STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. Building B. Wing	10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Runnells Center for Rehabilitation & Healthcare	40 Watchung Way Berkeley Heights, NJ 07922

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #2585508 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey State Department of Health (NJDOH) an injury of unknown origin and implement facility's policy for accidents and incidents by not thoroughly updating the care plan after an assessment. This deficient practice was identified for 1 of 3 residents (Resident #3) reviewed for accident/incident, and was evidenced as follows: On 10/31/25 at 9:00 AM, during an interview with the surveyor, the Assistant Director of Nursing (ADON) informed the surveyor that there were no reportable events (report filed with the NJDOH) found on file for Resident #3.The surveyor reviewed the medical record for Resident #3. A review of the admission Record, (an admission summary) reflected the resident was admitted to the facility with diagnoses that included dementia (memory loss with cognitive decline) with other behavioral disturbances.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 6/8/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident had a severely impaired cognition. The resident had no indicators of psychosis. Section GG, Functional Abilities reflected the resident was dependent on a helper for mobility that included: rolling left to right, sit to lying, for transfers from chair to bed, toileting and showering.A review of the nurse's Progress Note (NPN) dated 6/11/25 at 1:25 PM, reflected the resident was sent seen with redness on the right eye. During the shift, the right eye became bruised, and a bruise on the right arm was also observed. The physician was notified, who ordered a hold on the administration of Aspirin, the resident to be monitored and neuro-checks (an assessment for potential head injuries and monitored changes over time).A review of the facility provided a soft file for the Unknown incident on 6/11/25 when the unilateral right-side bruising was reported to the nurse. The file included witness statements. CNA #1 signed a statement on 6/10/25, that the resident's bruises were present at the start of her 3PM to 11PM. A review of CNA #2 undated witness statement reflected that she reported the skin redness to the nurse, while knowing that the nurse was aware of the unilateral bruise on the right eye and right arm. Further review of the soft file revealed the interdisciplinary team met on 6/13/25 [no specified time] revealed that the individualized comprehensive care plan (CP) was updated and floor mats on either side was implemented from 6/1/25. According to the facility investigation of the bruise of unknown origin the unilateral bruise on the right eye and the right arm was attributed to the resident's anticoagulant or due to poor safety awareness and disease process of dementia. A definitive root cause of the right eye and right arm bruises were not reflected. On 10/31/25 at 11:59 PM, during an interview with the surveyors, the Assistant Director of Nursing (ADON) confirmed that a reportable was not filed with the NJDOH when a unilateral bruise on the right eye and the right arm was found, that was investigated in the facility as a bruise of unknown origin. The ADON stated that the unilateral bruises found on the resident's right eye and arm were caused by the aspirin.A review of the CP did not reveal a focus, and intervention was made for the anticoagulant, the right arm bruise and dementia.On 10/31/25 at 11:59 PM, during an interview with the surveyors, the Assistant Director of Nursing (ADON) confirmed that a reportable was not filed with the NJDOH when a unilateral bruise on the right eye and the right arm was found, that was investigated in the facility as a bruise of unknown origin. The ADON stated that the unilateral bruises found on the resident was caused by the aspirin. At that time, the surveyor and the ADON reviewed the CP together. The ADON confirmed the Aspirin, should have been care planned. On 10/31/25 at 12:50 PM, in the presence of a surveyor, the Assistant Administrator (AIT), the ADON, the Regional DON, and the assisting Administrator of the Behavioral Health (LNHA), the surveyor discussed the concerns with not reporting the injury of unknown source and the individualized care plan that was not thoroughly updated to include, Aspirin, the right arm bruise and for diagnosis of dementia and its associated interventions.No further information was provided.A review of the facility provided policy for Accident and Incident - Investigation A review of the facility provided policy for Interdisciplinary Care Planning Policy and Procedure dated 8/1/25 included that individualized interdisciplinary [ID] interventions will be planned by each discipline to correct problems identified during IDCP conference. NJAC 8:39-4.1(a)(5)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Complaint # 2638227 Based on observation, interview, and record review it was determined that the facility failed ensure staff consistently documented care/services provided to residents in accordance with professional standard. This deficient practice was identified for 2 (two) of 3 (three) residents (Resident #1 and #3) reviewed for reviewed for accident/incident, and was evidenced as follows:This deficient practice 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 and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.1.) On 10/29/25, the Department of Health conducted a complaint survey at the facility. The surveyor reviewed Resident #1's closed medical record (MR) which reflected the resident was admitted to the facility with diagnoses which included Alzheimer's disease, dementia with psychotic disturbances, and type 2 diabetes (high blood sugar). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 9/24/25, reflected a brief interview for mental status (BIMS) score of 2 out 15, which indicated a severely impaired cognition. Section E - Behavior reflected the resident had behavioral symptoms (such as hitting or scratching self, pacing, rummaging.).Section GG Functional Abilities indicated the resident was independent for eating, required supervision or touching assistance for safe performance or better quality of oral/toilet/personal hygiene, shower/bathing, upper/lower body dressing, and for putting on/ taking off footwear. A review of the individualized comprehensive care plan (CP) initiated on 3/21/25, included a focus that Resident #1 was a wanderer who exhibited behaviors of urinating in the hallway and other resident's room. Further review of the CP reflected the resident exited the unit on 4/6/25, bit another resident on 7/10/25, and was pushed by another resident that resulted in a fall on 9/19/25. The intervention initiated on 3/21/25 was to identify patterns of wandering. On 7/10/25 another intervention was included to analyze, the times of day, places, circumstances, triggers and what de-escalates behavior and document. The CP also revealed the resident required safety rounds of at least every 2 hours initiated on 8/4/25.A review of the Documentation Survey Report (the report of the electronic point-of-care system (POCS) where the Certified Nursing Assistants (CNAs) electronically document patient care activities) revealed the following:-From 7/1/25 to 7/31/25, reflected there were 46 out 93 shifts, that reflected charting blanks for behavior monitoring that included wandering.-From 8/1/25 to 8/31/25, reflected there were 21 out of 93 shifts, that reflected charting blanks for behavior monitoring that included wandering.-From 9/1/25 to 9/30/25, reflected there were 25 out of 90 shifts, that reflected charting blanks for behavior monitoring that included wandering. 2.) The surveyor reviewed the medical record for Resident #3.A review of the admission Record, (an admission summary) reflected the resident was admitted to the facility diagnoses that included dementia (memory loss) with other behavioral disturbances.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 6/8/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident had a severely impaired cognition. The resident had no indicators of psychosis. Section GG, Functional Abilities reflected the resident was dependent on a helper for mobility that included: rolling left to right, sit to lying, for transfers from chair to bed, toileting and showering.A review of the individualized comprehensive care plan (CP) included a focus that Resident #3 was high risk for falls, initiated on 6/3/25. The interventions included to offer toileting to the resident prior to bed and rounding at least every two (2) hours at night, initiated on 6/20/25.A review of Resident #3's POCS from 06/01/25 to 06/30/25, reflected the following: -There were 21 out of 90 shifts, charting blanks for bowel and bladder elimination monitoring. - There were 22 out of 90 shifts, that reflected charting blanks for behavior monitoring that included wandering.On 10/31/25 at 11:50 AM, in the presence of two surveyors, the Assistant Director of Nursing (ADON) stated that they did not document anywhere the 2-hour monitoring for Resident #1 and the

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint # 2638227 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure the accuracy of a resident's weight and monitor the resident's food intake in accordance with the resident's care plan. This deficient practice was identified for 1 of 3 closed records reviewed (Resident #1) and was evidenced by the following: The surveyor reviewed the medical record for Resident #1. A review of the admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included Alzheimer's disease, dementia (memory loss with cognitive decline) with psychotic disturbances, and type 2 diabetes (high blood sugar).A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 9/24/25, reflected a brief interview for mental status (BIMS) score of 2 out 15, which indicated a severely impaired cognition. Section E - Behavior reflected the resident had behavioral symptoms (such as hitting or scratching self, pacing, rummaging.).Section GG Functional Abilities indicated the resident was independent for eating, however required supervision or touching assistance for safe performance or better quality of oral/toilet/personal hygiene, shower/bathing, upper/lower body dressing, and for putting on/ taking off footwear.A review of Weight and Vital Summary report located in electronic Health Record (eHR), revealed the following:On 6/4/25, the resident weighed 162 pounds (lbs; standing). On 7/4/25, the resident weighed 158.4 lbs (standing).On 8/8/25, the resident weighed 154.4 lbs (standing).On 8/20/25, the resident weighed 147.0 lbs (standing) was crossed off on 9/3/25 by the RD who documented incorrect documentation. A review of the electronic Progress Note (ePN) included a Nutrition/Dietary Note (NDN) dated 6/23/25, which was a quarterly review and indicated the resident's weight was 162.0 and to continue plan of care. No further review was documented until 8/20/25.A review of the NDN dated 8/20/25, which reflected the resident's monthly weight was 147 lbs an 11.4 lbs weight loss and was below the UBW usual body weight. The RD also documented speaking with the resident's family representative, added a nutritional supplement, Glucerna 8 ounces per day, recommended monitoring of acceptance of Glucerna, weights and appetite. A review of the Order Recap Report (ORR) reflected Glucerna was ordered on 08/20/25 as recommended by the RD.On 10/28/25 at 12:55 PM, during a telephonic interview with the surveyor, the Registered Dietician (RD) stated that on admission, the nursing department obtained the weights and entered the data into the electronic medical record (eMR). The weekly and monthly weights were also obtained by nursing but were reviewed and entered by the RD. At that time, the surveyor and the RD reviewed the eMR together. The RD stated that the 8/20/25, weight was struck out by her because there was no need for the resident's weight at that point. I thought the weight was an error based on the weight that came in September, which was more consistent, and that weight appeared to be an outlier. At that time, the RD stated she did not document re-weights in the eMR. The RD also stated that she may have the weight and re-weight in her office, but she was not in the facility, that day and nobody else had access to her records.On 10/28/25 at 12:40 PM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) stated they had a weight binder in the unit, within the binder was a weight form with a list of resident's names who needed weights provided by the RD. The Certified Nursing Assistants (CNAs) obtained the weight and wrote into the weight form. The LPN also stated that the RD provided the list of re-weights needed. On 10/28/25 at 12:45 PM, during an interview with the surveyor, the Assistant Director of Nursing (ADON) confirmed and acknowledged that a soft file was not part of the medical record. The ADON stated that weights and re-weights should have been available for review in the eMR allowing ancillary providers access to the information of the weight variance and evidence that the variance was thoroughly investigated. A review of the individualized comprehensive care plan included a focus area for nutrition, initiated on 3/21/25. The interventions included to monitor oral intake as needed that was also initiated on 3/21/25.A review of the Documentation Survey Report (the report of the electronic point-of-care system (POCS) where the Certified Nursing Assistants (CNAs) electronically document patient care activities). The POCS revealed the following:-during the resident's stay on July 2025, 16 of the 62 shifts the CNAs documented the percentage of meal that was eaten by the resident. There were 46 charting blanks.-during the resident's stay on August 2025, 6 of the 62 shifts the CNAs documented the percentage of meal that was eaten by the resident. There were 56 charting blanks.On 10/28/25 at 4:14 PM, in the presence of a surveyor, the Assistant Administrator (AIT), the ADON, the Regional DON, and the assisting Administrator of the Behavioral Health (LNHA), the surveyor discussed the concern that the evidence of a re-weight was not present in the medical record to ensure the weigh variance was investigated