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	08/14/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and policy review, the facility failed to ensure three of three residents (Resident (R) 172, R204, and R218) rights to a dignified dining experience. The residents were unable to protect their right to dignity due to their impaired cognitive status creating the potential for feeling of embarrassment or frustration.Findings include:Review of R172's electronic medical record (EMR) annual Minimum Data Set (MDS), located under the MDS tab, with an Assessment Reference Date (ARD) of 06/10/25 revealed her Brief Interview for Mental Status (BIMS) score was nine out of 15, this score revealed she had moderate cognitive impairment.Review of R204's EMR revealed an annual MDS, located under the MDS tab, with an ARD date of 06/04/25 revealed his BIMS score was four out of 15, this indicated he had severe cognitive impairment.Review of R218's EMR quarterly MDS with a ARD of 08/05/25, located under the MDS tab, revealed her BIMS score was zero which indicated she had severe cognitive impairment.Observation on 08/12/25 at 9:20 AM in the 3W unit dining room, revealed Certified Nursing Assistant (CNA) 2 was standing beside R172 and helping her to eat her breakfast. R172 is blind and was seated in a high back wheelchair. CNA2 fed R172 her entire breakfast this way. Other residents were present in the dining room. At 9:30, R204 was loudly saying he was still hungry. CNA2 took a bowl of hot cereal off of R218's breakfast tray and gave it to R204. CNA2 did not ask R218 if she was done eating or if she was still hungry.During an interview on 08/13/25 at 3:10 PM, CNA2 revealed she was aware she should sit by a resident when helping them to eat. CNA2 had hurt her back so sitting for too long and reaching up to help a resident sometimes would make her back hurt. CNA2 since R218 had not touched her hot cereal, she thought it was alright to give it to R204. CNA2 stated the cover was still on it. CNA2 agreed she had not observed R218 at all times to know if she had not taken the cover off, if she had taken a spoonful out and then put the cover back on.During an interview on 08/13/25 at 4:00 PM, the Director of Nursing (DON) agreed that staff should not stand beside a resident to help them to eat. The DON stated CNA2 was on light duty, but she was not aware she could not sit to help a resident with eating. The DON confirmed taking food off of one resident's tray and giving to another resident should not have been done. The DON stated if the resident was still hungry she should have requested a new bowl of cereal for R204.Review of the facility's Quality of Life - Dignity policy, dated 06/03/25, revealed, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. 'Treated with Dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. NJAC 8:39- 4.1(a)12

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that one of one residents (Resident (R) 16) reviewed with contractures out of 35 sample residents received a splint on her hands per the care plan. Failure to use the hand splints has the potential for the resident to develop skin breakdown in the palms of her hands.Findings include:Review of R16's Face Sheet located in the electronic medical record (EMR) under the admission tab documented that the resident was admitted to the facility on [DATE] with diagnoses of traumatic brain injury (TBI) and contracture of muscle of right and left hands.Review of R16's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/11/25 located in the resident's EMR under the MDS tab revealed the resident had persistent vegetative state (a severe brain disorder where a person is awake but unaware of themselves or their surroundings), functional limitation in range of motion bilaterally in upper and lower extremities, and was dependent of staff for all personal care.Review of R16's TBI Care Plan, located in the EMR under the Care Plan tab and dated 06/17/25, revealed the resident was totally dependent on the staff for her care, had contractures of both hands, and was to continue to wear her left hand splint and right grip orthosis to be applied after morning care, and removed before evening care. Review of R16's Physician Orders dated 08/01/25 found in the EMR under the Orders tab revealed no order for R16 to wear a splint to either hand. A review of R16's Nursing Notes dated 07/01/25 through 08/12/25 located in the EMR under the Progress Note tab did not reveal any documentation related to R16's splints.An observation on 8/11/25 12:49 PM revealed R16 sitting in her room in her chair. R16 had contractures on both hands and although R16 had splints on her feet, she had no splints on her hands. An observation on 08/12/25 at 12:26 PM revealed that R16 was sitting in her chair in her room and although R16 was wearing feet splints, she had no splints on her hands.During an interview on 08/12/25 at 12:20 PM, the Family Member (FM) 1 said although R16 was to wear splints on both of her hands, the staff had not been placing the splints on her hands. F1 stated she wanted some type of device on R16's hands to prevent her nails from rubbing and causing irritation to her hands.During an interview on 08/12/25 at 4:35 PM, Certified Nursing Assistant (CNA) 8 and CNA4 stated they were ready to transfer R16 back to bed. CNA8 and CNA4 said although they had removed R16's feet splints, R16 had no hand splints on her hand to remove. CNA4 said although she always observed feet splints on R16, which she removed prior to transferring back to bed, she never observed hand splints on R16. During an interview on 08/13/25 at 12:00 PM, CNA12 said she was assigned to provide care to R16 on 08/11/25 during the day shift. CNA12 said she was not told in report that R16 required hand splints, was not aware R16 wore splints to her hand, and therefore, did not place splints on her hands. During an interview on 08/13/25 at 2:16 PM, Licensed Practical Nursing Supervisor (LPNS) 2 said she was assigned as the nurse on R16's unit during the day shift on 08/13/25. She said she was not aware R16 was to wear splints on her hands.During an interview 08/13/25 at 8:04 AM, 1 [NAME] Unit Manager (WUM) said he had been on vacation the past week. He said R16's splints were in her room; she was to wear hand splints when out of bed and did not know why the staff were not placing splints on her hands. 1WUM said residents were to have a physician's order for splints and he was not aware R16 did not have a physician order for the hand splints.During an interview on 08/13/25 at 9:00 AM, the Director of Rehabilitation stated during her last quarterly assessment during the week of 08/03/25, R16 had splints on both hands and had no decrease in her range of motion. She stated she was not notified that R16 had any issues with her hand splints and had not been wearing the splints, which were part of her plan of care.During an interview on 08/13/25 at 5:30 PM the Director of Nursing (DON) confirmed an order was required for a resident to wear splints. The DON stated she was not aware R16 no longer had a physician order for hand splints. The DON further stated she was not aware the staff were not placing splints on R16's hands and had not (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been following the care plan.Review of the policy titled Contracture Management dated 06/03/25 documented: .Utilizing aids like splints, as recommended by healthcare professionals, can help maintain proper joint alignment and prevent progression of contractures . All interventions, including assessments, care plan implementation, and the resident's response to treatment should be meticulously documented .Review of the policy titled Making, Application and Care of Splints dated 06/03/25 documented: A physician's written order for a splint is required. NJAC 8:39- 27.1(a), 27.2(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to ensure proper glove use and hand washing was used during one of one meal services observed. One of one cook (Cook (C) 1) and two of three dietary aides (DA) (DA2 and DA4) touched ready-to-eat foods and the inside of coffee cups without performing hand hygiene when moving between tasks. The failure to ensure proper hand washing and glove use could contaminate the food served to the residents.Findings include:Observation on 08/13/25 at 10:30 AM in the kitchen revealed DA4 placing Styrofoam coffee cups with his gloved hands onto a tray. He put his fingers inside of each cup as he placed the cup on the tray. DA4 then filled a large pitcher with coffee and filled each coffee cup. When DA4 had filled the tray of coffee cups with coffee he carried it to a heated cart. DA4 opened the cart with the same gloves and then returned to fill another tray, again touching the inside of each cup. DA4 never changed his gloves during this process.Observation on 08/13/25 at 10:45 AM in the kitchen revealed C1 had gloves on and was pureeing rice, touching the three compartment sink multiple times in the process. After he completed pureeing the rice he placed the container in the steamtable. C1 removed the covers off of the other containers already in the steamtable. Without changing his gloves, he removed hamburger and hot dog buns from the bag and placed them on a plate. He then went to get some plastic wrap to cover the buns. Before tray service started C1 identified the food was not at the correct temperature for service. C1 removed each container of food from the steamtable and placed them on the stove top to ensure they were at the correct temperature. C1 never changed his gloves during this process. During the tray service, C1 dished all the food, retrieved the buns with his hands, and placed cooked hamburgers and hot dogs on the buns with his hands while wearing the same gloves.Observation on 08/13/25 at 11:55 AM of DA2 revealed she was preparing ham and cheese sandwiches to be grilled later. DA2 was wearing gloves. DA2 touched the handle to the walk-in cooler, retrieved cheese and ham, and returned to the prep area. DA2, while wearing the same gloves, picked up bread and placed it on a flat pan. DA2 then put a slice of cheese and then a slice of ham on the bread.During an interview on 08/13/25 at 12:30 PM, the Food Service Director who was covering from another facility agreed C1 and DAs 2 and 4 had not changed their gloves after they had touched other surfaces. She confirmed she had also observed the above incidents.Review of the facilities 2019 Bare Hand Contact with Food and Use of Plastic Gloves policy revealed Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed.NJAC 8:39-17.2(g), 19.7(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and policy review, the facility failed to ensure one of one Licensed Practical Nurse (LPN) (LPN 4) and one of one Certified Nursing Assistant (CNA) (CNA 13) used proper glove technique when providing wound care and personal care for one of one residents (Resident (R) 18) observed for wound care of 35 sample residents. This practice placed the resident at an increased risk for infections.Findings include:Observation on 08/12/25 at 10:34 AM of CNA13 as she provided personal care to R18. CNA13 entered R18's room and washed her hands and then put on a protective gown and two pairs of gloves. CNA13 retrieved her cell phone from the supply cart outside of the door and looked at her phone while a basin was filled with soapy water. R18 was handed a soapy washcloth, and he washed his own face. CNA13 took another cloth and washed his chest, abdomen, underarms, hands, and back. CNA13 then dried those areas with a towel, applied lotion and deodorant. CNA13 then provided perineal care to the front and used a towel to wash his legs. CNA13 removed the first layer of gloves. She then used another washcloth to cleanse his bottom. CNA13 removed the remaining gloves after dumping basin and washed her hands.Observation on 08/12/25 at 11:04 AM of LPN4 in R18's room revealed she had placed a package of 4 X 4's, a package of t-gauze, and a border dressing on the top of the wound cart. LPN4 left to retrieve a spray bottle of wound cleanser and 2 x 2 gauze in an open package. LPN4 entered the room and placed the dressing supplies on top of his bedside table, washed her hands, put on four layers of gloves, and a protective gown. LPN4 put a barrier on top of the overbed table and then placed the dressing supplies on the top of the table. LPN 4 removed the first pair of gloves and used the wound cleanser with the 2 x 2 gauze and cleansed the wound like that two times. LPN4 removed the second pair of gloves, put a layer of Triad paste (wound dressing) inside and around the outer border of the wound with her gloved hand and covered it with a border dressing. LPN4 removed the third pair of gloves, removed her protective gown, the last pair of gloves, and then washed her hands.Interview on 08/12/25 at 11:30 AM with LPN4 and CNA13 about the use of multiple gloves revealed CNA13 stated it saved time when going from a soiled task to another clean task. LPN4 stated that was how she was taught in nursing school.During an interview on 08/12/25 at 4:00 PM, the Infection Preventionist (IP) stated the practice of wearing multiple gloves did not follow the policy and procedure for the use of gloves. The IP said one pair of gloves should have been used with hand hygiene between each glove change.Review of the facility's Handwashing/Hand Hygiene" policy, revised 06/03/25, revealed no information on putting on multiple layers of gloves. The policy indicated that employees must wash hands after removing gloves. NJAC 8:39-19.4(a), 27.1(a)