STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315005	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Grove Rehabilitation and Healthcare Center	144 Gales Drive New Providence, NJ 07974

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 6 of 37 residents reviewed for accommodation of needs (Resident #70, #15, #1, #48, #13, and #86), and was evidenced by the following: a. On 10/22/24 at 10:43 AM, the surveyor observed Resident #70 in bed, with his/her eyes closed. Resident #70 did not respond to the surveyor's greeting. The surveyor observed the resident's call bell (a bell used to summon staff for assistance) was not within the Resident's reach. On 10/23/24 at 12:59 PM, the surveyor observed Resident #70 in bed with his/her eyes closed. Resident #70 did not respond to the surveyor. The surveyor observed the resident's call bell was not within the Resident's reach. The surveyor reviewed the medical record for Resident #70. A review of Resident #70's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to dementia, diabetes mellitus and chronic obstructive pulmonary disease (a lung disease which causes permanent lung damage and breathing difficulties). A review of Resident #70's annual Minimum Data Set (MDS) an assessment tool dated 4/8/24 revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated Resident #70 had a severe cognitive impairment. The MDS further revealed that the resident required staff assistance and or supervision for activities of daily living (ADLs). A review of Resident 70's individualized care plan (ICP) initiated on 4/2/23 included a focus area: resident is at risk for falls with interventions which included but were not limited to: be sure call light is within reach and provide reminders to use call bell for assistance as needed. On 10/24/24 at 1:30 PM, the surveyor observed Resident #70 in bed with his/her eyes closed. The surveyor observed Resident #70's call bell on the floor behind the resident's bed. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 1:35 PM, the surveyor accompanied by the Certified Nursing Assistant (CNA #1) assigned to care for Resident #70, entered the resident room. The surveyor and the CNA observed Resident #70's call bell on the floor under the resident's bed. The CNA confirmed that she should have checked to ensure that the call bell was within the resident's reach. b. On 10/23/24 at 1:15 PM, the surveyor observed Resident #15 in bed. The surveyor observed the call bell was under the resident's bed not within the resident's reach. On 10/24/24 at 8:00 AM, the surveyor in the presence of the Registered Nurse (RN #1), observed Resident #15's call bell under the resident's bed not within the resident's reach. The RN stated, it's stuck and further stated that it should have been clipped to the bed and kept within the resident's reach. The surveyor reviewed the medical record for Resident #15. A review of Resident #15's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to dementia, diabetes mellitus and repeated falls. A review of Resident #15's admission MDS dated [DATE] revealed Resident #15 had a BIMS score of 3 out of 15 which indicated Resident #15 had a severe cognitive impairment. The MDS further revealed that the resident required staff assistance and or supervision for activities of daily living. A review of Resident 15's ICP initiated on 5/10/24 included a focus area: resident is at risk for falls with interventions which included but were not limited to: be sure call light is within reach and provide reminders to use call bell for assistance as needed. c. On 10/23/24 at 1:20 PM, the surveyor observed Resident #1 was out of bed seated in a geriatric chair in his/her room. The surveyor observed the call bell was positioned in the middle of the resident's bed, not within the resident's reach. On that same day, at that same time, the surveyor observed RN #2 entered Resident #1's room. The surveyor showed RN #2 the call bell and asked RN #2 if the call bell should have been positioned so that the resident could reach it. RN #2 did not respond verbally to the surveyor's inquiry and positioned the call bell within Resident #1's reach. The surveyor reviewed the medical record for Resident #1. A review of Resident #1's Admission Record revealed Resident #1 was admitted to the facility with diagnoses which included but were not limited to acute respiratory failure, diabetes mellitus, chronic obstructive pulmonary disease and dementia. A review of Resident #1's most recent Minimum Data Set (MDS), an assessment tool, dated 9/20/24 revealed Resident #1 had short-term and long-term memory problems and had a severe cognitive impairment. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's ICP initiated on 5/25/24 included a focus area: Resident is at risk for falls with interventions which included but were not limited to: Be sure call light is within reach and provide reminders to use call bell for assistance as needed. d. On 10/24/24 at 7:50 AM, the surveyor and RN #1 entered Resident #48's room and observed Resident #48 in bed with their call bell on the floor under the bed, not within the resident's reach. RN #1 confirmed that the call bell should be kept within the resident's reach. A review of Resident #48's Admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited dementia, depression and an overactive bladder. A review of Resident #48's quarterly MDS dated [DATE] revealed Resident #48 had a BIMS score of 7 out of 15 which indicated Resident #48 had a severe cognitive impairment. The MDS further revealed that the resident required staff supervision and or assistance for ADLs. A review of Resident 48's ICP initiated on 11/13/23, included a focus area: Resident has an ADL Self Care Performance Deficit with interventions which included but were not limited to: Encourage me to use call bell for assistance. e. On 10/24/24 at 7:53 AM, the surveyor accompanied by RN #1 observed Resident #13 in bed. The surveyor and RN #1 observed Resident #13's call bell was behind the headboard, hanging down towards the floor. RN #1 stated that the call bell was stuck behind the bed and should have been within the resident's reach. A review of Resident #13's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to hypertension and chronic obstructive pulmonary disease. A review of Resident #13's most recent MDS revealed Resident #13 had a BIMS score of 2 out of 15 which indicated Resident #13 had a severe cognitive impairment. The MDS further revealed that the resident required staff supervision/ assistance for ADLs. A review of Resident 13's ICP initiated on 11/8/23, included a focus area: Resident has an ADL Self Performance Deficit with interventions which included but were not limited to: Encourage me to use call bell for assistance. f. On 10/24/24 at 8:00 AM, the surveyor accompanied by RN #1 observed Resident #86 in bed. The surveyor and RN #1 observed Resident #86's call bell was behind the headboard not within the resident's reach. A review of Resident #86's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to dementia and cognitive communication deficit. A review of Resident #86's admission MDS revealed Resident #86 had a BIMS score of 4 out of 15 which indicated the resident had a severe cognitive impairment. The MDS further revealed that the resident required staff assistance for ADLs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 86's ICP initiated on 7/3/24, included a focus area: I have an ADL Self Care Performance Deficit with interventions which included but were not limited to: Encourage me to use the call bell for assistance. On 10/24/24 at 8:10 AM, the surveyor interviewed RN #1 who stated that the nurses and CNAs should ensure that the call bells are always kept within the resident's reach. The surveyor attempted phone interviews with the assigned 11 PM-7 AM, CNAs for Residents #15, #48, #13, and #86. The surveyor left messages for both CNAs with no return calls. On 10/24/24 at 1:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns. The DON confirmed that call bells should be kept within the resident's reach. A review of the facility policy entitled, Answering the Call Light undated, reflected .The purpose of this procedure is to ensure timely responses to the resident's requests and needs . NJAC 8:39-31.8 (c)(9)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 19106 Based on observation, interview and record review, it was determined that the facility failed to issue the required Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and/or the Notice of Medicare Non-coverage (NOMNC) for 3 of 3 residents (#82, #349, #348) reviewed for facility change notifications regarding insurance termination. The evidence is as follows. On 10/28/24 at 11:28 a.m., the facility presented the surveyor with a list of residents who were discharged from the facility within 6 months and were required to have received Beneficiary Notices. The surveyor reviewed 3 of the residents listed (Resident #82, #349, #348) who were discharged from a Medicare Part A stay at the facility and were documented as having a discontinuation of their Medicare Part A insurance payment to the facility. Resident #82's last documented day of coverage for Medicare Part A service was 4/28/24. The resident elected to stay in the facility. The facility was required to provide both a SNF ABN form and a NOMNC form to the resident/responsible party. The facility provided a NOMNC, however, they did not present the resident with the required SNF ABN form to notify them of the termination of insurance. Resident #349's last documented day of coverage for Medicare Part A service was 6/27/24. The resident elected to stay in the facility. The facility was required to provide both a SNF ABN form and a NOMNC form to the resident/responsible party. The facility provided a NOMNC, however, they did not present the resident with the required SNF ABN form to notify them of the termination of insurance. Resident #348's last documented day of coverage for Medicare Part A service was 5/22/24. The resident was discharged either to home or to a lesser level of care. The facility was required to provide a NOMNC form to the resident/responsible party. A NOMNC was not presented to the resident. On 10/29/24 at 11:00 a.m., the surveyor informed the Administrator and the Director of Nursing of the above-noted concerns regarding insurance termination notification omissions. The Administrator stated there was a change in social service staff who were responsible for providing notification to residents which may have caused the errors. No additional information was provided. NJAC 8:39-5.4 (b)(c)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34421 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) discontinue a treatment order for a healed wound and b.) follow a physician's treatment order. The deficient practice was identified for 1 of 18 residents (Resident # 50) reviewed for physician orders and is evidenced by the following. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. On 10/22/24 at 1:30 PM, the surveyor observed Resident # 50 lying in bed alert and awake and able to make their needs known. On 10/23/24 at 1:30 PM, the surveyor reviewed the following medical records. The Admission Record revealed the following diagnoses, which included but were not limited to, atherosclerotic heart disease, acute and chronic systolic congestive heart failure and essential hypertension. The Minimum Data Set assessment tool (MDS) dated [DATE] revealed the brief interview for mental status (BIMS) score was 15 of a possible 15 indicating no cognitive deficits. The October 2024 Order Summary Report included two physician's orders as follows. Clean toe web spaces well with soap and water and place gauze in each web space to wick moisture daily every day shift for moisture. Cleanse right buttock deep tissue injury (DTI) with normal saline solution (NSS) and apply foam cover daily every day shift for DTI. The October 2024 Treatment Administration Record (TAR) indicated the nurse continued to sign the treatment order daily for the right buttock up to and including on 10/23/24. The 9/21/24 Wound Assessment Report noted that the right buttock wound had resolved. On 10/23/24 at 12:10 PM, the surveyor interviewed the Registered Nurse (RN) Supervisor. The surveyor and the RN Supervisor reviewed the resident's treatment orders which included the order for the right buttock DTI and the order for gauze placement in between toes. The RN Supervisor confirmed that nursing continued to sign the TAR daily up to and including on 10/23/24 even though the buttock wound was documented to have healed on 9/21/24. Additionally the treatment for gauze placement was signed as performed on 10/23/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that same time, the surveyor and the RN Supervisor went to the resident's room. The resident was interviewed and stated they were not receiving any wound treatments. The RN Supervisor inspected the resident's right buttock area and the resident's feet. The RN Supervisor confirmed there was no dressing on the right buttock or gauze placed in between the toes. On 10/23/24 at 1:20 PM, the surveyor discussed with the Director of Nursing the concerns regarding physician treatment orders. NJAC 8:39-27.1 (a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Complaint # NJ 172317, NJ 172237; NJ 174618; NJ 175890 Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 7 of 8 residents (Resident #82, #199, #48, #13, #86, #24, and #14) observed for incontinence care on 2 of 4 units (North Unit and [NAME] Unit). This deficient practice was evidenced by the following: On 10/24/24 at 7:35 AM, the surveyor completed an incontinence tour on the North Unit and observed the following: a. On 10/24/24 at 7:40 AM, the surveyor accompanied by Registered Nurse (RN #1) observed Resident #82 in bed. RN #1 exposed Resident #82's incontinence brief. At that time when RN #1 exposed the incontinence brief another incontinence brief was observed which was saturated with urine. RN #1 stated that no resident should be wearing two incontinence briefs. A review of Resident #82's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to dementia, diabetes mellitus, and anxiety disorder. A review of Resident #82's admission Minimum Data Set (MDS) an assessment tool dated 3/14/24 revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated Resident #82 had a severe cognitive impairment. The MDS further revealed that the resident required assistance from staff for personal hygiene, and he/she was frequently incontinent of bowel and bladder. A review of Resident 82's Individualized Care Plan (ICP) initiated on 3/12/24 included a focus area: Activities of Daily Living (ADL) self care deficit with interventions that included but were not limited to: resident is dependent on staff for toileting. b. On 10/24/24 at 7:45 AM, the surveyor accompanied by RN #1 observed Resident #199 in bed. RN #1 exposed Resident #199's incontinence brief. At that time when RN #1 exposed the incontinence brief another incontinence brief was observed which was saturated with urine. RN #1 stated that it did not appear as if the night aide had changed the resident recently. A review of Resident #199's admission record reflected Resident #199 was admitted to the facility with diagnoses which included but were not limited to Parkinson's Disease, dementia and anxiety disorder. A review of Resident #199's admission MDS dated [DATE] revealed Resident #199 had short-term and long-term memory problems and was assessed as having a moderate cognitive impairment. The MDS further reflected that Resident #199 required supervision from staff for personal hygiene, and was frequently incontinent of urine and bowel movements. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 199's ICP initiated on 10/15/24 included a focus area: Resident has bowel and bladder incontinence with interventions which included but were not limited to: check resident approximately every 2 hours and provide incontinence care as needed. c. On 10/24/24 at 7:50 AM, the surveyor accompanied by RN #1 observed Resident #48 in bed. The surveyor observed that Resident #48's adult pull- up was saturated with urine. The surveyor and RN #1 observed that Resident #48's sheets were also saturated with urine. A review of Resident #48's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited dementia, depression and an overactive bladder. A review of Resident #48's quarterly MDS dated [DATE] revealed Resident #48 had a BIMS score of 7 out of 15 which indicated Resident #48 had a severe cognitive impairment. The MDS further revealed that the resident required staff supervision for personal hygiene, and he/she was occasionally incontinent of bowel and bladder. A review of Resident 48's ICP initiated on 11/21/23, included a focus area: Resident is on diuretic therapy with interventions which included but were not limited to: Resident may need to void frequently and quickly. Routinely check and offer/provide toileting assistance. d. On 10/24/24 at 7:53 AM, the surveyor accompanied by RN #1 observed Resident #13 in bed. RN #1 exposed Resident #13's pull up. At that time when RN #1 exposed the pull up an incontinence brief was observed under the pull up. The surveyor and RN #1 observed both the pull up and incontinence brief were saturated with urine. The surveyor and RN #1 observed Resident #13's perineal area was very red. RN #1 stated that no resident should be wearing a diaper and pull up as it could cause skin breakdown. A review of Resident #13's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to hypertension and chronic obstructive pulmonary disease (a lung disease that causes permanent damage to the lungs.) A review of Resident #13's most recent MDS revealed Resident #13 had a BIMS score of 2 out of 15 which indicated Resident #13 had a severe cognitive impairment. The MDS further revealed that the resident required staff supervision for personal hygiene, and he/she was frequently incontinent of bowel and bladder. A review of Resident 13's ICP initiated on 11/16/23, included a focus area: Resident is on diuretic therapy with interventions which included but were not limited to: Resident may need to void frequently and quickly. Routinely check and offer/provide toileting assistance. e. On 10/24/24 at 8:00 AM, the surveyor accompanied by RN #1 observed Resident #86 in bed. RN #1 exposed Resident #86's incontinence brief. At that time when RN #1 exposed the incontinence brief another incontinence brief was observed. The surveyor and RN #1 observed both incontinence briefs were saturated with urine. The surveyor and RN #1 observed Resident #86's blanket was also saturated with urine. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #86's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to dementia and cognitive communication deficit. A review of Resident #86's admission MDS revealed Resident #86 had a BIMS score of 4 out of 15 which indicated Resident #86 had a severe cognitive impairment. The MDS further revealed that the resident required staff assistance for personal hygiene, and he/she was frequently incontinent of bowel and bladder. A review of Resident 86's ICP initiated on 7/3/24, included a focus area: Resident has bowel and bladder incontinence with interventions which included but were not limited to: check resident approximately every two hours and provide incontinence care as needed. On 10/24/24 at 8:10 AM, the surveyor interviewed RN #1 who stated that the facility policy was to use only one incontinence brief as two briefs could cause the resident's skin to breakdown. RN #1 further stated that incontinence care should be provided every two hours. f. On 10/24/24 at 8:15 AM, the surveyor observed RN #2 during medication administration observation on the North unit. The surveyor observed RN #2 prepared to administer an injection in Resident #24's abdomen. RN #2 exposed Resident #24's incontinence brief. At that time the surveyor and RN #2 observed another incontinence brief. The surveyor and RN #2 observed both incontinence briefs were saturated with urine. RN #2 stated that residents should not be wearing two incontinence briefs as it could cause skin breakdown. A review of Resident #24's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to dementia, muscle weakness and hypertension. A review of Resident #24's quarterly MDS revealed Resident #24 had a BIMS score of 3 out of 15 which indicated Resident #24 had a severe cognitive impairment. The MDS further assesses that the resident required moderate staff assistance for personal hygiene, and he/she was frequently incontinent of bowel and bladder. A review of Resident 24's ICP initiated on 10/29/21, included a focus area: Resident has episodes of incontinence of bowel and bladder with interventions which included but were not limited to: Check and change resident as needed. On 10/24/24 at 8:30 AM, the surveyor interviewed RN #2 who stated the facility policy was for the residents not to be double diapered and that they should be provided incontinence every 2 hours. g. On 10/24/24 at 10:30 AM, during the resident council meeting, Resident #14 stated that staff used a mechanical lift to transfer her/him from the bed to the wheelchair and that once he/she was lifted out of the bed into the chair she/he has to stay there and doesn't receive incontinence care until she/he was transferred back to bed in the evening. The resident stated that if she/he requested to go back to bed to be changed the staff would refuse to transfer her/him back into the chair and therefore stay in bed for the remainder of the day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 12:20 PM, the surveyor interviewed Resident #14 who stated that she/he was transferred out of bed with the mechanical lift at approximately 8:30 AM. The Resident confirmed that she/he had not received any incontinence care since that time. A review of Resident #14's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to chronic kidney disease, depression and overactive bladder. A review of Resident #14's annual MDS dated [DATE] revealed Resident #14 had a BIMS score of 15 out of 15 which indicated Resident #14's cognition was intact. The MDS further revealed that the resident was dependent on staff for toileting hygiene, and he/she was always incontinent of bowel and bladder. A review of Resident 14's ICP initiated on 10/30/2023, included a focus area: resident has bowel and urinary incontinence with interventions which included but were not limited to: check resident approximately every 2 hours and provide incontinence care as needed. On 10/24/24 at 12:30 PM, the surveyor interviewed the Certified Nursing Assistant on [NAME] Unit (CNA-W) assigned to provide care for Resident #14, who stated that she provided incontinence care for all residents every 2 hours which included residents who required mechanical lifts for transfers. The surveyor asked CNA-W if Resident #14 was incontinent of bowel and bladder. The CNA-W confirmed that she/he was. The surveyor asked the CNA why she had not provided incontinence care for Resident #14. The CNA replied it was because the resident had not asked to be changed. On 10/24/24 at 12:50 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the care of Resident #14 who stated that the facility policy was to provide incontinence care every 2-2 1/2 hours to all residents who were incontinent of bowel and or bladder. The surveyor stated that the CNA had not provided incontinence care for Resident #14 since that morning. The LPN replied that Resident #14 was alert and oriented and did not ask to be changed. On 10/24/24 at 12:55 PM, the LPN and CNA transferred Resident #14 back to bed with the use of a mechanical lift. The CNA exposed the incontinence brief and at that time, the LPN, CNA and surveyor observed a second incontinence brief in place. The surveyor, LPN and CNA all observed that both incontinence briefs were saturated with urine. At that same time, the resident stated that she/he requested 2 incontinence briefs because by the evening when she/he gets transferred back to bed she is saturated with urine. She/he further stated that even her/his clothing and mechanical lift pad were saturated with urine. Resident #14 stated that she/he bought a new spray to use on the mechanical lift pad so that he/she did not smell like urine. On 10/24/24 at 1:00 PM, the LPN stated that it was unacceptable that Resident #14 was saturated with urine and further stated that even though the resident was alert and oriented she/he should be offered incontinence care and be permitted to get back out of bed if that was her/his preference. On 10/24/24 at 1:54 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns. The DON confirmed that incontinence care should be provided every 2 hours on all shifts and that if residents requested 2 incontinence briefs it should be care planned. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Grove Rehabilitation and Healthcare Center	144 Gales Drive New Providence, NJ 07974

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor attempted phone interviews with the assigned 11 PM-7 AM, CNAs for Resident #82, #199, #48, #13, #86, and #24. The surveyor left messages for both CNAs with no return calls. A review of the facility's Urinary and Fecal Incontinence policy, undated reflected .the purpose of this procedure is to provide guidelines that will aid in preventing the resident's exposure to urine and feces . NJAC 8:39-27.1 (a), 27.2 (h)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45449 Complaint# NJ 174618 Based on interview, review of closed medical records, and review of pertinent facility documents, it was determined that the facility failed to ensure appropriate care was provided with no delay in treatment for a resident who sustained an injury during rehabilitation therapy on 2/23/24, complained of pain and was not assessed by a Registered Nurse until 2/25/24 (two days later), and the physician ordered an x-ray which indicated a non-displaced fracture of the medial malleolus (ankle fracture). This deficient practice was identified for 1 of 3 closed medical records reviewed (Resident #101), and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 10/24/24 at 10:00 AM, the surveyor reviewed the closed medical record for Resident #101. According to the Admission Record face sheet, an admission summary, reflected that Resident #101 was admitted to the facility with diagnoses that included; acute embolism (obstruction of an artery), thrombosis (blood clot in an artery or vein) of unspecified deep veins of unspecified lower extremity, and displaced bimalleolar fracture (a break in the ankle), acquired during the resident's stay in the facility. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 3/6/24, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the resident's functional range in motion reflected the resident had a lower extremity impairment (hip, knee, ankle, foot) to one side. Further review of the MDS revealed Resident #101 experienced frequent pain that caused difficulty to sleep and limited the resident's participation in rehabilitation (rehab) therapy sessions. The pain level measurement intensity was 6 out of 10, with 10 being the highest pain intensity and the resident received an as needed (PRN) pain medication or was offered and declined. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the individual comprehensive care plan included a focus area for pain, initiated on 1/24/24. The interventions included to administer analgesia (pain relief medication) per orders, observation of effectiveness, initiated on 1/24/24. A review of the Physical Therapy Treatment and Encounter Note (PT/TEN) dated and signed by the Physical Therapist (PT) and the Physical Therapy Assistant (PTA) on 2/23/24 at 5:07 PM, included that Resident #101 was moving about with contact guard assist (physical therapist uses one or two hands to help the patient perform a functional action, with no additional support required), then rolled on their ankle. At that time, the resident did not verbalize pain and did not convey nonverbal communication of pain. A treatment of cryotherapy (ice) and [brand name redacted] bandage wrapping was applied to the left ankle. The PT/TEN did not include documentation that the nursing staff and the physician were informed of the sustained injury. A review PT/TEN signed by the PT and the PTA dated 2/24/24 at 2:36 PM, included that Resident #101 was seen for physical therapy and was noticed to have a swelling on the left ankle. The resident complained of pain upon movement with an intensity of 9 out of 10 (severe), and pain at rest with an intensity of 4 out of 10 (moderate). The bandage was removed due to increased swelling and the left lower extremity was elevated with pillows in bed. The PT/TEN reflected that the nurse was notified of the left ankle swelling and of the resident's verbalized pain. A review of the Nursing Progress Notes (NPN) did not include any documentation/data entry made by the nursing staff on 2/24/24, regarding the resident's pain or injury. A review of the February 2024 electronic Medication Administration Record (MAR) included a physician's order dated 1/23/24, for Tylenol 325 milligram (mg; a pain relief medication); give 2 (two) tablets by mouth every 6 (six) hours PRN for mild pain (1-3). Tylenol was administered on 2/25/24 at 4:00 PM. There was no documented administration of pain medication from 2/23/24, until the Tylenol received on 2/25/24 at 4:00 PM. Further review of the MAR revealed that the nurses documented every shift on 2/23/24 through 2/25/24, that the resident was assessed with no pain, which contradicted the PT/TEN from 2/24/24 at 2:36 PM. A review of the Nursing Daily Skilled Pathway (a daily head to toe assessment/evaluation of the resident) that included skin/wound and pain assessments did not include a daily assessment on 2/24/24. A review of the NPN dated 2/25/24 at 4:00 PM, reflected a documentation made by the Registered Nurse (RN #2) that included, Resident #101 was in bed awake, alert, oriented to person, place, and time. Resident #101 was quoted I twisted my ankle whilst at therapy on Friday, therapy and nursing staff were aware. The nurse assessed Resident #101's ankle, and observed it was red, warm, and edematous (swollen with fluid). The NPN further revealed that the physician was notified, who ordered an x-ray, (radiology imaging to diagnose and treat) and Tylenol 325 mg, two (2) tablets were administered (on 2/25/24 at 4:00 PM) and documented that the Tylenol was effective on 2/25/24 at 5:43 PM. At 8:30 PM, the x-ray was taken, and the resident denied pain at that time. At 11:45 PM, the physician was made aware of the x-ray result of non-displaced fracture of the medial malleolus (ankle fracture without bone displacement), and the physician ordered a transfer of Resident #101 to the emergency room for evaluation. A review of the Radiology Result Report dated 2/25/24 at 9:32 PM, reflected the resident had a non-displaced fracture of the medial malleolus. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the Accident/Incident Report signed 2/27/24, for an incident that occurred on 2/23/24, included the following: A review of the PTA statement included that the resident twisted their ankle during rehab. The PTA documented that while Resident #101 was moving with the rollator (mobility aid that helps people with limited mobility walk longer distances) the resident informed the PTA that they had twisted their ankle. The PTA seated the resident, observed no swelling, and applied a precautionary therapy of ice and bandage. The PTA explained to the resident that they will be placed in bed, with their foot elevated, and that the PTA and Resident #101 were going to inform nursing on the way back to the resident's room. As they approached the resident's room, Resident #101 stated to the nurse I'm [going to] need some help, I twisted my ankle in therapy but first I am [going to] have a cigarette. The PTA went back to check on the resident who was seated in the sitting room and was informed by the resident that they did not think it would hurt that bad. The report further revealed that the PTA was under the impression that the resident had discussed it with the nurse and that everything was okay. The investigative statement of the nurse reflected that she was not aware of the incident. The investigative statement made by Resident #101 reflected that at that time, they were not in much pain. The conclusion was the resident was participating in physical therapy session, and while walking with the rollator, resident twisted their left ankle. The resident was seated, ice pack applied and [brand name redacted] bandage wrap was applied. An x-ray was performed on 2/25/24, and indicated a left ankle fracture. The resident was sent to the emergency room for further evaluation. Inservice training report was completed. A review of the included inservicing dated 2/26/24 at 12:00 PM, indicated that the Physical Therapy Assistant/Director of Rehabilitation (PTA/DOR) inserved the rehab staff to communicate with nursing about [resident] care. On 10/24/24 at 2:23 PM, during an interview with the surveyor, the PTA/DOR stated that if an accident occurred during rehab, the rehab staff notified nursing, who assessed the resident, and notified the physician, and rehab evaluated the injury. On 10/28/24 at 9:52 AM, the surveyor interviewed RN #1 regarding the facility's policy and procedure for a resident injury/accident, who stated that she remained with the resident, requested for assistance, asked the resident what had occurred, and began an assessment of the resident with another nurse which included pain evaluation. If a resident was in pain, she asked the resident what had occurred to cause the pain, and administered the PRN pain relief medication, such as Tylenol. After the assessment the physician, supervisors, and family were notified of the injury/accident sustained and results of the assessment conducted by the nurses. RN #1 continued that an incident report was initiated and the care plan interventions were adjusted. The nursing department documented under progress notes of the injury/accident and all the activities that were pending and conducted. The resident was reoriented to call us (the nursing staff) for any needs to prevent future accidents, and the staff increased their surveillance of the resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/28/24 at 10:10 AM, during an interview with the surveyor, the Licensed Practical Nurse/Supervisor (LPN/S) stated that the expectation for a situation that involved a resident who had an injury/accident in rehab was that the rehab department informed the nursing department immediately after an injury/accident had occurred. The nurse then assessed the resident and determined what had happened and documented in the progress notes. The LPN/S stated rehab documented in their own notes and rehab may apply treatment of ice and bandage to the injured site if there was an order, but the nurse assessed the resident first. After the assessment of vitals, skin, and pain level, the physician, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), and family were notified. The LPN/S continued that when a resident experienced pain, he asked where the pain was, assessed the resident, and based on the orders, he administered the standard PRN Tylenol for pain relief. The LPN/S stated that in the event a resident had no orders for pain relief or had a pain intensity greater than five (5), he notified the physician. The LPN/S did not recall Resident #101. On 10/28/24 at 10:42 AM, in the presence of the survey team, the DON, LNHA, the Regional Director of Clinical Operations (RDCO), and the Regional Director of Clinical Services (RDCS), the surveyor discussed the concerns regarding the failure to notify the nursing department immediately on 2/23/24, when Resident #101 had an injury/accident in rehab, which caused a delay in treatment, and the resident was not assessed until 2/25/24, and an x-ray was ordered which resulted in an ankle fracture. On 10/28/24 at 12:43 PM, the PTA/DOR, in the presence of the survey team and the LNHA, stated that she was made aware after the incident of Resident #101's injury/accident but could not recall exactly when. The PTA/DOR stated that the expectation was that after a witnessed injury that occurred during rehab, rehab notified nursing immediately, and the nursing staff notified the physician. The PTA/DOR acknowledged that the rehab staff did not inform nursing immediately after the injury on 2/23/24, but documented informing the nursing staff of the injury and pain observed on 2/24/24. On 10/28/24 at 1:20 PM, the DON, in the presence of the survey team, stated that nursing should have been informed at the time of the injury, and that the previous DON and the previous LNHA investigated on 2/26/24 (three days after the injury/accident), obtained witness statements, and the PTA/DOR and the rehab staff was provided education on communication with nursing and resident care. On 10/29/24 at 10:58 AM, the DON confirmed and acknowledged that the rehab department should have notified the nursing department to conduct an assessment, that the resident should not be expected to report their own injury/accident to the nurse. The DON confirmed and acknowledged that the resident should have been medicated for the pain, the physician should have been notified, and the delay in notification resulted in the delay of the diagnosis. The DON stated that after the result of Resident #101's ankle fracture, it should have been reported to the Ombudsman. A review of the undated facility's Change in Resident's Condition or Status policy included that the nurse would notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident. Prior to notifying the physician or health care provider the nurse would make detailed observations and gather relevant and pertinent information for the provider . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the undated facility's Charting and Documentation policy included that all services provided to the resident, progress towards 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 . A review of the facility provided Accidents, and Incidents - Investigating and Reporting policy dated revised July 2017, included under Policy Interpretation and Implementation that the nurse supervisor/charge nurse/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident . A review of the facility provided Accident and Incident policy dated August 2021, included that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator and that the administrator and/or director of nursing shall promptly initiate and document investigation of the accident or incident . No additional information was provided. NJAC 8:39-11.2(b); 27.1(a)

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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. 36419 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer oxygen therapy according to the physician's order for 1 of 1 resident, (Resident #1) reviewed for respiratory care and services. This deficient practice was evidenced by the following: On 10/23/24 at 1:20 PM, the surveyor observed Resident #1 in his/her room seated in a geriatric chair. The resident did not respond to the surveyor. The surveyor observed an oxygen concentrator in the Resident's room, not in use. The surveyor observed a sign above the resident's bed which instructed to ensure oxygen was in use. At that time, the surveyor observed the Registered Nurse (RN) assigned to Resident #1's care entered the room and stated that the oxygen should have been on since the resident was supposed to be on continuous oxygen. The RN moved the concentrator closer to the resident's bed, plugged the concentrator into the outlet, turned it on, applied the nanal cannula tubing, set the gauge at 2.5 Liters Per Minute (lpm) and exited the resident's room. A review of Resident #1's Admission Record revealed Resident #1 was admitted to the facility with diagnoses which included but were not limited to acute respiratory failure, diabetes mellitus, chronic obstructive pulmonary disease (a lung disease that causes permanent lung damage) and dementia. A review of Resident #1's most recent Minimum Data Set (MDS), an assessment tool, dated 9/20/24 revealed Resident #1 had a short-term and long-term memory problem and had a severe cognitive impairment. A review of the resident's individual care plan (ICP) initiated on 6/23/24 included a focus: resident may require supplemental oxygen r/t acute respiratory failure with interventions that included but were not limited to: oxygen at 2 liters via nasal cannula as needed for shortness of breath. A review of the October 2024 Order Summary Report (OSR) revealed an active physician order (PO) with an order date of 8/31//24 for Oxygen 2 lpm via NC continuously. On 10/23/24 at 1:45 PM, the surveyor observed Resident #1 in their room, seated in a geri chair with the oxygen concentrator in use and the oxygen gauge set at 2.5 lpm via nasal cannula. At that time, the surveyor asked the RN to accompany her to the resident's room. The surveyor and the RN entered Resident #1's room, and both observed the resident was wearing a nasal cannula and the oxygen concentrator was on with the gauge set at 2.5 lpm. On that same day at the same time, the surveyor and the RN reviewed the electronic medical record (EMR) for the resident's order for oxygen. The RN confirmed that the resident's PO was for 2LPM, not 2.5 LPM and acknowledged she should have followed the PO. On 10/24/24 at 1:40 PM, the surveyor observed Resident #1 in their room seated in a geriatric chair. The oxygen concentrator was off. On that same day, at that same time, the RN entered the resident's room and stated, oh no, I did it again. The RN proceeded to turn on the concentrator, applied the nasal cannula and set the gauge at 2 lpm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy entitled, Oxygen Administration revised 10/2010 revealed .the purpose of this procedure is to provide guidelines for safe oxygen administration .verify that there is a physician order . review the physician order or facility policy for oxygen administration . On 10/24/24 at 1:54 PM, the survey team met with the administration to discuss the above observations and concerns. 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. 45449 Based on the interview, record review, and review of the facility provided documents, it was determined that the facility failed to identify psychoactive medication irregularity, twice in four months, during the monthly MRR (Medication Record Review) of the CP (Consultant Pharmacist) for one (1) of five (5) residents reviewed for unnecessary medication, Resident #30. This deficient practice was evidenced by the following: On 10/23/24 at 11:20 AM, the surveyor observed the Resident's door of the room was closed. The surveyor knocked on the door and was opened by the Licensed Practical Nurse/Supervisor (LPN/S). The LPN/S offered his assistance, to the surveyor, and the surveyor politely declined. The LPN/S exited the room, while the surveyor entered the room. At that time, the surveyor observed Resident #30 was asleep, and was not roused by the surveyor's voice. Resident #30 had a short sleeved top and had no bruising on both arms but the upper arm to the shoulder was not visible since it was covered by the resident's sleeves. On 10/24/24 at 10:55 AM, the surveyor observed Resident #30 asleep, not roused by the surveyor's voice and could not be interviewed. On 10/24/24 at 11:12 AM, during an interview with the surveyor, LPN/S #2 stated that the resident was blind, needed assistance with eating, and was monitored for constantly touching their own arms. LPN/S also stated, She does sleep a lot and was not sure of the behavior/side effect of drowsiness and sleepiness was reported to the physician. The surveyor reviewed Resident #30's hybrid (paper and electronic) medical record. According to the Admission Record (admission summary) Resident # 30 was admitted to the facility with diagnoses that included unspecified dementia without behavioral disturbances (loss of memory, language, problem-solving and other thinking abilities), obsessive compulsive disorder (long lasting confusion of recurring thoughts engaging in repetitive behavior), anxiety, and major depressive disorder (persistent feelings of sadness and loss of interest). A review of the most recent quarterly MDS (qMDS; an assessment) dated 7/22/24, reflected a Brief Interview for Mental Status score of four (4) out of 15 which indicated the resident had severe cognitive impairment, with no indication of hallucination or delusions. The resident showed behaviors associated with rejection of care and had active diagnoses of anxiety, depression, and psychotic disorder (severe mental condition that causes abnormal thinking and perception, not schizophrenia). Section N, of the qMDS reflected that the resident received an antipsychotic medication (used to treat psychosis) and an antidepressant. A review of the Order Summary Report, dated 10/29/24 included the following physician's orders: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Escitalopram 10 milligram (Lexapro; mg), 1 tablet by mouth at bedtime, for depression. The physician order was started on 4/16/24. -Mirtazapine 30 mg (Remeron), 1 tablet by mouth at bedtime, for depression. The physician order was started on 4/16/24. -Quetiapine 100 mg (Seroquel), 1 tablet by mouth two times a day, for psychosis. The physician order was started on 4/16/24. -Seroquel 300 mg, 1 tablet by mouth at bedtime, for psychosis. The physician order was started on 4/16/24 and discontinued on 4/16/26. -Seroquel 300 mg, 1 tablet by mouth in the evening, for psychosis. The physician order was started on 4/18/24. A review of the monthly Psychoactive (a medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) Medication Monthly review from 8/13/24 to 10/1/24, included potential side effects and documented as: dizziness, drowsiness, tiredness, lack of energy, increase appetite, upset stomach, vomiting and nausea. The sleep pattern was documented as: sleeps well, no complaint, and no issues for Resident #30 who was assessed with severe cognitive impairment. A review of the Psychiatric Progress Notes (PPS) dated 5/18/24, reflected that the Advanced Practical Nurse/ Board Certified Psychiatric Nurse Practitioner (APN-C) made recommendations that included to decrease Lexapro to 5 mg once a day for depression, a gradual dose reduction (GDR) attempt. A review of the Physician's Progress Note from 5/2024 to 10/6/24 did not reflect knowledge of the GDR made by APN-C and did not reflect a rationale for not following the APN-C's recommendation, no evidence that the optimal dose was achieved without trialing a gradual dose reduction for Lexapro, and did not have a documented discussion with the family regarding risk versus benefit of the Lexapro dose reduction, prior to surveyor inquiry. A review of the CP recommendations from 5/1/24 to 9/30/24, did not show that the CP identified the irregularity, between the APN-C's GDR recommendation regarding Lexapro, and physician's progress note that did not indicate a rationale for not following the APN-C's recommendation for the GDR. The CP recommendations included the following: -on 5/20/24, no recommendation -on 6/16/24, recommendation to consolidate vitamins -on 7/18/24, no recommendation -on 8/25/24, no recommendation -on 9/17/24, recommendation to consolidate vitamins (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315005	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Grove Rehabilitation and Healthcare Center	144 Gales Drive New Providence, NJ 07974

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the PPS dated 7/24/24, reflected that the Advanced Practical Nurse/ Board Certified Psychiatric Nurse Practitioner (APN-C) made recommendations that included to decrease Seroquel to 50 mg once a in the morning [a GDR attempt], to continue the 100 mg at 4:00 PM and 300 mg at bedtime for psychosis. A review of the Physician's Progress Note from 5/2024 to 10/6/24 did not reflect knowledge of the GDR made by APN-C and did not reflect a rationale for not following the APN-C's recommendation, no evidence that the optimal dose was achieved without trialing a gradual dose reduction for Seroquel, and did not have a documented discussion with the family regarding risk versus benefit of the Seroquel dose reduction, prior to surveyor inquiry. A review of the CP recommendations from 5/1/24 to 9/30/24, did not show that the CP identified the irregularity, between the APN-C's GDR recommendation regarding Seroquel, and the physician's progress note that did not indicate a rationale for not following the APN-C's recommendation for the GDR. On 10/28/24 at 10:42 AM, in the presence of the survey team, the Director of Nursing, the Licensed Nursing Home Administrator (LNHA), the Regional Director of Clinical Operations (RDCO) and the Regional Director of Clinical Services (RDCS), the surveyor discussed the concerns regarding the failure of the consultant pharmacist (CP) to identify the irregularity twice, after the APN-C's recommendation on 5/18/24 and on 7/24/24. Additionally, the surveyor discussed the concern with the physician, who did not have a documented rationale for not following the APN-C's recommendation of the GDR of Lexapro and of Seroquel while Resident #30 was observed to be drowsy, and often sleeping. On 10/28/24 at 1:20 PM, in the presence of the survey team, the DON stated that the physician was made aware of the prior GDRs and that the family member had declined the GDR. The DON confirmed that the Physician Progress Note did not reflect that a discussion with the niece had occurred, which was the reason the GDR did not occur. The DON stated that the documentation was being entered into Resident #30's medical record as she spoke with the survey team. On 10/29/24 at 10:58 AM, in the presence of the survey team, the LNHA, the RDCO and the RDCS the DON confirmed and acknowledged that when a GDR was recommended, the nurse should have followed- up with the physician, the physician would then determine the outcome of the interventions recommended. The physician should have documented in the medical record, the discussions with the family. At that time, the DON confirmed and acknowledged that the CP should have spoken with the nursing staff, reviewed the resident's chart, documented recommendations, and sent the recommendation to the physician. A review of the undated/unsigned Consultant Pharmacist Provider Agreement provided by the facility, included the following: 1.1.3 Consultant shall assist Facility in determining that resident's medication therapy is necessary and appropriate. 1.1.5 Consultant shall identify any irregularities as defined in the State Operations Manual. (continued on next page)

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	315005	A. Building B. Wing	10/29/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the undated, facility provided policy, Pharmacy Services, Role of the Consultant Pharmacist included under section 5, b. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services including medication irregularities and pertinent resident-specific documentation in the medical record . No further information was provided. NJAC 8:39- 29.1(b), 29.3 (a)(1)