing Comprehensive Assessment (NCA) dated 12/6/25 at 3:04 PM, completed by the Nursing Supervisor (NS #1), included an Elopement Evaluation that indicated that Resident #3 had one elopement attempt that was not successful. It further indicated that the resident had a diagnosis of an anxiety disorder, listed under the .conditions which contribute to elopement risk. section. The evaluation further indicated that the resident was exhibiting behaviors that included periods of restlessness and aggressiveness.A review of Resident #3's Assessment Outcomes, linked to the aforementioned NCA, noted that Resident #3's Elopement Score was an ll.0, which meant the resident was at High-Risk for Elopement.A review of Resident #3's progress notes (PN) did not reveal any mention of the resident's elopement risk.A review of Resident #3's care plan (CP) did not include a focus related to elopement.A review of Resident #3's medical record did not include an Elopement Assessment.During a telephone interview on 12/19/25 at 12:07 PM, NS #1 stated that nursing supervisors were responsible for completing assessments for all new admissions to the facility. NS #1 further stated that the source of information used to complete the NCA for (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 included the resident, medical records received from the sending facility, and report that NS #1 received from the sending nurse. The surveyor reviewed the responses noted in the NCA, which indicated that NS #1 recalled a conversation with a nurse from the transferring facility which described an incident that involved Resident #3 that required security to respond. NS #1 stated that she completed the elopement section based on information she received from the transferring nurse. NS #1 stated that the Elopement Assessment was not completed because they were unsure if the resident had an actual elopement attempt or if it was a behavioral incident.On 12/19/25 at 2:16 PM, the surveyor attempted to conduct an interview with CNA #1, who did not answer.During a telephone interview on 12/19/25 at 2:20 PM, Licensed Practical Nurse (LPN #1) stated that at approximately 2:30 AM, the assigned Certified Nursing Assistant (CNA #1) for Resident #3 approached the nursing desk and stated that the resident was not in their room. LPN #1 further stated that CNA #1 heard the resident arguing on the phone, . was loud for a while, cursing, and then [CNA #1] heard nothing and felt a draft. LPN #1 stated that when she entered Resident #3's room on the second floor, the window was wide open but the resident was not in the room. LPN #1 stated that they then initiated elopement protocol which includes search of facility grounds. LPN #1 further stated while they were searching the facility grounds, they noticed tree branch located directly under the resident's window appeared split, and footsteps were observed on the ground under the window.During a joint interview with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) on 12/19/25 at 2:55 PM, the DON stated that for a resident with a history of elopement, they would complete an assessment and based on the result of the assessment, they would develop and implement interventions based on the resident's needs.On 12/24/25 at 3:04 PM the surveyor received an email that included an Evaluation Outcome dated 12/6/25 at 11:04 PM. This indicated that Resident #3 had an Elopement Risk Score of 99.0, which meant that no risk was identified for that category. This information conflicted with the NCA completed by NS #1. The document also referenced that a PN had been completed, by Licensed Practical Nurse (LPN #2), for the same date and time. A review of the corresponding PN did not reference an elopement history nor an elopement risk. During a follow-up interview with the DON on 12/29/25 at 12:31 PM, the DON confirmed that the record contained conflicting information regarding Resident #3's elopement risk. No evidence was provided that LPN #2 completed an Elopement Assessment.During an interview on 12/29/25 at 12:31 PM, the Medical Director (MD) stated that the expectation was that when a resident was admitted to facility, staff would complete an assessment that included an elopement risk assessment. The MD further stated that if a resident was identified to be an elopement risk, staff would develop and implement appropriate interventions to prevent elopement. A review of the facility's policy titled Elopements and Wandering Residents dated 9/1/24, included Policy: This facility ensures that residents. at risk for elopement receive adequate supervision and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk [.] Policy Explanation and Compliance Guidelines: [.] 3. The facility shall. utilize a systemic approach to monitoring and managing residents at risk for elopement [.] 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: a. Residents will be assessed for risk of elopement and unsafe wandering. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. NJAC 8:39-11.1; 11.2(d); 27.1(a)