STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Point	Three David Brainerd Drive Monroe Township, NJ 08831

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 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, interview, record review, and review of the facility policy, the facility failed to implement residents' care plans related to a mechanical lift transfer (hoyer) for one of 24 sampled residents (Resident (R) 112). This failure placed the resident at risk of harm due to inappropriate transfers.Findings include:Review of the facility's policy titled, Resident Care Plan, dated 10/2024 revealed, .Specific, individualized steps or approaches that staff will take to assist the resident to achieve goals will be listed. Interventions should be short and concise, easy for all staff to follow and serve as a care guide.Review of R112's Face Sheet located on the Home Page of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included a history of multiple sclerosis (MS-a neurological disorder) and vascular dementia with behavioral disturbances.Review of R112's annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/08/24 revealed R112 had a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated R112 was severely cognitively impaired. The MDS also indicated the resident had no upper or lower body range of motion impairment and was totally dependent on one to two staff members for all activities of daily living (ADLs) including transfers.Review of R112's Comprehensive Care Plan, dated 11/02/23 and located in the Care Plan tab of the EMR revealed, .I am at risk for developing skin impairment due to weakness, impaired mobility, and balance, bladder incontinence, pain, multiple sclerosis, and dementia. Interventions included but not limited to: I am a two person assist via Hoyer [mechanical full body] lift, staff will ensure I am being transferred from and to bed via Hoyer with two persons.Review of R112's Facility Investigation, dated 12/23/24 and provided by the facility revealed, [Certified Nurse Aide (CNA) 1's Name] did not use a Hoyer transfer to transfer resident to bed on the 3-11PM shift. This was discovered after interviewing [CNA1's Name] a second time and watching the surveillance footage. This transfer occurred on Saturday 12/21/24 on [the] 3-11PM [shift]. That same day, our investigation revealed that the hospice aide [HCNA] transferred this resident using a Hoyer lift without the assistance of another staff member. Both CNAs are stating that the transfers were without incident. The 11PM to 7AM staff from 12/21/24 to 12/22/24 did not notice any issues during changes that evening. CNA1 was terminated and HCNA was asked not to return to the facility.CNA was asked to review the video footage and her recent statements. CNA1 had reported earlier that she and CNA3 had used the Hoyer lift to transfer the resident to bed between 7-7:30PM. CNA1 reported that no incident occurred. CNA1 then changes her statement too. 'She did not have a Hoyer pad under her this morning. We did Hoyer her [CNA3's Name] and I.' When I asked how they did that [CNA1's Name] changed her statement again. [CNA1] stated, 'She has the Hoyer pad that is removable, and we removed it to use for someone else.' [CNA1] did not answer how they transferred the resident at this time.The video footage timeline was reviewed with [CNA1]. On 12/21/24 at 8:43PM, [CNA1] looks into room [number withheld] and continues (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	down the hall. At 9:05 PM, the Medication Cart and Nurse are at the end of the hall. At 9:08 PM, the Nurse went into the room and left. At 9:52PM, [CNA1] is seen going into the room, placing the dirty linen and garbage bags outside the room. At 9:57 PM [CNA1] is placing linen and garbage into bag. Her phone is in her hand face up. It looks like she is looking at the phone. [CNA1] goes back into the room. At 10:08 PM, [CNA1] placed a blue diaper in the garbage bag. Picks up the dirty linen and garbage and leaves the area.This timeline was reviewed with [CNA1]. Explained to her that I noted her pushing the Hoyer down the hall past [R112's room]. At no time did I see the Hoyer or [CNA3] enter R112's room. I asked [CNA1] again what happened on Saturday, how did you transfer R112 to bed. [CNA1] stated, 'I did not use the Hoyer; I transferred her on my own. Nothing happened.The Facility investigation included that the HCNA was interviewed and verified that she was having difficulty when getting R112 dressed on Saturday 12/21/24. The HCNA was asked how she transferred R112. The HCNA stated, I used the Hoyer lift both days without a second person. I could not find anyone. The HCNA denied having difficulty or incidents related to the transfer.Conclusion: .At this time, on 3 different occasions from 12/21/24 to 12/22/24 the resident's care plan was not followed. Policy and procedures were not followed.During an interview on 07/24/25 at 9:18 AM, the Previous Administrator confirmed that CNA1 was terminated for not following policy and the HCNA was asked not to return to the facility.During an interview on 07/24/25 at 12:27 PM, the HCNA confirmed that she did not use two persons when transferring R112 per the care plan. NJAC 8:39-11.2(e) thru(i)NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure activities of daily living (ADLs) were provided for two of three residents (Residents (R) 2 and R76) reviewed for ADLs out of 24 sampled residents. The facility failed to ensure showers were received per the shower schedule. This failure placed the residents at risk for a diminished quality of life.Findings include: Review of the facility policy titled, Showering the Resident, revised 01/21/25 revealed, A shower will be given to residents as requested or as per the care plan. 1. Review of R2's Face Sheet located on the Home Page of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE]. Review of R2's admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) 06/09/25 revealed R2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 was cognitively intact. The MDS also revealed R2 required substantial/maximum assistance with showering. Review of R2's Care Plan, dated 06/03/25 and located in the Care Plan tab of the EMR revealed, I require assistance with care due to right leg weakness, generalized weakness and impaired mobility. Interventions included:a. I will be evaluated and treated by therapy as indicated.b. Staff will assist me with care daily and as needed.c. Staff will encourage me to participate in my care as I can tolerate.The Care Plan contained no further documentation related to bathing/showering or resident preferences. During an interview on 07/22/25 at 9:01 AM, R2 was lying in bed, awake. His beard was unkempt. R2 was asked if he was receiving his showers weekly. R2 stated, I am only getting one shower a week, I think I am to get two. Review of R2's shower sheet documentation dated from 07/01/25 to 07/22/25 and provided by the facility revealed the resident only received three showers. The documentation revealed the resident did not refuse any showers; however, sink was documented 26 times. Review of R2's CNA Care Plan, dated 06/26/25 and provided by the facility revealed R2 was to receive a shower (his preference) on Monday and Thursdays on the 3:00 PM to 11:00 PM shift and required one staff assist with bathing. 2. Review of R76's Face Sheet located on the Home Page of the EMR revealed R76 was admitted to the facility on [DATE] and readmitted [DATE]. Review of R76's admission MDS located in the MDS tab of the EMR with an ARD of 06/27/25 revealed R76 had a BIMS score of 15 out of 15 which indicated R76 was cognitively intact. The MDS also indicated the resident required substantial/maximum assistance with showering. Review of R76's Care Plan, dated 06/23/25 and located in the Care Plan tab of the EMR revealed, I need assistance with care and functional abilities due to weakness and impaired mobility. Interventions included:a. My personal belongings will be within reach at all times.b. Staff will assist me with care daily and as needed.c. Staff will encourage me to participate in my care as I can tolerate.The Care Plan contained no further documentation related showering/bathing or resident preferences. During an interview on 07/21/25 at 10:47 AM, R76 was sitting up in his wheelchair fully dressed. R76 was asked if he was receiving his showers per the facility schedule or his preferences. R76 stated, I have not received but one shower in the last 11 days. Review of R76's CNA Care Plan, dated 07/12/25 and provided by the DON revealed R76 had a preference for showers, they were to be given on Mondays and Thursdays on the 3:00PM to 11:00PM shift and he required one staff member to assist him. Review of R76's Shower Sheet from 07/01/25 to 07/22/25 and provided by the facility revealed that R76 had refused shower assistance two times (the day he went to the hospital 07/01/25 and the day he returned from the hospital 07/11/25) and was administered one shower on 7/15/25 per the documentation. During an interview on 07/23/25 at 11:39 AM, Certified Nurse Aide (CNA) 5 stated, R76 has been here for about 6 weeks. The first two to three weeks he was in a lot of pain, so we did a bed bath. CNA5 was asked what did the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	word sink mean on the shower sheets. CNA5 stated, I have never heard that terminology before. CNA5 stated that when he worked, he would give R76 a shower. CNA5 was asked when a resident refused a shower, what was the protocol. CNA5 stated, We are to let the nurse know and then reapproach. If they still refuse, I document the shower was refused. During an interview on 07/22/25 at 4:58 PM, The DON stated, There does not seem to be follow-up, by nursing, to ensure showers are being done or documented to show why a shower was not done. The DON was asked what it meant if sink was documented on the shower sheets. The DON stated, A sink is just a clean-up, and is not considered to be a shower.NJAC 8:39-27.1(a)

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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 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 observations, interviews, record review and review of facility policy, the facility failed to provide care and services for two residents (Residents (R) 112 and R44) out of 24 sampled residents. The facility failed to ensure R112 had adequate monitoring and timely medical care after the facility identified discoloration and swelling to R112's right leg which was later identified as a closed right tibial fracture. In addition, the facility failed to ensure R44 received medications as ordered by the provider. These failures placed residents at risk for unmet care needs and a diminished quality of life.Findings include:Review of the facility's policy titled, Change of a Resident's Condition, dated 08/01/01 revealed, .To ensure that when a resident has a change of condition, appropriate assessments are performed, documented and that timely notification of the resident's physician and family occurs.All accidents involving the resident which results in injury and has the potential for requiring physician intervention.A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications).A decision to transfer or discharge the resident from the facility. When a change of condition occurs, the licensed nurse will perform an assessment based on the signs and symptoms the resident is experiencing. 1. Review of R112's Face Sheet located on the Home Page of the electronic medical record (EMR) revealed R112 was admitted to the facility on [DATE] with diagnoses that included a history of multiple sclerosis (MS-a neurological disorder) and vascular dementia with behavioral disturbances. Review of R112's annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 11/08/24 revealed R112 had a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated R112 was severely cognitively impaired. The MDS also indicated the resident had no upper or lower body range of motion impairment and was totally dependent on one to two staff members for all activities of daily living (ADLs) including transfers. In addition, R112 was on scheduled pain medications and had indicators of pain which included vocal and facial expressions of pain for one to two days out of the previous five days during the observation period.Review of R112's Change in Condition note dated 12/21/24 at 2:34 PM, completed by Licensed Practical Nurse (LPN) 2 and located in the Assessments tab of the EMR revealed, I was asked by the aide to come and look at bruising on resident's right lower front leg. I observed bruising and swelling in the area. I asked the resident if she had fallen, she replied no. I also noticed the leg had begin [sic] to ooze at the bruising area. I went to evergreen [another unit in the facility] to inform the supervisor to come assess the resident. She was not there; [sic] I then went to Aspen [another unit in the facility] and couldn't find her. I went to [NAME] [another unit in the facility] and spoke with the Nurse there. We called the supervisor on the phone, and she didn't answer. I asked the nurse if she see [sic] her can she please tell her I am looking for her. I was told by the Nurse on 12/23/24 that the supervisor did come to [NAME] and she [was] informed that I was looking for her and that my resident had swelling and bruising and weeping from her Right leg, however, the supervisor never came to Sandlewood [sic] to see me and I then endorsed to the 3-11PM Nurse of my finding.I applied ice to the area for the swelling.Review of R112's EMR and hard chart revealed no documented evidence LPN2 had notified the physician, had done a skin assessment after the identification of the bruising and swelling, or documented if R112 was having pain and what intervention she performed to control her pain.Review of the Facility Investigation [for R112] provided by the Director of Nursing (DON) revealed, Type: Skin Issue.Reported by: [Licensed Practical Nurse (LPN) 1's Name] on 12/22/24 at 3:15 PM.Location: Unknown; Assigned Caregiver: [Certified Nurse Aide (CNA) 1's Name]; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician notified on 12/22/24 at 3:17 PM.Family notification on 12/22/24 at 3:20 PM.Ambulance called on 12/22/24 at 5:00 PM.Sent to hospital on [DATE] at 9:00 PM.Review of R112's Nurse's Note, dated 12/23/24, completed by LPN1 and located in the Facility Investigation revealed [On 12/22/24] Around 3:15 PM, Day shift nurse reported discoloration on resident's rt [right] lower leg. Upon assessment, noted bluish discoloration on Lt [left] chest wall (4.5 cm [centimeters] x 1.7 cm) and bluish discoloration on rt lower leg (23 cm x 7.5 cm) and edema [swelling] on rt lower leg. Pain was noted when the right lower leg is palpated and with movement. The supervisor assessed the resident's affected area and notified resident's son and hospice nurse. Resident was transferred to [hospital] for RLE [right lower extremity], pain, edema, and bruising.Resident unable to explain due to cognitive impairment.The Conclusion of the Facility Investigation revealed .Team met to discuss the bruise to her left chest wall. Spoke with the hospice aide and she reported that R112 was agitated on Saturday 12/21/24 when getting dressed she was pulling and grabbing at her T-shirt. Aide reports there was a red mark to chest after the incident.At this time R112 is in the hospital for the right lower leg discoloration. Investigation is on-going.R112 returned on 12/24/24 on the 3-11(PM) shift.Investigation was unable to conclude the etiology of the fracture. Resident is non-surgical candidate. Returned with knee brace will follow up with orthopedics. Continues to be a Hoyer lift transfer and Tylenol for pain.Review of the 12/22/24 at 11:02 PM Hospital Records provided by the DON revealed, Chief complaint R leg swelling. On arrival here, the knee and RLE [right lower extremity] are discolored and R knee swollen. ED [Emergency Department] spoke with the facility and they denied any trauma. She is essentially bedbound/wheelchair bound; except for transfers. Patient is comfortable. Imaging here suggests proximal [closer to the center of the body] tibial [shin] fracture.During an interview of 07/24/25 at 8:30 AM, Unit Manager (UM) 1 was asked if she remembered the incident from 12/21/24 and 12/22/24 regarding R112's right leg fracture. UM1 stated, I really do not remember the event. I do remember that on 12/23/24 when she went out to the hospital, she was having pain or a bruise, I think. I remember she (LPN2) had not come looking for me. People came to me and stated that no one came looking for me. UM1 was asked if she made rounds on the Sandalwood unit on Saturday 12/21/24. UM1 stated, I did not make rounds on Sandalwood in the morning but, I did make rounds in the afternoon. I was not made aware that there were any problems.During an interview on 07/24/25 at 9:18 AM, the Previous Administrator was asked why there was a delay in treatment on 12/22/25 from 5:00 PM when the ambulance was called to 9:00 PM before R112 had left in the ambulance. The Previous Administrator stated, I can only guess it was a non-emergent transfer.During an interview on 07/24/25 at 12:27 PM, Hospice CNA (HCNA) was asked about the incident involving R112 on 12/21/24 and 12/22/24. The HCNA stated, I was the aide the morning of the 21st on the 7-3 shift. I usually start at about 6:00 am. Everything was fine. I returned on 12/22/24 at the same time and when I saw [R112's Name], she was all 'tucked in tightly.' I went to get my supplies and her clothes and when I uncovered her and took her gown off, I noticed that the knee was swollen, and the bottom of the foot was bruised. The HCNS further stated, I went to tell the nurse around 7:00AM-7:30 AM about the swelling and the bruise. The nurse left the medication cart, and she followed me to the room. I brought R112 to the dining table for breakfast and I told the nurse she was in pain, and she said she would give her something. I don't know if she did or not as I went on to care for my other residents there.Review of R112's December 2024 Medication Administration Record (MAR) revealed R112 had received, Tylenol 325 mg [milligrams]. Give (2) tablets one time daily before wound care. Dated 11/01/23. Documentation showed that she received this dose of Tylenol as scheduled but the time of the administration is unknown per the EMR. In addition, R112's MAR showed that she had as needed medications for pain which included Morphine and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	release (1 tablet) .extended release 24 HR [hour] oral one time daily for overactive bladder. The MAR revealed the pyridoxine was not administered to the resident on 02/23/25; and the Myrbetriq was not administered to the resident on 02/08/25 nor on 02/09/25. The MAR indicated the medications were .not administered (pharmacy called-med being delivered).Review of R44's Pharmacy Order Details provided by the facility revealed the pyridoxine was ordered from the pharmacy on 02/23/25, the same day the resident missed the dose of medication due to the facility not having in on hand. The Pharmacy Order Details also revealed the resident's Myrbetriq was ordered from the pharmacy on 02/09/25 two days after the facility ran out of the mediation.Review of R44's MAR, dated March 2025 and located in the EMR under the MAR tab revealed the resident was ordered diltiazem ER 120 mg capsule, 24 hr, extended release (1 capsule).oral one time daily. for A-Fib. The MAR indicated the medication was not administered to the resident on 03/09/25 nor on 03/24/25. The MAR also indicated the mediation was .not administered (pharmacy called-med being delivered). Review of R44's Pharmacy Order Details provided by the facility revealed the diltiazem was ordered from the pharmacy on 03/09/25 and 03/24/25, the same days the resident missed the doses of medication due to the facility not having in on hand.Review of R44's MAR, dated May 2025 and located in the EMR under the MAR tab revealed the resident was ordered Cinacalcet (used to regulate mineral imbalances) 60 mg tablet (1 tab) .oral one time daily. for hyperparathyroidism and ergocalciferol (vitamin D2) 1,250 mcg (50,000 unit) capsule (1 capsule) .one time weekly starting.for a supplement. The MAR revealed the Cinacalcet was not administered to the resident on 05/26/25; and the ergocalciferol was not administered to the resident on 05/26/25. The MAR indicated the medications were .not administered (pharmacy called-med being delivered). Review of R44's Pharmacy Order Details provided by the facility revealed the Cinacalcet was ordered from the pharmacy on 05/26/25, the same day the resident missed the dose of medication due to the facility not having in on hand. The Pharmacy Order Details also revealed the resident's ergocalciferol was ordered from the pharmacy on 05/26/25 the same day the resident missed the dose of medication due to the facility not having in on hand.Review of R44's MAR, dated June 2025 and located in the EMR under the MAR tab revealed the resident was ordered diltiazem ER 120 mg capsule, 24 hr, extended release (1 capsule) . oral one time daily.for A-Fib [atrial fibrillation] and Myrbetriq 25 mg tablet, extended release (1 tablet) .oral one time daily.for overactive bladder. The MAR revealed the diltiazem was not administered to the resident on 06/03/25; and the Myrbetriq was not administered to the resident on 06/03/25. The MAR indicated the medications were .not administered (pharmacy called-med being delivered). Review of R44's Pharmacy Order Details provided by the facility revealed the diltiazem was ordered from the pharmacy on 06/03/25, the same day the resident missed the dose of medication due to the facility not having in on hand. The Pharmacy Order Details also revealed the resident's Myrbetriq was ordered from the pharmacy on 06/01/25 the same day the facility did not have the medication on hand for the medication to be administered. The medication was delivered on 06/03/25; however, the medication was not administered to the resident on 06/01/25 nor on 06/03/25.During an observation on 07/21/24 at 12:09 PM, R44 was in her room sitting in her wheelchair, dressed and groomed. R44 was asked if she received her medications timely. R44 responded, some days, not always as her blood pressure and other medications were not given because they run out due to poor planning. R44 stated she was especially concerned about her blood pressure medication and the effect it could have on her blood pressure. R44 stated so far, her blood pressure had been okay. During an interview on 07/23/25 at 4:33 PM, Unit Manager (UM) 1 was asked why R44's January 2025 through June 2025 MARs revealed medications were not administered (pharmacy called- med being delivered) but the nurse initialed the med for that day. UM1 stated the pharmacy was late getting the medication delivered to them, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Point	Three David Brainerd Drive Monroe Township, NJ 08831

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stating for example if they call that day, the pharmacy may not get it until after the dose was due. UM1 stated the nurse should be ordering the medication three to five days ahead of time before running out. UM1 stated they do have a medication machine the nurse could have gotten a backup medication, but it should have been documented on the MAR. During an interview on 07/24/25 at 10:40 AM, the Director of Nursing (DON) was asked how far in advance should staff reorder medications. The DON stated she instructed the staff to reorder them a week in advance. The DON was asked if she was aware some of R44's medications were not administered due to not being reordered timely. The DON stated she was only aware of R44's blood pressure medication because the facility paid for it. However, the DON was not aware of other medications. The DON was asked if she completed audits and she stated she reviewed the pharmacy reports. During a follow up interview on 07/24/25 at 11:08 AM, UM1 was asked about the notes at the end of R44's January through June 2025 MARs that listed medications that were not administered. UM1 reviewed the MARs and stated some of the medications were stock medications and the nurse could have retrieved them from the stock. UM1 was asked if that was the case, why was the medication not administered. UM1 then checked the nurses' names on the MARs and stated the nursing staff that failed to reorder timely or use the stock medications, were agency nurses and they must not have been educated on the process. UM1 asked if the agency nurse was on duty and she stated, No. During an interview on 07/24/25 at 5:24 PM, the Clinical Implementation Analyst (CIA) was asked to run a report for R44's medications listed on the last page of the January 2025 MAR to confirm if they were or were not administered as the nurse had initialed the MAR but also documented a note that stated the medication was not administered. The CIA reviewed the 01/20/25 date for ergocalciferol (vitamin D2) and the 01/04/25 and 01/24/25 dates for potassium citrate-citric acid. These dates were highlighted in red. The CIA stated the red meant the medications were not administered and the nurse's initials did not confirm the medication was given. CIA stated if the other MARs had the same note not administered the date would be red as well for the medications not administered. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Village Point		STREET ADDRESS, CITY, STATE, ZIP CODE Three David Brainerd Drive Monroe Township, NJ 08831	

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 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 interview, record review, and review of the facility policy, the facility failed to ensure the medical record was complete and accurate for one resident (Resident (R) 5) out of 24 sampled residents. This failure placed the residents at risk for unmet care needs.Findings include:Review of the facility's policy titled, Charting and Documentation, dated 01/10/25 revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.Review of R5's Face Sheet located on the Home Page of the electronic medical record (EMR) revealed that R5 was admitted to the facility on [DATE] with diagnoses that included right hip fracture with hip replacement.Review of R5's admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 06/12/25 revealed R5 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 was cognitively intact.Review of R5's Care Plan, dated 06/06/25 and revised on 07/09/25 revealed, I have the potential for infection and retention due to the use of an indwelling catheter in my bladder, due to urinary retention. Interventions included:a. a. Staff will provide foley catheter care every shift.b. b. Staff will assess me for bladder distention dribbling or feelings of bladder fullness.c. c. Staff will confer with MD regarding the continued need for a catheter.d. d. Staff will maintain a closed, sterile system ensuring that the tubing is free of kinks.e. e. Staff will monitor my urine appearance noting color, amount, and clarity every shift.Review of R5's Physician Order, dated 07/07/25 and located in the resident's EMR under the Orders tab indicated that the Indwelling Urinary Catheter was removed on 07/07/25.Review of R5's Urinalysis Laboratory Report, dated 07/14/25 and located in the hard chart revealed that R5 had an abnormal urinalysis report which indicated per the culture on 07/15/25 that R5 had bacteria in her urine and would require antibiotics.Review of R5's Physician Order, dated 07/17/25 and located in the hard chart revealed, Cipro [an antibiotic] 500 mgs [milligrams] to give twice daily for seven days for a Urinary Tract Infection (UTI).Review of R5's Assessments tab in the EMR showed no documentation as to what symptoms R5 was having or the reason for the Urinalysis test.Review of R5'sSkilled Nursing Documentation, dated 07/18/25 and located in the EMR under the Assessments tab revealed antibiotic was checked however, there was no narrative at the bottom of the page to indicate why R5 was on an antibiotic.During an interview on 07/23/25 at 3:04 PM, the Director of Nursing (DON) stated, I did not find a note [from the nurses] regarding the signs/symptoms of the UTI. It was noted on the 24-hour report that the specimen was obtained. I spoke to [Registered Nurse (RN) 2's Name] who stated that the resident had complained to the doctor about her cloudy urine on the 17th [07/17/25]. The DON was asked if there should be a progress note or change of condition note in the EMR. The DON stated, Yes, there should have been a progress note in the EMR. NJAC 8:39-35.2