STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315010	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmora Hills Health & Rehabilitation Center	225 W Jersey Street Elizabeth, NJ 07202

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to ensure accurate documentation and review of a resident's advance directives for one (1) of two (2) residents (Resident #25) reviewed. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (electronic and paper) medical records of Resident #25. According to the Admission Record (a summary of important information about the resident) Resident #25 was admitted with diagnoses that included but were not limited to, chronic obstructive pulmonary disease, dementia, and hypertension. A comprehensive Minimum Data Set (MDS), an assessment tool to facilitate the management of care, dated 7/18/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #25 scored a 6 out of 15, which indicated the resident had severe cognitive impairment. A Physician's Order (PO) dated 6/10/2023 read, Do Not Intubate. The resident's paper chart included: a DNR[DO NOT RESCUSCITATE] sticker on the outside of the chart, and an Advance Directive for Health Care form completed prior to the resident's admission which indicated the resident wished to have a DNR and Do Not Intubate (DNI) code status. Additionally, in the paper chart was a another document [name] DO NOT RESUSCITATE signed by the Resident's Representative (RR), and physician in 2016. The Care Plan Evaluation progress notes, dated 7/30/24, 5/01/24, 01/31/24, 11/01/23, 5/03/23, and 02/01/23, documented Resident #25's DNR/DNI code status was maintained. On 8/14/24 at 01:36 PM, the surveyor interviewed the Charge Nurse/Licensed Practical Nurse (CN/LPN) about advance directives. The CN/LPN stated advance directives documentation would be in the resident's hybrid chart, there would be stickers on the paper chart to indicate the resident's code status and the resident's code status would be documented in the electronic medical record (EMR). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CN/LPN further explained in the EMR, the code status was documented on the dashboard (summary of important information about the resident) of the resident's EMR and included in the PO. The CN/LPN in the presence of the surveyor reviewed Resident #25's hybrid chart. The CN/LPN confirmed the hard copy chart indicated the resident's advance directive documentation indicated the resident had a DNR code status. The CN/LPN reviewed Resident #25's EMR including the care plan evaluation notes, the resident's dashboard, and PO summary. The CN/LPN confirmed there was no PO for DNR code status, and the dashboard documented the resident had a DNI code status only. The CN/LPN stated she would have to follow up (f/u) to clarify the resident's advance directives and that besides nursing, the Social Worker (SW)was also responsible for advance directives. On 8/14/24 at 01:52 PM, the surveyor interviewed the SW responsible for Resident #25. The SW stated upon admission advance directives for a resident were assessed, education was provided and the resident was offered to make advance directives. The SW stated a resident's advance directives would be communicated to nursing to f/u with the resident's physician for orders. The SW stated that long term care (LTC) residents' advance directives were reviewed quarterly and annually to confirm advance directives and if they desired to make any changes. The surveyor reviewed with the SW regarding the concerns of the Resident #25's advance directives and there being no documentation of the resident's DNR code status in the PO and dashboard. The SW stated she would have to review and would provide further information. The SW further stated if resident is DNR it should be clarified to reflect resident is DNR. On 8/15/24 at 10:44 AM, the surveyor interviewed the CN/LPN who stated the SW followed up with the RR to clarify Resident #25's advance directive. The CN/LPN stated the resident's code status was updated to include DNR and that when the resident was readmitted in 2023 that the DNR order was not re-entered in the EMR, it was missed. On 8/15/24 at 11:05 AM, the SW informed the surveyor that she spoke to the RR who confirmed the resident desired to be DNR/DNI code status. The SW stated the PO for DNR code status was ordered, DNR AND DNI stickers placed on the chart. The SW acknowledged there should have been a DNR code status indicated on the EMR and was not sure exactly what happened. The surveyor was asked about the process of reviewing advance directive during quarterly reviews and who was responsible for checking advance directives. The SW replied that the SW and nursing were responsible for reviewing advance directives. She further stated for quarterly reviews, I try to double check everything and would document in note if resident/RR wanted to make any changes. On 8/21/24 at 01:03 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and Regional Registered Nurse Consultant (RRNC) of the above concerns. On 8/22/24 at 11:07 AM, the LNHA, DON, RRNC, [NAME] President of Clinical Services, and [NAME] President of Skilled Nursing Division met with the survey team. The LNHA stated the DNR code status was corrected immediately. The LNHA further explained that when the resident was readmitted to facility last year the order did not get transcribed when the resident returned to the facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided policy titled, Advance Care Planning with a last revised date of [DATE] read under Procedure: .2. Upon admission, the presence of an existing Advance Directive, POLST [Physician Orders for Life-Sustaining Treatment], or DNR order will be determined by nursing staff/SW/physician .7. At least quarterly, or if there is a significant change in the resident's/patient's medical condition or as otherwise needed, the resident/patient (and if the resident/patient agrees, the resident's/RR) will be invited to participate in reviewing the resident's/patient's Advance Directive during the quarterly Interdisciplinary Care Plan process . N.J.A.C. 8:39-9.6

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49078 Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for two (2) of five (5) newly hired licensed staff reviewed, (Staff #8 and #10). This deficient practice was evidenced by the following: On 8/22/24, the surveyor reviewed ten randomly selected new employee files. The review for license verification for two of the new licensed employees revealed the following: 1. Staff #8, an Administrator, hired 8/01/22. The surveyor was unable to locate a license verification in the employee file. There was no documented evidence that Staff #8's license was verified prior to the date of hire (doh). 2. Staff #10, a Certified Nurse Aide (CNA), hired 9/04/23, had a New Jersey Division Consumer Affairs license verification printout that was un-dated. The file also contained a background screening and license verification performed by an outside company. The printout from the outside contractor revealed the following information: Report Run Date 8/20/24, Date Last Checked 8/20/24, Retrieved on 8/20/24. The verification was completed after the staff member was hired. There was no documented evidence that Staff #10's license was verified prior to the doh. On 8/22/24 at 12:40 PM, the Human Resource (HR) director provided an Employee File Check List (undated) to the survey team. The surveyor reviewed the check list. The check list revealed spaces for Criminal Background Check and License Verification. On 8/23/24 at 11:26 AM, the surveyor in the presence of the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Registered Nurse Consultant (RRNC) and the Infection Preventionist (IP). The surveyor notified the facility management of the concern that there was no license verification for Staff#8 on file. The surveyor also notified the facility management that the background check and license verification for Staff#10 was dated 8/22/24 and a license verification for the same CNA was undated. The RRNC stated that the license verification for the LNHA would be at the corporate HR office. On that same date and time, the LNHA stated that a license verification was done for Staff#10. That same time, the surveyor showed the LNHA a copy of the verification that had no date when it was accessed and a copy of the background check that was dated 8/22/24. A review of the facility provided copy of the LNHA license to the survey team coordinator during the entrance conference revealed that the copy was undated. The LNHA's copy of license did not reflect if the license was verified prior to doh. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24 at 12:37 PM, the surveyor in the presence of the survey team interviewed the HR director. The surveyor asked if the facility has a policy for conducting background checks and license verification upon hiring new employees. The HR director stated there was no policy that she was aware of, and that she just knew what to do as facility's practice. The surveyor asked what the purpose for conducting these checks (criminal background check and license verification). The HR director stated that something could be a red flag on a criminal background investigation. The facility did not provide any further pertinent information. NJAC 8:39-43.15(a, b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38327 Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for one (1) of 38 residents, Resident #111, reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: On 8/14/24 at 10:56 AM, the surveyor observed an EBP (enhanced barrier precaution) sign posted outside the door of the resident. Both the Licensed Practical Nurse (LPN) and the surveyor inside the resident's room observed Resident #111 with continuous oxygen (O2) via the laryngeal opening with a mask, attached to a humidified concentrator (a medical device that provides supplemental O2) at 4 LPM (four liters per minute). At that same time, the LPN confirmed that the resident had O2 at 4 LPM and stated that the humidified water had a date of 8/11/24 which indicated that the tubing was changed on that date. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #111 and revealed: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to malignant neoplasm (cancerous tumor) of unspecified bronchus or lung, essential hypertension (elevated blood pressure), primary osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down) right shoulder, dysphagia (difficulty swallowing is a symptom of many different conditions, including brain and muscle disorders and blockages in throat), anemia (low blood count), and encounter for palliative care. The most recent quarterly MDS with an assessment reference date (ARD) of 6/15/24, under Section C Cognitive Patterns, reflected on cognitive skills for daily decision-making showed that the resident was coded for number three which indicated that the resident's cognition was severely impaired. Section O Special Treatments, Procedures, and Programs reflected that the resident did not receive an O2, tracheostomy/laryngeal care, or respiratory treatment while at the facility. A review of the August 2024 Order Summary Report (OSR) revealed the following Physician's Orders (PO): 1. PO dated 5/16/24 for Acetylcysteine solution 10% 3 ml (milliliters) via trach (tracheostomy) one time a day related (r/t) to chronic obstructive pulmonary disease (COPD; a group of lung diseases that block airflow and make it difficult to breathe). 2. PO dated 3/28/24 for DuoNeb Solution 0.5-2.5 (3) MG/3ML (milligrams/milliliter) (Ipratropium-Albuterol) 3 ml via trach two times a day r/t COPD. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. PO dated 8/14/24 for O2 via trach collar continuous at 2 LPM with humidification every shift for SOB (shortness of breath) Administer O2 via trach collar. Monitor pulse ox (oximeter) every shift. Notify MD if pulse ox less than or equal to 90%. 4. PO dated 3/28/24 for laryngectomy stoma care every shift to maintain airway dry and clean every shift. Further review of the hybrid medical records showed that the above PO were transcribed to the electronic Medical Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) for August 2024 and were signed by nurses as administered and provided. On 8/21/24 at 9:28 AM The surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN). The MDSC/RN informed the surveyor that the information reflected in the MDS was gathered from the assessment, nursing notes, consultation notes, orders, eMAR, and eTAR of the resident. On that same date and time, the MDSC/RN stated that she was familiar with Resident #111 and that the O2 was a recent order. The surveyor notified the MDSC/RN of the above findings and concerns. The MDSC/RN stated that she would have to check the resident's records and get back to the surveyor about why the MDS for ARD 6/15/24 did not capture the resident's O2, trach, and respiratory care and treatment in Section O. On 8/21/24 at 11:15 AM, the MDSC/RN informed the surveyor that after checking the medical records of the resident, she found out that the nurses were signing the electronic eTAR for June 2024 for the whole month for O2 and laryngectomy stoma care every shift which should have been captured in the section O of MDS. She further stated that the MDS for ARD 6/15/24 will be modified to reflect the resident's care. The MDSC/RN also provided a copy of the Section RAI (Resident Assessment Instrument) manual and the June 2024 eTAR. On 8/21/24 at 12:58 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional Registered Nurse Consultant (RRNC). The surveyor notified the facility management of the above findings and concerns. On 8/22/24 at 11:07 AM, the survey team met with the LNHA, DON, [NAME] President Skilled Nursing Division, RN VP of Clinical Services, and RRNC. The LNHA stated that the MDS concern was modified and corrected by the MDSC/RN, and the MDSC/RN was educated. A review of the provided CMS's (Centers for Medicare and Medicaid Services) RAI Version 3.0 Manual dated October 2023 that was provided by the MDSC/RN showed: O0110: Special Treatments, Procedures, and Programs O2 Therapy: Code continuous or intermittent O2 administered via a mask, cannula, etc., delivered to a resident to relieve hypoxia in this item Check if O2 therapy was continuously delivered for 14 hours or greater per day . Tracheostomy care: .This item includes laryngectomy tube care. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing, Infection Preventionist/Registered Nurse, and RRNC for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:39-11.1, 11.2(e)(1)

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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. 49078 Based on interview and record review, it was determined that the facility failed to promptly notify the physician of a medication being consistently not administered to a resident due to limits on the physician's order (hold parameter), document the physician's notification, and the physician's response. This deficient practice was identified for one (1) of 38 residents (Resident #190) reviewed, according to the standards of clinical practice. 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 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. 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. The surveyor reviewed the closed medical record of Resident #190 and revealed: The resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to congestive heart failure (a condition in which the heart is unable to pump blood effectively) and hypertension (elevated blood pressure). According to the resident's electronic Medication Administration Record (eMAR), the resident had and order for and was administered Metoprolol succinate (a medication (med) that is used to lower blood pressure (BP), treat chest pain and/or treat heart failure) ER (extended release) 100 mg (milligram) one tablet one time a day scheduled at 9:00 AM. The Metoprolol order had a limitation commonly known as a hold parameter, (instructions to not give the med if BP or heart rate (HR) was outside an indicated range). The hold parameter reflected an indicated range to not give the med if the resident's systolic BP (the pressure of the blood as the heart beats) is less than 100 or a HR less than 60. Further review of the resident's eMAR revealed: -for the month of June 2024, the resident did not receive Metoprolol fifteen (15) times out of thirty days. -for July 2024 the resident did not receive Metoprolol nine (9) times out of twenty-two (22) days. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the days the resident did not receive the Metoprolol, the eMAR reflected that it was not given due to the resident's BP or HR being outside the limits of the hold parameter. Further review of the resident's electronic medical record (EMR), there was no documented evidence that the physician (MD) was informed of the Metoprolol being held frequently. There was no documented evidence that the Consultant Pharmacist (CP) identified the irregularity of med being held frequently as identified on the above findings. On 8/20/24 at 9:20 AM, the surveyor interviewed the Director of Nursing (DON). The surveyor asked the DON what he would expect from nursing staff if a med was held multiple times and what documentation, and any other procedures should there be. The DON stated he would expect the staff to contact the MD if there was a pattern of holding meds. He further stated he would not expect the staff to contact the MD if the med was only held one or two times or if MD had previously been notified and they wished to continue the med as is. The surveyor asked if fifteen (15) times in one month would be considered enough to notify the MD. The DON stated yes, he would expect the med nurse to inform the charge nurse to follow up with the MD. The surveyor asked the DON for the facility policy for holding meds and MD notification. On 8/20/24 at 10:44 AM, the surveyor interviewed the Registered Nurse (RN) on the 2N (2 North) unit. The surveyor asked the RN what the procedure was if a med was held due to parameter. The RN stated she would document in eMAR, and if it was more than once or was a pattern she would notify charge nurse to contact the MD. She further stated that the MD would make final decision for any med changes. The RN also stated that she would document a note in the record as well about contacting the MD or having the charge nurse call the MD. On 8/20/24 at 10:48 AM, the surveyor interviewed the Charge Nurse/Licensed Practical Nurse (CN/LPN) of 2N. CN/LPN stated that she would call the MD after at least two instances of the med being held. CN/LPN further stated that they check every morning with the morning report for meds that were held. A review of the facility's Medication Holds and Physician Notification Policy dated January 2024 that was provided by the DON revealed: Section II. Policy: To ensure the safe and effective administration of meds by establishing clear guidelines for holding meds based on defined parameters and ensuring timely communication with MD when necessary. Section III. Procedure: 2. Physician Notification: For med holds in accordance with the MD orders: The MD or prescribing practitioner should be notified if a trend of meds being held is identified with the potential for adverse effect on the resident's health. The facility will document the date and time of MD notification, and any recommendations or orders received in the resident's medical record. 3. CP's Monthly Med Regimen Review (MRR): the CP will review each resident's med regimen monthly, including any documented med holds. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 01:08 PM the survey team met with the Licensed Nursing Home Administrator (LNHA), the DON, and the Regional Registered Nurse Consultant (RRNC) to discuss concerns. The surveyor notified the DON of a concern with Resident #190's Metoprolol being held frequently with no documentation of any MD notification. There was no further pertinent information provided by the facility. NJ 8:39-11.2 (b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) follow the physician's order (PO) with regard to hypoglycemic protocol, b.) clarify the PO regarding tube feeding (TF) and insulin sliding coverage orders, and c.) ensure staff followed protocol for accurate and timely documentation for one (1) of three (3) residents, Resident #58, reviewed for care and treatment of TF and hypoglycemic protocol according to facility's policies and standards of clinical practice. 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 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 8/14/24 at 10:49 AM, the surveyor observed Resident # 58 lying on the bed with the Certified Nursing Aide (CNA) at the bedside. The surveyor observed there was a pistol syringe (to aid in the feeding tubes, as well as medicine dispensation). The CNA informed the surveyor that he provided morning care to the resident and waiting for another CNA to help him with the Hoyer lift (which allows a resident to be lifted and transferred with a minimum of physical effort) transfer. The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #58. The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to metabolic encephalopathy (occurs when problems with metabolism cause brain dysfunction. Causes range from low blood sugar to excess fluid in the brain) essential hypertension (elevated blood pressure), and type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy (a complication of diabetes that affects the eyes) without macular edema (when blood vessels leak into a part of the retina called the macula) bilateral. According to the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 5/06/24, revealed in Section C Cognitive Patterns that the resident had severely impaired cognitive skills for daily decision making. Section K Swallowing/Nutritional Status revealed that the resident with TF. Section N Medications showed that the resident received insulin injections during the seven-day lookback period. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the August 2024 Order Summary Report revealed the following: -PO dated 5/30/24 Enteral feed order four times a day Glucerna 1.5 8 oz (ounces) bolus via peg check placement of TF prior to bolus feeding. -PO dated 8/06/24 Blood sugar (BS) via fingerstick once daily with no insulin coverage one time a day for monitoring. [the order was discontinued (d/c) on 8/08/24] -PO dated 8/08/24 Humalog solution 100 unit/ml (milliliters) (insulin lispro) inject as per sliding scale: If 0-200=0 units less than 60 call MD (medical doctor); 201-250=2 units; 251-300=4 units; 301-350=6 units; 351-400=8 units more than 400 call MD, Subcutaneously before meals and at bedtime related (r/t) to type 2 diabetes mellitus without complications. -PO dated 4/29/24 If blood glucose is less than 70 mg/dl (milligrams per deciliter) (whether symptomatic or not) or less than 80 mg/dl and symptomatic, initiate tx (treatment) for hypoglycemia: administer approx. (approximately) 15 gm (grams) of glucose or carbohydrates found in any one of the following: 1/2 cup juice, 1/2 cup applesauce, 1 cup milk as needed (PRN) for hypoglycemia symptoms after administration-wait 15 minutes & re-check BS. -PO dated 4/29/24 Glucagon Emergency kit 1 mg inject 1 mg/ml intramuscularly (IM) PRN for hypoglycemic symptoms if unable to swallow-BS is less than 70 mg/dl (whether symptomatic or not) or less than 80 mg/dl & symptomatic, administer Glucagon immediately. Recheck BS in 15 min (minutes). If no response, may repeat x 1. Contact MD for continuing orders. A review of the above orders showed that they were transcribed into the August 2024 electronic Medication Administration Record (eMAR). Further review of the August 2024 eMAR revealed the following: - the Glucerna 1.5 bolus 4 x/day plotted at 1 AM, 9 AM, 1 PM, and 7 PM vs the order for Humalog sliding scale before meals and bedtime plotted for 8:30 AM, 9:00 AM, 1 PM, and 7 PM and the results of accucheck for 8/07/24 at 8 AM was 66 mg/dl and 8/13/24 at 5:30 PM was 50 mg/dl. -On 8/07/24 at 0800 (8 AM) the BS was 66 (mg/dl). The PO PRN for the Glucagon Emergency kit and PRN for blood glucose less than 70 mg/dl were blank for the date 8/07/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that the PRN orders for hypoglycemic protocol were followed or why it was not followed for BS below 70 mg/dl which was 66 mg/dl on 8/07/24. -On 8/13/24 at 1730 (5:30 PM) the BS was 50 (mg/dl). The PO PRN for the Glucagon Emergency kit and PRN for blood glucose less than 70 mg/dl were blank for the date 8/13/24. There was no documented evidence that the PRN orders for hypoglycemic protocol were followed or why it was not followed for BS below 70 mg/dl which was 50 mg/dl on 8/13/24. A review of the BS Summary under Weights and Vitals Summary of Resident #58 showed and included the following: -8/13/24 at 9:20 PM 165 mg/dl 8/13/24 at 6:24 PM 50 mg/dl 8/13/24 at 12:02 PM 245 mg/dl -8/08/24 at 5:30 PM 80 mg/dl 8/08/24 at 8:50 AM 83 mg/dl -8/07/24 at 8:53 AM 66 mg/dl 8/07/24 at 8:31 AM 66 mg/dl -8/06/24 at 8:26 AM 84 mg/dl On 8/20/24 at 8:38 AM, the surveyor interviewed the Licensed Practical Nurse/Charge Nurse (LPN/CN) in the 2 South nursing station. The LPN/CN showed the eMAR for August 2024 and the surveyor notified of the above findings and concerns regarding the Glucerna 1.5 bolus 4 x/day plotted at 1 AM, 9 AM, 1 PM, and 7 PM vs the order for Humalog sliding scale before meals and bedtime plotted for 8:30 AM, 9:00 AM, 1 PM, and 7 PM and the results of accucheck for 8/07/24 at 8 AM was 66 mg/dl and 8/13/24 at 5:30 PM was 50 mg/dl and there was no documented evidence that the PO for PRN hypoglycemic protocol was followed. On that same date and time, the LPN/CN informed the surveyor that the order for insulin sliding scale and bolus feeding should be coordinated and the order should have been clarified so the 7 PM bolus should be adjusted for the 5:30 PM sliding scale order for Humalog. She further stated that the nurses should have followed the PO for the Glucagon kit to administer the PRN Glucagon injection, signed the eMAR, rechecked the BS, documented it in the medical records, and notified the physician as ordered and documented also in the progress notes (PN). The LPN/CN confirmed that if the PRN August 2024 eMAR was blank it means that the PRN hypoglycemic protocol orders were not administered or provided. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 12:39 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) regarding the above findings and concerns. The LPN stated that the order for the Humalog insulin sliding scale should correspond to the Glucerna order when it was being given. She further stated that the orders should have been called and clarified with the MD. On 8/20/24 at 01:50 PM, the surveyor called and spoke to LPN#2 in the presence of the survey team. The LPN informed the surveyor that she recognized and knew the resident, she stated that she was a regular floater of the facility at 3-11 shift. The surveyor notified the LPN of the above findings and concerns regarding the timing of the bolus feeding, the Humalog insulin sliding scale order, the Glucagon kit order, and other hypoglycemic protocol orders. The LPN stated that she does not give the insulin without the resident receiving the bolus feeding. The surveyor then asked the LPN if she did not give the insulin without bolus feeding and how she administered insulin for the 5:30 PM sliding scale when the bolus on her shift was at 7 PM. LPN#2 responded that she gives the insulin for 5:30 PM at a later time after the 7 PM bolus. The surveyor then asked the LPN, how about the 9 PM sliding scale would that be too close for the 7 PM insulin if she administered insulin at 7 PM and should that be clarified with the physician instead. The LPN had no response. On that same date and time, the surveyor notified LPN#2 of the above findings and concerns that on 8/13/24 at 5:30 PM, her initial showed on that date the accucheck was 50 mg/dl, and there was no documentation that she administered the Glucagon kit and other hypoglycemic protocol orders. The LPN stated that the 50 result of accucheck was probably a typo because there is no such thing as 50. The LPN was not able to state what the accucheck results then if 50 mg/dl was a typo error and why it was not corrected on that same date and time. On 8/21/24 at 8:44 AM, the Director of Nursing (DON) showed a handwritten explanation of LPN#2 that the 50 mg/dl result on 8/13/24 at 5:30 PM was a typo error and it should have been 150 mg/dl. The DON also showed a copy August 2024 eMAR that the 8/13/24 at 5:30 PM result was now 150 mg/dl. The surveyor then asked the DON how they were able to change the 50 mg/dl to 150 mg/dl in the eMAR. The DON stated that LPN#2 was able to go back to eMAR and change it and they can change the records after eight days. The DON acknowledged that the changes in the eMAR were done after the surveyor's inquiry. On 8/21/24 at 10:20 AM, the surveyor in the presence of another surveyor interviewed LPN#1 regarding the August 2024 eMAR and the BS on 8/07/24 at 8:31 AM 66 mg/dl and at 8:53 AM it was 66 mg/dl. Surveyors and LPN#2 checked the eMAR and observed no documented evidence that the PRN hypoglycemic protocol was followed and no PN as to why it was not followed. At that same time, the surveyor asked LPN#1 why it was not followed the PO for PRN hypoglycemic protocol, the LPN stated Probably after checking the BS when it was 66 mg/dl, she provided the order for bolus feeding and then rechecked the BS after 15 minutes and it was okay. The surveyor then asked why when she rechecked it as shown in the BS Summary, at 8:53 AM it was still 66 mg/dl, and the PO for PRN hypoglycemic protocol was not administered or provided. The LPN had no response. Furthermore, LPN#1 stated that if she administered the Glucagon or the PRN medications for hypoglycemic protocol it should have been documented and if she called the physician, it should be in the PN. The LPN acknowledged that there were no documented evidence that the MD was called and the PRN hypoglycemic protocols were administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 12:58 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Regional Registered Nurse Consultant (RRNC). The surveyor notified the facility management of the above findings and concerns. On 8/22/24 at 11:07 AM, the survey team met with the LNHA, DON, [NAME] President Skilled Nursing Division, RN VP of Clinical Services, and RRNC. The DON stated that LPN#1 wrote a handwritten statement that when the nurse rechecked the BS on 8/07/24 it was 97 mg/dl and that the nurse entered the results in error. The DON stated that the documentation in the PRN hypoglycemic orders on 8/07/24 was entered after the surveyor's inquiry. DON stated that the hypoglycemic protocol in service was provided to the staff. The DON acknowledged that the change in August 2024 eMAR to include the PRN hypoglycemic protocol orders were signed after the surveyor's inquiry which was after 14 days. A review of the facility's Physician Services Policy with a revised date of January 2024 that was provided by the DON, revealed: III. Notification The resident's Attending Physician may be notified in the following circumstances: -In the event of an acute change of condition (ACOC). ACOC is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. -In accordance with previously established Physician orders, care plans, or facility policies. A review of the facility's Retention of Medical Records Policy that was provided by the DON with a reviewed date of [DATE] showed: Medical records shall be retained by the facility in accordance with current applicable laws. On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing, Infection Preventionist/Registered Nurse, and RRNC for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:39-3.2(a,b), 11.2(b), 27.1(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain infection control practices to reduce the risk of infection during a pressure ulcer (PU) treatment and perform a PU risk assessment quarterly for one (1) of four (4) residents (Resident #131) and b.) ensure that comprehensive assessment was done and documented to reflect the skin impairment of one (1) of four (4) residents reviewed for PU/injury (Resident #164) according to standards of clinical practice and facility policy. The deficient practice was evidenced by the following: Reference: National Pressure Injury Advisory Panel's Pressure Injury Prevention Points included the following: Risk Assessment Consider bedfast and chairfast individuals to be at risk for development of pressure injury. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission). Refine the assessment by including these additional risk factors. Fragile skin Existing pressure injury of any stage, including those ulcers that have healed or are closed Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use Pain in areas of the body exposed to pressure Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels: Acute care . Every shift Long term care . Weekly for 4 weeks, then quarterly Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems. 1. On 8/14/24 at 12:01 PM, the surveyor observed Resident #131 lying in bed on an air mattress. The surveyor attempted to interview Resident #131 but the resident did not respond to the surveyor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #131's Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain), hypertension (high blood pressure) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to perform even the simplest tasks). A review of Resident #131's Physician Order (PO) Set included the following order: Medihoney Wound/Burn Dressing Gel (Wound Dressings) (supports the removal of necrotic tissue and aids in wound healing) Apply to sacrum topically every day shift for wound care cleanse with NSS (normal saline solution). Pat dry. Apply Medihoney to wound base. Cover with Calcium Alginate (a hemostatic used to absorb excess moisture and promote healing), then cover with foam dressing daily and prn (as needed) with an order date of 6/05/24. On 8/15/24 at 10:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) regarding Resident #131's PU. LPN#1 stated that Resident #131 had a small area that had ordered to place on medihoney and calcium alginate. LPN #1 stated that it was from moisture and had it in the past. On 8/19/24 at 9:30 AM, the surveyor interviewed the third floor Charge Nurse/LPN (CN/LPN) regarding the Braden Scale assessment. The CN/LPN stated that the Braden Scale was not done routinely and that it was done on admission and if a resident acquired a PU. She then stated that it was an assessment in the computer and that it was not part of the quarterly assessment. She then added that it used to be but for some reason it was stopped. On 8/19/24 at 9:47 AM, the surveyor observed LPN #1 perform the PU treatment for Resident #131 who wore the appropriate personal protective equipment which included a gown and gloves. After LPN #1 appropriately cleansed the PU and patted it dry, LPN #1 took the medihoney multiple use tube in her hand and squeezed the container to apply the medihoney directly on Resident #131's sacral PU. LPN #1 did not change her gloves after cleaning the PU and before applying the medihoney. The tip of the tube did not touch the resident. LPN #1 then removed her gloves and performed hand hygiene with an alcohol based handrub. LPN #1 applied a new pair of gloves and picked up the same medihoney tube and squeezed a small amount of the medihoney onto a small square piece of calcium alginate and placed it on Resident #131's sacral PU. LPN #1 then finished the treatment (tx) and wiped the medihoney tube with a disinfectant wipe and put it in the tx cart. After the tx was complete, the surveyor asked LPN #1 why she applied the medihoney directly from the tube. LPN #1 stated that she was told that she could squeeze it that way. She added that she could have put it in a cup and use an applicator. The surveyor then asked LPN #1 if she should have changed her gloves and performed hand hygiene after cleaning the wound and before application of the medihoney. LPN #1 stated that she should have done hand hygiene before applying the medihoney. A review of Resident #131's electronic record revealed that Resident #131 had a Braden Scale (an assessment for Predicting Pressure Sore Risk which was developed to foster early identification of patients at risk for forming pressure sores) performed on Admission, August 2022 and after Resident #131 developed a PU, June 2024. There was no documented evidence that a Braden Scale was done quarterly to assess the risk for PU. The Braden Scale was done after the PU had developed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #131's most recent last three quarterly Minimum Data Set's (qMDS), an assessment tool used to facilitate the management of care, which were prior to the development of the PU, reflected the following under section M-Skin Conditions: Determination of Pressure Ulcer/Injury Risk B. Formal assessment instrument/tool (e.g. Braden, [NAME], or other)-No C. Clinical assessment-No Further review of the above qMDS revealed that there were no assessments done to determine the resident's risk for developing a PU. On 8/19/24 at 10:24 AM, the surveyor interviewed the Infection Preventionist (IP) regarding PU treatment. The IP stated that after cleaning the PU, gloves should be removed, hand washing should be done and then new gloves applied before the tx should be applied. The IP stated that the tx cream or ointment should be placed into a small cup and use a tongue depressor to apply it. On 8/21/24 at 12:59 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON and Regional Registered Nurse Consultant (RRNC) the concern that the LPN did not change her gloves and perform hand hygiene after cleaning the sacral PU and before applying the medihoney and brought the multiuse tube and squeezed it directly on the resident and did not put the medihoney in a medicine cup and apply it with an applicator during Resident #131's PU tx. On 8/21/24 at 01:05 PM, the surveyor reviewed the facility provided incident report/investigation for Resident #131's newly identified PU which was dated 6/05/24. There was a document attached which included the following: Pressure ulcer prevention and management quality improvement tool Process for all wounds (Ongoing) Measure Risk assessment (Braden or Norton Plus) is completed: weekly after admission for a total of 4 weeks; Quarterly; With a change in condition (including a new wound) The staff member marked yes for this section. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 9:41 AM, the surveyor interviewed the Director of Nursing (DON) regarding the Braden Scale. The DON stated that the Braden Scale was done on admission and a significant change. The surveyor asked the DON the reason a quarterly Braden Scale was not done any longer. The DON stated that he was at the facility since February 2023 and that maybe before he was at the facility it was done quarterly but that a quarterly was not done now. On 8/22/24 at 9:50 AM, the surveyor asked the DON about the Pressure Ulcer Prevention and Management Quality Improvement Tool. The DON stated that the form was outdated. He added that the person that filled out the form was the person that did the incident report. The DON stated that he thought that the person marked yes to show that the risk assessment was done that day. The DON stated that it was no longer policy to do the assessment quarterly. The surveyor asked the DON what the purpose of the Braden Scale was. The DON stated that it was to look for the risk of skin breakdown. On 8/22/24 at 11:26 AM, in the presence of the survey team, LNHA, RRNC, [NAME] President of Clinical Services (VPoCS) and VP of Skilled Nursing Division (VPoSND), the DON stated that at that time he did not have any information about the PU tx. On 8/22/24 at 12:05 PM, the surveyor interviewed the MDS/Registered Nurse (MDS/RN #1) and MDS/RN #2 regarding the risk assessment for PU. The MDS/RN #1 stated that she was not sure if the Braden scale was done quarterly and that it would be the nurse on the unit that would do it. On 8/22/24 at 12:55 PM, in the presence of the survey team, the surveyor notified the LNHA, DON, RRNC, VPoCS and VPoSND the concern that Resident #131 did not have a quarterly PU risk assessment. On 8/23/24 at 9:12 AM, in the presence of the survey team, the DON stated that he was providing the surveyor with the quarterly MDS which was an assessment. The surveyor asked the DON where the MDS nurse obtained the information for the MDS assessment. The DON stated that would be a question for the MDS nurse and that he was told MDS was an assessment for skin. The DON then added that he performed a competency with the LPN after the concern of the PU tx was received. The surveyor asked the DON if the LPN should have performed hand hygiene prior to application of the medihoney and should have used a different method to apply the medihoney. The DON stated yes. On 8/23/24 at 11:28 AM, in the presence of the survey team, LNHA, DON, and IP, the RRNC stated that the Braden Scale was done on admission and any significant change and that it was addressed in the MDS. She added that Resident #131 had a Braden Scale assessment when the skin change was noted, we followed our policy. A review of the facility provided policy titled, Dressing Change with a revised date of Mar (March) 2024, included the following: Clean the wound per the PO 1. Clean the wound from the center outward using a circular motion or vertical strokes. Use a clean gauze or swab and discard after each use. 2. Remove gloves and wash hands and don a new pair of gloves. Wound tx as ordered by the physician (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Treat the wound as ordered by the physician by applying medicated ointments etc. 2. Apply the ointment directly to the wound site using cotton-tipped applicator. DO NOT apply the ointment directly to the dressing and place it over the wound. 3. Begin to apply the ointment at the center or top of the wound and apply the ointment outward in a circular or vertical motion. 4. Use the applicator only once and discard into the moisture-proof bag. Select another applicator for additional ointment application if necessary A review of the facility provided policy titled, Pressure Ulcer Prevention with a reviewed date of April 2024 included the following: II. Policy .Residents will also be assessed for risk of development of PU. Interventions to eliminate or minimize risk factors will be introduced at the earliest possible time. Our goal will be to prevent facility acquired PU unless the resident's clinical condition clearly demonstrates that they are unavoidable. IV. Risk Assessment The Braden Scale will be the standard assessment scale .The Braden Scale will be completed on admission, and whenever there is a significant change in condition. V. Turning and Repositioning Turning and repositioning will be determined based on risk assessment. 46049 2. On 8/14/24 at 11:14 AM, the surveyor observed Resident #164 resting in bed with their eyes closed. The resident was not verbally responsive to the surveyor's greeting. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #164. The AR documented that the resident had diagnoses that included but were not limited to, dementia, muscle weakness, and osteoarthritis (type or arthritis that occurs when flexible tissue at the ends of bones wears down). A comprehensive MDS dated [DATE], indicated under Section M-Skin Conditions, that the resident had PU wounds and was receiving pressure ulcer/injury care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of PO included a wound tx order dated 8/09/24 that read, Medihoney Wound/Burn Dressing Gel (Wound Dressings) Apply to left chest topically every day shift for wound care cleanse (SPECIFY SITE) with NSS. pat dry. Apply skin prep (a fast drying, sterile, liquid film-forming skin protectant that prepares damaged or intact skin for attachment sites, tapes, films, and adhesive dressings) to peri wound then apply medihoney to wound base. Cover with gauze slightly moistened with NSS, then cover with foam dressing daily and prn. A PO dated 01/30/24 read WEEKLY SKIN ASSESSMENT 1=NO SKIN INJURY; 2=NEW SKIN INJURY/WOUND; 3=PREVIOUSLY NOTED SKIN INJURY/WOUND every day shift every Fri [Friday]. A review of the electronic Treatment Administration Record (eTAR) for August 2024 revealed for the weekly skin assessment entry on 8/09/24 a 2 was documented by the nurse indicating that the resident had a new skin injury/wound. A review of progress notes and assessments revealed there was no wound assessment documentation. A review of the wound consultant notes revealed there was no note found on 8/09/24 or after to indicate an assessment of the resident's wound. On 8/19/24 at 12:42 PM, the surveyor interviewed LPN #2 who had cared for the resident. LPN #2 confirmed that the resident multiple wounds which were being treated. LPN #2 stated the resident had a wound to left rib/chest area which was being treated with medihoney topical tx. LPN #2 stated weekly skin checks were performed and documented in the eTAR. If there was any new wound any incident report would be completed, the resident representative, and the physician would be notified. Additionally, the resident would be seen by the wound care consultant who visited the facility weekly. The surveyor asked LPN #2 if the wound care consultant evaluated Resident #164's and any wound assessment documentation. LPN #2 stated that the resident was seen by the wound care consultant after the left chest wound was identified. LPN #2 in the presence of the surveyor reviewed the hybrid medical record and could not find a wound care consultant note for after 8/09/24. LPN #2 stated the wound care consultant would send their visit notes to the facility and would have to follow up with the consultant. On 8/19/24 at 01:18 PM, the DON provided the surveyor with the Wound care consultant's skin and wound note for Resident #164, dated 8/14/24. A review of the skin and wound note revealed there was no wound assessment and no documentation of the resident having a new wound to the left chest area. The surveyor reviewed the facility's policy titled, Wound Care, with a review dated of April 2024. The policy did not further address wound and skin assessments completed by nurses. On 8/21/24 at 01:03 PM, the surveyor informed the LNHA, DON, and RRNC of concerns there was no wound assessment documentation for Resident #164's left chest wound. The surveyor requested any additional policies related to skin assessments and wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 11:07 AM, the survey team met with the LNHA, DON, RRNC, VPoCS, and VPoSND. The DON stated an incident report for left chest wound was completed on 8/09/24 when the new wound was identified and included an assessment of the wound. The surveyor discussed with the DON if there was any documentation in report of a description and measurement of the resident's wound and if the incident report was part of the resident's medical record. The DON replied that the incident report documented the resident wound as being small and an abrasion. There was no additional response or documentation provided. On 8/23/24 at 10:30 AM, the surveyor requested from the LNHA for any additional policy related to wound and skin assessments other than the Wound Care policy already provided to the survey team. There was no additional information provided by the facility. NJAC 8:39-27.1 (e)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39885 Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure a fall risk assessment was done quarterly in accordance with their facility policy for one (1) of four (4) residents reviewed for accidents. The deficient practice was evidenced by the following: On 8/19/24 at 9:13 AM, the surveyor observed Resident #161 asleep in a low to floor bed. A review of Resident #131's Admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to fracture of left femur (broken thighbone), hypertension (high blood pressure) and cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain). A review of Resident #161's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected under Section J-Health Conditions indicated that the resident had a fall since admission/entry or reentry or prior assessment. The MDS does not include a question about risk for fall and a fall risk assessment being done. On 8/19/24 at 10:53 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for any incidents from the last six months for Resident #161. On 8/21/24 at 8:26 AM, the surveyor reviewed the facility provided investigation that was for an unwitnessed fall which occurred on 02/22/24. A review of Resident #161's electronic medical record revealed that Resident #161 had a fall risk assessment done on admission in January 2023, readmission in February 2024 and when the fall occurred on 02/22/24. There was no documented evidence that a quarterly fall risk assessment was done. On 8/22/24 at 12:00 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding fall risk assessment. The LPN stated that the charge nurse did the assessment and that it was done on admission, a change of status and when a fall occurred. On 8/22/24 at 12:02 PM, the surveyor interviewed the Charge Nurse/LPN (CN/LPN) regarding fall risk assessment. The CN/LPN stated that the fall risk assessment was not done quarterly. She added that it was done on admission, when a fall occurred and a change in condition. On 8/22/24 at 12:05 PM, the surveyor interviewed the MDS/Registered Nurse (MDS/RN #1) and MDS/RN #2 regarding the fall risk assessment. MDS/RN #1 stated that the information for falls was obtained from the nurse's notes and that the fall risk assessment was done on admission and when a resident had a fall. She added that she was not sure if it was done quarterly and that it would be done by the nurse on the unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 12:55 PM, in the presence of the survey team, the surveyor notified the LNHA, Director of Nursing (DON), Regional Registered Nurse Consultant (RRNC), [NAME] President of Clinical Services (VPoCS) and VP of Skilled Nursing Division (VPoSND) the concern that Resident #161 did not have a quarterly fall risk assessment. On 8/23/24 at 9:12 AM, in the presence of the survey team, the DON stated that he was providing Resident #161's MDS which was the assessment that included the fall risk which was done quarterly. The surveyor reviewed the provided MDS and there was no indication on the MDS that a fall risk assessment was included. On 8/23/24 at 11:28 AM, in the presence of the survey team, LNHA, DON, and Infection Preventionist (IP), the RRNC stated that the fall risk assessment was done on admission and significant change in condition. She added that Resident #161 had a fall and had an assessment, we followed our policy. A review of the facility provided policy titled, Fall Prevention with a revised date of September 2024, included the following: II. Policy The purpose of the profile is to identify residents at risk for falls. It is the goal that once the risk is identified preventive measures can be implemented to reduce and/or eliminate incidents. III. Procedure Upon admission each resident is to be evaluated for fall risk based upon history of falls, diagnosis, hospital records, fall assessment score, and actual attempts upon admission to get up unassisted. A resident at risk will have approaches developed for prevention of falls by admitting nurse. All risks and approaches should be reevaluated by the IDC (interdisciplinary) team and addressed on the care plan. Thereafter it shall be reevaluated quarterly . N.J.A.C. 8:39-27.1 (a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48423 Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to administer Tube Feedings per Physician's order (PO). This deficient practice was identified for one (1) of three (3) residents (Resident #48) reviewed for receiving nutrition via Tube Feeding (TF) and was evidenced by the following: On 8/14/24 at 10:49 AM, the surveyor entered Resident #48's room and observed the resident sitting in their wheelchair (w/c), and non-verbal. The surveyor observed that the resident had a TF (nutrition received through a flexible tube surgically inserted into the stomach) formula hanging on a pole, attached to a TF pump, and infusing at a rate of 90 ml/hr (milliliters per hour). On 8/15/24 at 12:36 PM, the surveyor observed the resident in their room, sitting in their w/c and a visitor was sitting next to them. The surveyor further observed a TF connected to a TF pump, and infusing at a rate of 90 ml/hr. Later on, the TF rate was verified with second surveyor. The surveyor reviewed the medical record for Resident #48. According to the Admission Record or face sheet (admission summary), the resident was admitted to facility with diagnoses which included but were not limited to: cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), gastro-esophageal reflux disease (stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), aphasia (affects how you communicate), and gastrostomy status (a surgical procedure used to insert a flexible tube, often referred to as a G-tube, through the abdomen and into the stomach, in which they receive nutrition). According to the most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/02/24, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated the resident was severely cognitively impaired. A review of the Quarterly Nutritional Assessment note dated 7/26/2024, revealed that the dietician indicated the resident's weight was trending up, with a weight gain of ~28#[pounds] over the past year, and the TVI would be slightly lowered. Additionally, the dietician recommended TF change from Jevity 1.5 @ 90mL/hr, TVI 1350 to Jevity 1.5 @ 80 ml/hr, TVI 1250. The Order Summary Report revealed a PO dated 7/26/24 for the following: Enteral Feed Order one time a day Jevity 1.5 via pump time up= 12 AM CC [milliliters] rate per hour= 80 ml/hr with a start date 7/27/24. The above PO for Jevity 1.5 via pump was transcribed to the July and August 2024 electronic Medication Administration Record (eMAR) indicated that Resident #48 had received TF at 80 ml/hr and was signed by the nurses. A review of the Care Plan ([CP] a document that summarizes a person's health condition, specific care needs and health condition) included a focus for: Receiving enteral feedings to meet nutrition & hydration needs. Interventions included to Administer feeding as ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the CP revealed a focus for: Resident with enteral feeding as main source of nutrition/ hydration. It documented .7/26/24 - TF TVI [total volume infused] reduced . During an interview with the surveyor on 8/15/24 at 01:33 PM, the Charge Nurse/Licensed Practical Nurse (CN/LPN) explained the process of TF that he would check the PO first to see what type of feeding and the rate that was ordered for the resident. The CN/LPN further stated, it was important to check PO to make sure that you do not hang the wrong feeding or at wrong rate. The surveyor presented their concerns about the TF rate that was observed on Resident #48's pump to the CN/LPN. The CN/LPN further acknowledged that it was not acceptable that the resident was receiving the TF at wrong rate, and he would call and inform the physician and the dietitian. On 8/15/24 at 01:39 PM, the Licensed Practical Nurse (LPN) accompanied the surveyor to Resident #48's room, and observed the TF infusing (running) at 90 ml/hr. The LPN reviewed the PO in presence of the surveyor and stated, the TF rate is at 80 ml/hr, which was created by dietitian on 7/27/24 and the TF was usually hung by the overnight nurse. The LPN acknowledged that the rate on the TF pump was a mistake and that it was not changed when the new orders were put in on 7/27/24. A review of the facility provided Enteral Feeding policy, reviewed on January 2024, did not specify nurse's responsibility for residents who are receiving TF and following the PO. A review of the undated facility provided Job Description for Position: LPN document revealed under Duties and Responsibilities: 1.) Provides nursing care according to physician instructions On 8/19/24 at 01:49 PM, the survey team met with Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional Registered Nurse Consultant (RRNC). The surveyor notified the facility management of the above findings. On 8/23/24 at 9:12 AM, the DON informed the survey team that the physician was notified of the resident receiving the TF at the wrong rate. The DON provided the physician's progress note (PPN). The surveyor reviewed the PPN which was dated 8/19/24 at 21:22 (9:22 PM) and under assessment, the physician documented Apparently no adverse reaction for over feeding. NJAC 8:39-27.1(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. 39885 REPEAT DEFICIENCY Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services of residents that were receiving oxygen, according to the standard of clinical practice and facility's policy and procedure, specifically a.) the posting of cautionary and safety signs indicating the use of oxygen were utilized for residents that received oxygen therapy, b.) that respiratory equipment were stored in accordance with facility policy and infection control measures for one (1) of two (2) residents reviewed for respiratory care (Resident #66), c.) administer oxygen therapy according to the physician's order for one (1) of two (2) residents, Resident #111, reviewed for respiratory care, and d.) ensure staff followed the appropriate hand hygiene and use of personal protective equipment (PPE) protocol during tracheostomy care for one (1) of one (1) of resident, Resident #111, reviewed for tracheostomy (including laryngeal care) care. 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 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. 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. Reference: National Institutes of Health defines oxygen (O2) as a colorless, odorless and tasteless gas. It will support life. It is noncombustible, but will actively support the burning of combustible materials. Some materials that will not burn in air will burn in O2. Materials that burn in air will burn more vigorously in O2. 1. On 8/15/24 at 12:11 PM, the surveyor observed Resident #66 seated in a wheelchair in the dining room eating lunch. The surveyor observed Resident #66 was receiving O2 via a nasal cannula (n/c) at 2 LPM (liters per minute), that was connected to a portable O2 tank. The nasal cannula tubing was not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 12:29 PM, the surveyor entered Resident #66's room and observed Resident #66's O2 concentrator at the bedside. The surveyor observed a n/c tubing that was connected to the O2 concentrator that was dated 8/12/24. The n/c tubing was laying on top of the O2 concentrator. The tubing was not placed in the clear plastic bag that was connected to the O2 concentrator. The surveyor observed that Resident #66's entrance to their room did not have an O2 in use sign. On 8/15/24 at 12:30 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) regarding the process for O2. The LPN stated that the O2 tubing should be dated and that it was changed once a week. The LPN stated that when the O2 tubing was not in use that it would be placed in a plastic bag. The surveyor asked the LPN if a resident that received O2 should have a sign that indicated O2 in use. The LPN stated that there should be a sign. The surveyor then asked the LPN to view Resident #66's O2 tubing that was on the O2 concentrator. The LPN confirmed that the n/c tubing was placed on top of the concentrator and not in the clear plastic bag. The LPN stated that the Certified Nursing Assistant (CNA) had done that when the CNA just got the resident out of bed and that the tubing should have been placed in the clear plastic bag. LPN#1 stated that she would discard the tubing and get a new one. On that same date and time, the surveyor then asked LPN#1 to observe Resident #66 in the dining room. The LPN confirmed that the O2 tubing that Resident #66 had on was not dated and that it should have been dated. The LPN added that sometimes they write on the tubing but that it should be written on a piece of tape. On 8/15/24 at 12:36 PM, the surveyor interviewed Charge Nurse/Licensed Practical Nurse #1 (CN/LPN#1) in the 3rd floor regarding the process for O2. CN/LPN#1 stated that the O2 tubing should be dated and in a bag plastic when not in use. The surveyor asked CN/LPN#1 if there should be a sign on the resident's door. CN/LPN#1 stated that there should be a sign. On 8/15/24 at 12:44 PM, CN/LPN#1 stated that the facility was not a smoking facility, so they did not have to put up the O2 in use sign. On 8/15/24 at 01:01 PM, the Licensed Nursing Home Administrator (LNHA) stated that the facility was a non smoking facility and that they did not have to put up O2 in use signs. He added that he believed the signs were for a smoking facility. On 8/21/24 at 12:58 PM, in the presence of the survey team, the surveyor notified the LNHA, Director of Nursing (DON) and Regional Registered Nurse Consultant (RRNC) the concern that Resident #66's O2 tubing that was in use was not dated, the O2 tubing that was not being used by the resident was not placed in a plastic bag and there was no O2 in use sign posted outside the room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 11:18 AM, in the presence of the survey team, DON, RRNC, [NAME] President of Clinical Services (VPoCS) and VP of Skilled Nursing Division (VPoSND), the LNHA stated that the resident had a care plan for non compliance and a history of removing the O2. The LNHA stated that it was possible that the resident placed the O2 tubing on the concentrator. The LNHA stated that he did not know why the other tubing was not dated. The surveyor asked if the resident needed assistance to transfer from the bed to a wheelchair. The DON stated that the resident was supposed to be helped by the CNA and that the CNA placed it [O2 tubing] on the concentrator The LNHA stated that according to NFPA (National Fire Protection Association) 101 that in a nonsmoking facility it was not required to have signage outside O2 storage rooms and resident rooms that had O2 in use. The LNHA provided the survey with a printout of a NFPA regulation. A review of the facility provided printout included the following: NFPA 101 19.7.4 Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or O2 is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. The above NFPA 101 Smoking information revealed that there was no reference regarding O2 in use sign. On 8/22/24 at 12:59 PM in the presence of the survey team, the DON, the RRNC, VPoCS and VPoSND, the LNHA stated that O2 in use signs were specific to smoking and that as far as he knew there was no issue during previous surveys. A review of the facility provided policy titled, Oxygen Administration with a revised date of April 2024, included the following: 7. Equipment Maintenance: Date and initial tubing and humidifiers when started each week. The policy did not include how to store the O2 tubing when not in use. 38327 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 8/14/24 at 10:40 AM, the surveyor interviewed CN/LPN#2 who informed the surveyor that residents on Enhanced Barrier Precautions (EBP) were those residents with tube feeding (TF), wounds, dialysis, and tracheostomy (trach; an incision in the windpipe made to relieve an obstruction to breathing). The CN/LPN further stated that Resident #111 had a wound, laryngeal stoma (Laryngectomy stomas are formed following excision of the larynx, usually for the treatment of an underlying malignancy. This is a permanent stoma in which the trachea is separated from the esophagus and brought to an opening in the neck). On 8/14/24 at 10:56 AM, the surveyor observed an EBP sign posted outside the door of the resident. Both LPN#2 and the surveyor inside the resident's room observed Resident #111 with continuous O2 via the laryngeal stoma (open hole) with a mask, attached to a humidified concentrator (a medical device that provides supplemental O2) at 4 LPM. At that same time, LPN#2 confirmed that the resident had O2 at 4 LPM and stated that the humidified water had a date of 8/11/24 which indicated that the tubing was changed on that date. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #111 and revealed: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to malignant neoplasm (cancerous tumor) of unspecified bronchus or lung, essential hypertension (elevated blood pressure), primary osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down) right shoulder, dysphagia (difficulty swallowing is a symptom of many different conditions, including brain and muscle disorders and blockages in throat), anemia (low blood count), and encounter for palliative care. The most recent quarterly MDS with an assessment reference date (ARD) of 6/15/24, under Section C Cognitive Patterns, reflected on cognitive skills for daily decision-making and showed that the resident was coded for number three which indicated that the resident's cognition was severely impaired. A review of the August 2024 Order Summary Report (OSR) revealed the following physician's orders (PO): -PO dated 8/14/24 for O2 via trach collar continuous at 2 LPM with humidification every shift for SOB (shortness of breath) Administer O2 via trach collar. Monitor pulse ox (oximeter) every shift. Notify MD if pulse ox less than or equal to 90%. -PO dated 3/28/24 for laryngectomy stoma care every shift to maintain airway dry and clean every shift. -PO dated 3/28/24 Laryngectomy stoma care every shift to maintain airway dry and clean every shift. Further review of the hybrid medical records showed that the above orders were transcribed to the electronic Treatment Administration Record (eTAR) for August 2024 and were signed by nurses as administered and provided. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 8:29 AM, LPN#2 informed the surveyor that she would suction and provide trach care for the resident. Inside the resident's room, both the surveyor and the LPN observed the resident's O2 was at 3 LPM via trach. The LPN stated that the resident's O2 should be set at 2 LPM and not 3 LPM. She further stated that she wanted to correct what she said to the surveyor yesterday (8/14/24) that the resident's O2 order was 4 LPM. The LPN also stated that she did not know why the O2 was at 4 LPM yesterday and now at 3 LPM. The LPN immediately adjusted the setup of O2 to 2 LPM and stated that the order was at 2 LPM. On that same date and time, the surveyor observed LPN#2 pull the curtain for privacy with gloves, open the nightstand table, and stated she was looking for the suction catheter. The LPN found the suction catheter on top of the suction machine, the suction catheter was inside a plastic and placed the suction catheter (still inside the bag) near the resident's pillow, then pulled the curtain, removed gloves, donned (put on) a new pair of gloves without performing hand hygiene. The LPN with gloves, pulled the curtain again for privacy, took 4x4 gauze near the suction machine, and wet it with NSS (normal saline solution). The LPN did not remove gloves that were used in touching the resident's immediate environment. The LPN with the same gloves, cleansed the laryngeal stoma, and the surrounding area. The LPN doffed off (removed) gloves, performed hand hygiene with the use of alcohol base hand rubbed (ABHR) inside the resident's room, donned gloves, and suctioned the resident. The LPN suctioned the resident 4x and the LPN stated that there were secretions. After suctioning the resident, the LPN removed gloves, performed hand hygiene with the use of ABHR, immediately went outside the resident's room without removing the gown, and took the O2 saturation (sat) hand machine (or pulse oximeter). Inside the resident's room, the LPN donned a new pair of gloves without performing hand hygiene and checked the resident's O2 sat. The LPN after checking the O2 sat, removed gloves, went to the resident's toilet room, placed the O2 sat machine on top of the sink and the LPN performed handwashing for 55 seconds, dried hands with a paper towel, took another paper towel and took the O2 sat machine outside the room without removing gown that was used for suctioning the resident. Then the LPN returned to the resident's room with the same gown. At that time, the surveyor asked LPN#2 about the observation of hand hygiene and PPE use. The LPN stated that she should have performed hand hygiene after removing gloves and prior to donning gloves. She further stated that she should have removed the gown inside the room before exiting the room because the gown was contaminated during suctioning. On 8/15/24 at 11:22 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN). The IP/RN informed the surveyor that she was responsible for the facility staff's education regarding infection control that included hand hygiene and PPE use. The surveyor notified the IP/RN of the above findings regarding the laryngeal stoma and respiratory care concerns. On that same date and time, the IP/RN informed the surveyor that LPN#2 should have performed hand hygiene after the direct contact of the LPN's hand with gloves in the immediate environment of the resident's curtain and nightstand table drawer, in between use of gloves [before and after gloves donning and doffing]. The IP/RN stated that the LPN should have removed the gown and other PPE when exiting the resident's room. The IP/RN also stated that the LPN should have used a sterile suction kit and a new suction catheter at that time. On 8/21/24 at 12:58 PM, the survey team met with the LNHA, DON, and RRNC. The surveyor notified the facility management of the above findings and concerns. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 11:07 AM, the survey team met with the LNHA, DON, VPoSND, VPoCS, and RRNC. LNHA also stated that the facility did multiple in-services to address the concerns and findings of the surveyor with regard to Resident #111. A review of the facility's Oxygen Administration Policy with a revised date of April 2024 that was provided by the LNHA revealed: II. Policy: O2 will be administered as per the MD (medical doctor) order to aid in breathing. III. Procedure: 1. Check MD Order On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing, IP/RN, and RRNC for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 38327 Based on the interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure: a.) that the Physician's Order (PO) for pain management was clarified according to the appropriate pain level for one (1) of two (2) residents, Resident #111, and b.) the PO for as needed pain medications were separated according to indications for two (2) of two (2) residents, Residents #111 and #164, reviewed for pain management according to standards of clinical practice and facility policy. The 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 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. 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. 1. On 8/14/24 at 10:40 AM, the surveyor interviewed the Charge Nurse/Licensed Practical Nurse (CN/LPN) who informed the surveyor that Resident #111 was in hospice care. On 8/14/24 at 10:56 AM, the surveyor observed an EBP (enhanced barrier precaution) sign posted outside the door of the resident. Both Licensed Practical Nurse #1 (LPN#1) and the surveyor inside the resident's room observed Resident #111 with continuous oxygen (O2) via the laryngeal stoma (open hole) with a mask, attached to a humidified concentrator (a medical device that provides supplemental O2) at 4 LPM (four liters per minute). The LPN also stated that the resident was recently admitted for hospice care. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #111 and revealed: The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to malignant neoplasm (cancerous tumor) of unspecified bronchus or lung, essential hypertension (elevated blood pressure), primary osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down) right shoulder, dysphagia (difficulty swallowing is a symptom of many different conditions, including brain and muscle disorders and blockages in throat), anemia (low blood count), and encounter for palliative care. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent quarterly MDS with an assessment reference date (ARD) of 6/15/24, under Section C Cognitive Patterns, reflected on cognitive skills for daily decision-making and showed that the resident was coded for number three which indicated that the resident's cognition was severely impaired. A review of the August 2024 Order Summary Report (OSR) revealed the following PO: -PO dated 8/05/24 for [name of hospice] hospice care evaluation and treatment. -PO dated 7/17/24 for Acetaminophen 325 mg (milligrams) give two tablets (tab) via g-tube (gastrostomy tube) every six hours (hrs) as needed (PRN) for pain, do not exceed 3 gms (grams) of Acetaminophen from all sources in 24 hrs. -PO dated 8/08/24 for Morphine Sulfate (concentrate) solution 20 mg/ml (mg/milliliters) give 0.25 ml sublingually every four hrs PRN for Pain/SOB (shortness of breath). May repeat in 30 min (minutes) if the first dose is ineffective (0.25 ml=5 mg). On 8/20/24 at 8:50 AM, the surveyor interviewed the CN/LPN. The surveyor notified the CN/LPN of the above findings and concerns. The CN/LPN informed the surveyor that the resident was nonverbal and cognitively impaired, and it was the hospice nurse who recommended the PRN Morphine. The CN/LPN stated that the PRN Tylenol and Morphine should have been clarified with the doctor for medications (meds) sequencing to determine which med to administer first according to pain level. She further stated that the PRN Tylenol should be for mild pain and the PRN Morphine should be for moderate to severe pain. On that same date and time, the CN/LPN stated that the order for PRN Morphine should have been separated, one for PRN Pain and one for PRN SOB. She further stated that she would call the doctor and clarify the orders. On 8/20/24 at 02:19 PM, the Director of Nursing (DON) stated that the facility had no policy with regard to the sequencing of meds. On 8/21/24 at 12:58 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Regional Registered Nurse Consultant (RRNC). The surveyor notified the facility management of the above findings and concerns. On 8/22/24 at 11:07 AM, the survey team met with the LNHA, DON, [NAME] President of Skilled Nursing Division (VPoSND), VP of Clinical Services (VPoCS), and RRNC. LNHA also stated that the facility did multiple in-services to address the concerns and findings of the surveyor with regard to Resident #111. A review of the facility's Pain Management Policy with a reviewed date of April 2024 that was provided by the DON revealed: II. Policy: it is the policy of the facility to provide a uniform method of assessing and documenting our residents' complaints of pain and effectively treat residents with both chronic and/or acute pain . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Procedure: all residents will be assessed for pain on admission and readmission and as needed thereafter. IV. Purpose: -to reduce pain and perception of pain. -to reassess pain relief and pain intensity at a regular interval . V. Resident Rights: 1. Residents have the right to understand their options for pharmacologic and non-pharmacologic pain control strategies. 2. Residents may describe verbally or nonverbally the pain, location, and characteristics of the pain . On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing, IP/RN, and RRNC for an Exit Conference and there was no additional information provided by the facility management. 46049 2. On 8/14/24 at 11:14 AM, the surveyor observed Resident #164 resting in bed with their eyes closed. The resident was not verbally responsive to the surveyor's greeting. On 8/15/24 at 01:31 PM, the surveyor interviewed LPN#2 who was assigned to care for the resident. LPN#2 confirmed that the resident was receiving hospice care and was no longer alert or verbally responsive. The LPN further stated the resident was to be kept comfortable and there were no reported concerns. The surveyor reviewed the hybrid medical records of Resident #164. The AR documented that the resident had diagnoses that included but were not limited to, dementia, depression, muscle weakness and osteoarthritis. A PO dated 7/31/24 read, Hospice eval [evaluation] & care by [Hospice Agency Name] A PO dated 8/01/24 read, Morphine Sulfate Oral Solution 20 MG/5ML Give 0.25 ml by mouth every 4 hours PRN for Pain;SOB administer 0.25ml = 1mg A review of the electronic Medication Administration Record (eMAR) for August 2024 revealed the resident received morphine sulfate nine times for pain. The numerical pain scale documented ranged from 5 (five) to 8 (eight). On 8/21/24 at 01:03 PM, the surveyor informed the LNHA, the DON, and the RRNC of the concern for the morphine sulfate having the two indications for pain and SOB. The facility to review to provide additional information. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 11:07 AM, the survey team met with the LNHA, the DON, the RRNC, the VPoCS, and the VPoSND. The DON stated nursing staff were provided in-service education about clarifying and entering orders for medication with multiple PRN indications separately. The RRNC added that the facility followed up with the hospice agency as the hospice nurse had written the recommendation for morphine sulfate as it was carried out. The RRNC acknowledged that the order should have been carried out by the nurse at the time of order entry. NJAC 8:39-27.1 (a)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 49078 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a.) a non-certified Nurse Aide (NA) did not continue to work as an NA after the specified 120 days for one (1) of two (2) NAs reviewed, (NA #1) and b.) there was a delineated policy and/or program in place for the hiring of non-certified NAs. This deficient practice was evidenced by the following: Reference: State of New Jersey (NJ) Department of Health memo dated April 21, 2023, sent to Nursing Homes included the following: On February 27, 2023, the Centers for Medicare and Medicaid Services (CMS) announced that all nurse aide emergency training waivers will terminate at the end of the Federal Public Health Emergency (PHE). The PHE is expected to end on May 11, 2023. At that time, all Temporary Nurse Aides (TNAs) hired prior to the end of the PHE and who have enrolled in a NATCEP (Nurse Aide Training and Competency Evaluation Program) and completed the first 16 hours of training prior to May 11, 2023, must complete the NATCEP and pass the nurse aide written exam and the clinical skills competency exam by September 10, 2023. Nurse aides hired after the end of the PHE will have four months to complete a NATCEP program and pass the exams, as required by N.J.A.C. 8:39-43.1. The New Jersey Department of Health issues this memorandum to update facilities on the interpretation of the CMS guidance, P.L. 2021, c. 326, c. 368 and Executive Directive (ED) 20-004 (Revised July 6, 2022). Facilities are advised as follows: II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 8/14/24, at 01:11 PM, the Licensed Nursing Home Administrator (LNHA) provided the survey team of the facility's list of new hires form from the last recertification survey to 8/14/22 that was requested by the survey Team Coordinator (TC) during the facility entrance conference. The surveyor randomly chose ten new hire employee files to review and requested the files from the LNHA that included NA#1. On 8/20/24, the surveyor reviewed the employee file for NA #1 provided by the LNHA. The file revealed the following: -had a date of hire of 4/24/24. -a Certificate of Completion for a Certified Home Health Aide issued 9/20/23 (undated). (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a signed job description for a Certified Nursing Aide (CNA). -a duplicate result report that reflected that NA #1 passed a skill test that was a manual skill portion of the NJ CNA competency exam. -the cover of the employee file folder, under job title reflected CNA. The file did not show any proof of school enrolment or completion, or successful completion of state approved 90 hours of training. On 8/21/24 at 12:02 PM, the surveyor in the presence of the survey team interviewed the Human Resources Director (HRD). The surveyor asked for documentation for NA #1 showing that they are currently enrolled in school and successful completion of 90 hours of state approved training. The surveyor also requested any policy for hiring or on boarding for NA's and/or new employees. On 8/22/24 at 12:37 PM, the HRD provided documents to the survey team and revealed: -a timecard report for NA #1 for the dates of 8/01/24 through 8/21/24 which reflected dates NA #1 worked in the facility which were 8/01, 8/03-8/06, 8/08, 8/11-8/15, and 8/17-8/20. -an undated appointment confirmation for NA #1 to take an exam for NJ CNA. On that same date and time, the HRD stated that NA #1 was finishing up her training today and she was not enrolled in school when she was hired. She further stated that NA #1 finished classes in September of 2023. The HRD also stated that she did not know the Certificate in the file was for a Home Health Aide not a CNA. The HR director provided an Employee File Check List to the survey team and stated that there was no policy for hiring or on boarding. On 8/23/24 at 9:50 AM, the HRD provided to the survey team an undated document that was a copy of a Certificate of Completion of a CNA program of 90 total hours for NA #1. The HRD stated that the school made a mistake and sent the wrong certificate referring to the previous certificate that was in NA #1's file. The new certificate reflected an issued date of 9/20/23. On 8/23/24 at 11:26 AM, the survey team met with the facility administrative team consisting of the LNHA, the Director of Nursing (DON), Regional Registered Nurse Consultant (RRNC), and the Infection Preventionist (IP). The surveyor team discussed the concern with NA #1's verification of school and training prior to hire. On 8/23/24 at 12:25 PM, the survey team met with the LNHA, DON, IP and RRNC for any responses to concerns. The LNHA stated clarifying the school verification, the skills test means she was in school. The facility has no other pertinent information to offer. N.J.A.C. 8:39-43.1

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 49078 Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for one (1) of thirty-six (38) residents reviewed, (Resident #147). The deficient practice was evidenced by the following: On 8/15/24 at 11:18 AM, the surveyor observed Resident #147 in a wheelchair in hallway. The resident agreed to speak with the surveyor. During the brief interview, the resident stated they were very happy at the facility and was here because of a fall at home. The surveyor asked if the resident has any pain or other complaints. The resident did not state anything specific but did refer to some dizziness and headache at times. The surveyor reviewed Resident #147's electronic medical record (EMR) which revealed the following: A review of Resident #147's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to congestive heart failure, (a condition that occurs when the heart muscle can not pump blood efficiently) and anemia (low blood count). Resident #147's Medicare 5-day Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/28/24, reflected that the resident had a Brief Interview for Mental Status (BIMS), a tool used to screen and identify cognitive condition, score of 14 out of 15, which indicated that Resident #147 was cognitively intact. The resident's list of medication (med) reflected a Physician's order (PO) for Ropinirole .25 mg (milligram) tablets, once a day, scheduled to be given in the morning at 9:00 AM. The order reflected a diagnosis of Other Muscle Spasm. The surveyor reviewed the manufacturer's package insert for Ropinirole. The package insert reflects Federal Drug Administration approved indications for use of the med. FDA indications reflected were treatment of Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) and moderate to severe restless leg syndrome (RLS). The recommended dose for Parkinson's Disease is .25 mg 3 times a day up to a maximum (max) of 24 mg total per day. The recommended dose for RLS is .25 mg once per day, 1 to 3 hours before bedtime, increasing to a max of 4 mg per day. Further review of the Resident #147's EMR did not reveal a diagnosis of Parkinson's Disease or RLS. A diagnosis of Other Muscle Spasm was reflected in the EMR. Review of the Physician's Progress Notes (PN) in the EMR did not reveal any documentation that reflected a statement of using Ropinirole outside of the manufacturer's indication or a statement of benefit versus risk to the resident for using Ropinirole for other muscle spasms. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 11:34 AM, the surveyor interviewed the Charge Nurse/Licensed Practical Nurse (CN/LPN) on the unit where Resident #147 resides. The CN/LPN stated that Resident #147's physician (MD) usually visits on the weekends. On 8/19/24 at 11:38 AM, the surveyor interviewed the resident while in bed. The resident stated they felt terrible, with head pain like an axe and very dizzy in bed. On 8/19/24 at 11:39 AM, the surveyor notified the CN/LPN of Resident #147's statements of pain and dizziness. On 8/20/24 at 01:23 PM, the surveyor documented attempts to reach Resident #147's MD by telephone. They surveyor attempted three (3) times, at 12:53 PM, 01:16 PM, 01:17 PM and reached a recording each time. On 8/21/24 at 9:45 AM, the surveyor attempted to reach the MD by telephone and reached a recording. Unable to reach MD for an interview. On 8/21/24 at 01:08 PM the surveyor in the presence of the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Regional Registered Nurse Consultant (RRNC). The surveyor asked the DON to provide any information for the use of Ropinirole for Resident #147 including any record of diagnosis, indications, or benefit versus risk. On 8/22/24 at 11:07 AM, the survey team met with the LNHA, DON, RRNC, the [NAME] President of clinical services (VPoCS) and the VP of the skilled nursing division (VPoSND). The DON stated that Resident #147 was taking Ropinirole in the hospital and was ordered for muscle cramping. The DON also stated the med was ordered as an as needed order from the hospital and the MD changed it to a routine order and for other muscle spasm as a diagnosis code was difficult to find for muscle cramping. The DON stated that other could mean leg muscle. On 8/23/24 at 9:14 AM, the DON provided a nursing PN dated 8/23/24 that reflected communication with Resident #147's MD. The DON stated that the MD stated that he was not a neurologist and cannot diagnose restless leg. The nursing PN the DON provided reflected a discussion between the DON and MD. The PN reflected that the MD stated restless leg syndrome may present as other muscle spasm. The PN reflected that he wanted a follow up with a neurology consult, continue the med at the current dose and change the administration time to 9:00 PM. The facility provided no further pertinent information as of 8/23/24 at 12:52 PM. N.J.A.C. 8:39-27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49078 Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in two (2) of four (4) medication carts inspected on two (2) of three (3) floors. This deficient practice was evidenced by the following: On 8/19/24 at 10:25 AM, the surveyor conducted the Medication Storage and Labeling task. The surveyor inspected a medication (med) cart located on the third-floor north unit in the presence of Licensed Practical Nurse #1 (LPN#1) assigned to that med cart. The surveyor observed nine (9) medications (meds) of various sizes, shapes and colors located on the bottom of the second drawer of the med cart. The surveyor showed the loose meds to the LPN and asked if those meds should be there. The LPN stated no, there should not be any loose meds. The surveyor observed the LPN dispose of the loose meds. The surveyor inspected a med cart located on the second-floor south unit in the presence of LPN#2 assigned that med cart. The surveyor observed two (2) meds, white in color, on the bottom of the second drawer of the med cart. The surveyor showed the loose meds to the LPN and asked if those meds should be there. The LPN stated no, they should remain in packaging until used. They surveyor observed the LPN dispose of the loose meds. On 8/21/24 at 01:08 PM, the surveyor, in the presence of the survey team, informed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Registered Nurse Consultant (RRNC). The surveyor asked the DON if there should be any loose med in the med carts. The DON stated, no, there should not be. The surveyor requested the facility policy for Medication Storage. On 8/22/24 at 11:07 AM, the DON provided the facility policy for Medication Storage, with a revised date of August 2024, to the survey team. A review of the facility's Medication Storage Policy with a revised date of August 2024 revealed: Section II. Purpose: To ensure the safe and secure storage of all meds and biologicals, preventing unauthorized access, maintaining med integrity, and promoting patient safety. Section III. Scope: This policy applies to all meds and biologicals stored within the facility, including those in med rooms, carts, boxes, and refrigerators. Section IV. Policy: 1. Secure Storage: Line 3- Med storage areas must be kept clean and sanitary. 2. Labeling: Line 1- All meds and biologicals must be labeled in accordance with currently accepted professional principles . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Medication Carts: Line 2- Meds on carts must be organized and labeled clearly. On 8/23/24 at 10:59 AM, the DON provided to the survey team, a Consultant Pharmacist (CP) unit inspection report for Unit 2 North, dated 7/23/24. A review of the CP unit inspection report reflected, under the section Additional Comments, Unit Comment. Please remove loose pills from bottom of med drawers. On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing, Infection Preventionist, RRNC for an Exit Conference. There was no additional information provided by facility. NJAC 8:39-29.4(a)(f-h)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39885 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure palatable and appetizing temperature of food for one (1) lunch meal observed on one (1) of four (4) nursing units (Third floor unit). This deficient practice was evidenced by the following: Reference: Sanitation in Retail Food Establishments and Food and Beverage Vending Machines N.J.A.C. 8:24-3.5 Limitation of growth of organisms of public health concern (f) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under (g) below, potentially hazardous food shall be maintained: 1. At 135 F or above, except that roasts cooked to safe cooking temperatures or reheated as specified under N.J.A.C. 8:24-3.4(g)5 may be held at a temperature of 130 F; or 2. At refrigeration temperatures. On 8/19/24 at 10:38 AM, the surveyor held a Resident Council meeting with four residents (Resident #94, #98, #122 and #159). Two of the four residents complained that the hot food was cold by time the food got to the floor. The residents thought it was related to staffing and that not everyone got their tray timely. The residents stated that they brought their concerns to the monthly food meetings but that there was no change. On 8/21/24 at 11:20 AM, during the food tray line, the surveyor, in the presence of another surveyor, asked the Food Service Director (FSD) to place an extra tray on the food cart that was going to the third floor unit to be tested . The surveyor asked the FSD if he had done test trays to check the temperature on the unit. The FSD stated that he did one or two trays a week. On 8/21/24 at 11:28 AM, in the presence of another surveyor, the surveyor observed the first cart that was going to the third floor unit was completed with the residents trays and one extra test tray and the FSD placed a clear plastic bag over the open metal tray cart. The FSD then took the tray cart to the unit. The surveyor, in the presence of another surveyor, asked the FSD about his thermometer. The FSD stated that he had calibrated the thermometer about an hour ago to 32 degrees using the ice method. The surveyor observed that one of the two elevators had a sign that the elevator was not working. On 8/21/24 at 11:32 AM, in the presence of another surveyor, the surveyor observed the FSD went on the elevator with the tray cart. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 11:35 AM, in the presence of another surveyor, the surveyor observed the FSD arrived on the third floor unit with the lunch cart. While waiting for the lunch trays to be passed out by the unit staff, the surveyor, in the presence of another surveyor, asked the FSD if he received complaints about the food not being served hot. The FSD stated that he did not receive any complaints in a long time because there was a palate that kept the plate hot. On 8/21/24 at 11:38 AM, in the presence of another surveyor, the surveyor observed a unit staff member remove the clear plastic bag from the lunch tray cart and she and one other staff member started to pass the trays. The surveyor observed that during the passing of the trays three additional staff at different times joined the initial two staff members pass trays. The surveyor observed that when a staff member took off a tray from the cart that they had to take the empty cup and pour the desired beverage into the cup before bringing the tray to each resident. On 8/21/24 at 11:50 AM, in the presence of another surveyor, the surveyor observed a staff member take the last resident tray off the cart and as the tray was being removed, the surveyor notified the FSD to take the temperatures of the food on the extra test tray. In the presence of another surveyor, the surveyor observed the FSD obtain the following temperatures from the sample tray: Chicken 128.3 degrees in one part and then 130 degrees in another part Spinach 118 degrees Corn on the cob 129 degrees Watermelon (cut in small pieces) 54.9 degrees At that time, the surveyor, in the presence of another surveyor, asked the FSD what he expected the temperatures to be. The FSD stated that hot food should be between 130 and 135. He added that he would expect it to be more than that but that it should at least be that. The FSD stated that the cold should be in the 50's but no more than 60. He added that considering the time the staff took to pass the trays was a factor. He added that he expected the last tray to be passed 15 to 20 minutes from the time it left the kitchen. The FSD stated that it should take three minutes to come up to the unit, three to five minutes waiting for passing to start and be passed in the range of 10 minutes. Furthermore, the surveyor, in the presence of another surveyor asked the FSD how he performed test trays. The FSD stated that he did the test tray downstairs in the kitchen, that he would leave a tray in his office and test it five to 10 minutes later. The surveyor in the presence of another surveyor asked the FSD if the temperature of the hot food was acceptable. The FSD stated that he would expect it to be hotter. On 8/21/24 at 12:59 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Regional Registered Nurse Consultant (RRNC) the concern regarding the lunch tray temperatures and the temperatures that were taken on each item. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 11:21 AM, in the presence of the survey team, DON, RNCC, [NAME] President of Clinical Services (VPoCS) and VP of Skilled Nursing Division (VPoSND), the LNHA stated that food had to be served at a palatable temperature. He added that he had interviewed residents after the lunch meal and the residents were extremely happy with the meal. The LNHA provided the surveyor with a printout of the Dining Order Report, which had the residents listed for the lunch cart that was observed the previous day. The Dining Order Information had 21 residents listed in order by room number. A review of the facility provided printout included the following handwritten and signed by the LNHA: I interviewed: Unsampled Resident (listed as #6 on the dining order)-Lunch was delicious today. I loved the corn. It was hot and tasty. Resident #122 (listed as #3 on the dining order)-The lunch was really good today. [I (LNHA) asked if it was warm) Resident replied yes. Unsampled Resident (listed as #5 on the dining order)-Lunch was real tasty today. It was warm. The chicken breast and corn and spinach were really warm and good. Unsampled Resident (listed as #2 on the dining order)-Lunch was really nice. I ate my entire plate. It was nice and hot. A review of the undated facility provided policy titled, Timely Meal Service included the following: Policy: Food will be delivered promptly to ensure safe, palatable and high-quality food served at the proper temperature. Procedure: 1. Nursing staff will notify the food and nutrition services department in writing of individuals who wish to eat in their rooms so food can be delivered to the correct location. 2. Meals will be placed in the delivery cart in sequence to achieve the most effective service. Each meal will be identified by the meal identification (ID) card/ticket with the individual's name, room number and physician ordered diet. 3. Food and nutrition services staff will notify the appropriate staff as each cart is ready for delivery. Food and nutrition services staff will deliver the carts to the Units. Nursing or food and nutrition services staff will return the carts to the kitchen after meal service per facility policy. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Meals will be distributed promptly with supervision as needed by nursing staff. Staff should check each name and room number to verify correct information and check items on the plate or tray against the meal ID card/ticket to assure accuracy. 5. Food will be served at acceptable temperatures (hot foods hot and cold foods cold) as discerned by the patients/residents and customary practice. 6. Food will be delivered as per truck delivery schedule. N.J.A.C. 8:39-17.4(a)(2);(g)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on the interview and review of facility documentation, it was determined that the facility failed to ensure that facility wide assessment included the resources required to establish policies and procedures for the management of staffing contingency plan and linen and/or supplies in order to meet the requirements and needs of all residents in the facility. This failure had the potential to affect all 186 residents who currently live in the facility. This deficient practice was evidenced by the following: During the entrance conference on 8/14/24 at 9:50 AM, Surveyor #1 (S#1) requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) a copy of the Facility Assessment (FA). Both the LNHA and DON stated that the facility's census (the number of residents currently under the care of a specific facility) was 186. A review of the facility's Facility Assessment with a date of August 24 (2024). The submitted FA of the LNHA on 8/15/24 at 9:05 AM did not include information about the facility's contingency plan for staffing and information about information on addressing the resident's need for supplies for linens. On 8/19/24 at 10:38 AM, Resident #122 informed S#2 during the Resident Council meeting that at times there was a shortage of linen and towel supplies. The resident was unable to further elaborate on the concern. On 8/22/24 at 9:21 AM, the surveyor interviewed the LNHA regarding FA. The LNHA informed the surveyor that he was aware of the updates and new memo from CMS (Centers for Medicare and Medicaid Services) about the FA with an effective date of 8/08/24. The surveyor asked the LNHA what the facility's process for FA was. The LNHA stated that the facility utilizes a tool [name] wherein the interdisciplinary team (IDT) which includes the Maintenance Director, DON, Corporate nurses, and the IDT meets quarterly. He further stated that my understanding, of the FA was on how the facility handles the facility's staffing, environmental needs, and acuities. The LNHA also stated that I would think so, there will be a number to follow or a grid, for staffing of the facility. He further stated that the facility followed the New Jersey (NJ) Mandated law for staffing, and that should be in their FA. The LNHA acknowledged that the FA should address the needs of the residents in the facility. On that same date and time, the surveyor notified the LNHA of the concern that the previously submitted FA did not include information about the NJ Mandated staffing law, the contingency plan for staffing, and the grid that the facility should follow. At that same time, the LNHA reviewed the previously provided FA copy. The LNHA stated and showed page 21 (total pages 40) and revealed: A.1. Function-Sufficiency Analysis Summary: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Staffing and scheduling systems. Each department utilizes a staffing system and staffing patterns that are directly correlated to the resident population and resident care requirements in the facility. The surveyor then asked the LNHA how the above information correlates to NJ mandated law for staffing. The LNHA then further reviewed the FA paper and stated some documents were missing in the previously provided FA and would get back to the surveyor. On 8/22/24 at 9:41 AM, the LNHA provided additional documents that included the staffing plan for direct care staff plan were 1:8 ratio Days (total licensed or certified), 1:10 ratio Evening, and 1:14 ratio Nights. The LNHA stated that the ratio was derived from the NJ Mandated law for staffing. A review of the provided documents did not include the Staffing Contingency Plan and grid for supplying linens to address the needs of the residents at the facility. On that same date and time, the surveyor asked the LNHA does the facility had a plan for maximizing the recruitment and retention of direct care staff. The LNHA stated by following the mandated law. The surveyor also asked does the facility assessment includes a contingency plan that was informed by the FA. The LNHA stated he would get back to the surveyor. On 8/22/24 at 12:55 PM, the survey team met with the LNHA, DON, [NAME] President (VP) Skilled Nursing Division, LNHA, VP of Clinical Services, and Regional Registered Nurse Regional Consultant (RRNC). The surveyor notified the facility management of the above findings and concerns. On 8/23/24 at 8:31 AM, the LNHA provided a copy of the Staffing Contingency Plan. The LNHA acknowledged that the Staffing Contingency Plan was done after the surveyor's inquiry. On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing, Infection Preventionist/Registered Nurse (IP/RN), and RRNC for an Exit Conference. The facility management did not provide additional information. NJAC 8:39-5.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38327 Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for four (4) of nine (9) staff (two Recreation Staff, one Certified Nursing Aide, and one Hospice Aide) and b.) follow appropriate infection control practices to prevent the potential spread of infection for two (2) of two (2) rooms observed during laundry area tour in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. According to the CDC guidelines dated 4/02/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) included information for EBP when to use PPE (personal protective equipment) during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for EBP include: Dressing . Providing hygiene Changing linens . Device care or use: central line, urinary catheter, . Implementation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When implementing Contact Precautions or EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of a gown and gloves. Make PPE, including gowns and gloves, available immediately outside of the resident room . Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education Provide education to residents and visitors . 1. On 8/14/24 at 11:56 AM, the surveyor observed lunch at the 2NW (North West) dining room with a total of 12 residents assisted by Recreation Staff #1 (RS#1) and RS#2 with residents' plastic bibs (for eating, waterproof protector for crumb catcher). Both RS#1 and #2 donned (applied) a pair of gloves without performing hand hygiene and distributed disinfecting wipes to all residents. Both Recreation Staff collected the used disinfecting wipes from the residents. On that same date and time, RS#1 did not perform hand hygiene after she discarded the used disinfecting wipes, and removed her used gloves. RS#1 immediately checked by touching the folded green tablecloth at the separate table inside the dining room, then sat down at the back of the dining room. At that same time, RS#2 did not perform hand hygiene after she discarded the used disinfecting wipes, and removed her used gloves. RS#2 immediately wheeled Resident #163's wheelchair to the table without performing hand hygiene. During an interview, RS#1 acknowledged that she should have washed her hands after removing used gloves. During an interview, RS#2 stated that I forgot to perform hand hygiene after removing gloves and prior to touching the resident. Later, the surveyor observed the Certified Nursing Aide (CNA) enter the 2NW dining room and perform handwash, scrub her hands with soap for four seconds, then proceed to wash her hands under the stream of running water, used a paper towel to dry hands, and discarded used paper towels in the garbage receptacle. During an interview, the CNA informed the surveyor that she should scrub her hands for at least 20 seconds. The surveyor asked the CNA if she scrubbed her hands for at least 20 seconds, and the CNA stated, I think so. The surveyor then notified the CNA of the above observation. Afterward, the CNA assisted the other residents at the dining table by repositioning them on the table and the CNA washed her hands again. The surveyor observed the CNA scrubbed her hands for nine seconds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/15/24 at 11:22 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN). The IP/RN informed the surveyor that she was responsible for the facility staff's education about infection control including hand hygiene and PPE use and competencies. The surveyor then notified the IP/RN of the above findings regarding RS#1 and #2 and CNA's hand hygiene and gloves use during dining observation on 8/14/24 at lunch in the 2NW dining room. On that same date and time, the IP/RN informed the surveyor that she was made aware yesterday by the Assistant Director of Nursing (ADON) of what had happened because the ADON was at the dining room at that time when the surveyor observed both the Recreation Staff. The IP/RN stated that the two Recreation staff were educated again regarding hand hygiene. The IP/RN further stated that the CNA will also be educated. At that time, the surveyor asked the IP/RN what should have happened. The IP/RN stated that the Recreation Staff should have washed their hands before and after removing gloves. She further stated that the CNA should have washed her hands outside the stream of running water for at least 20 seconds, the 20 seconds should be the scrubbing of hands and not the entire handwashing process. 2. On 8/20/24 at 8:18 AM, the surveyor toured the laundry area on the ground floor. The surveyor interviewed Laundry Staff #1 (LS#1) inside the laundry room. LS#1 informed the surveyor that she was assigned to the linens and LS#2 was assigned to the personal clothing of the residents who were currently in the other room. There was a pen, paper, and a crumpled paper towel on top of a clipboard, a personal tumbler, two bottles of water, a used surgical mask, a box of opened gloves, an open snack, and a personal cellphone on top of the table where LS#1 was observed folding the blanket that came out of the dryer. The personal cell phone was near the folded blankets on the same table. Later, LS#1 informed the surveyor that the folding table was considered a clean area. The surveyor then asked LS#1 if the table was considered clean, and why there were multiple personal items on top of the table where she actively folded blankets. LS#1 stated that the surgical mask was hers and it was a used mask, the water tumbler, two bottles of water, and the cell phone were her items. She further stated that there was no other place to put them which was why it was on top of the clean folding table. LS#1 confirmed the open snacks were hers and she was eating them at that time. The folded clean blankets were uncovered. On that same date and time, the surveyor observed a heavy accumulation of whitish color substances on top of the four washers, on the floor near the washers and the surrounding area of the laundry room, and there was equipment that blew air directly into the area where LS#1 was folding blankets. LS#1 stated that the whitish substances was accumulation of dust and lint. LS#1 informed the surveyor that the equipment that blew air was the blower that was being used by housekeeping for drying floors and was being used as a fan in the laundry room. LS#1 stated that there was no air circulating and at times it got hot inside the laundry room which was why it was being used as a fan. At that same time, the surveyor observed there was another room inside the laundry area and LS#1 stated that was the room for clean folded linens that would be delivered to the unit. The room for clean folded linens was observed with pieces of paper on the floor and dust. LS#1 was unable to state if there was accountability for cleaning the laundry area and when was the last time it was cleaned. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmora Hills Health & Rehabilitation Center	225 W Jersey Street Elizabeth, NJ 07202

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/24 at 8:31 AM, the surveyor and LS#2 both went inside a room named Podiatrist, and LS#2 stated that was the room for the clean personal clothing of the residents and for the donated clothes and shoes. LS#2 informed the surveyor that she was the assigned laundry staff for personal clothing. The surveyor observed a folding table where LS#2 was folding clothes at that time. The surveyor observed keys that were used by LS#2 in opening the room that she took from her uniform pocket. On top of the folding table also were two coffee makers, on top of the coffee maker was a cup with a straw. LS#2 stated that the folding table was considered a clean area. LS#2 stated that the coffee makers had been there for a long time, and she does not use them. LS#2 had no answer when asked why it was placed on top of the folding table where there were clean clothes. On 8/20/24 at 9:15 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the above findings and concerns in the laundry area. The LNHA stated that he would take care of the concerns. On 8/21/24 at 12:58 PM, the survey team met with the LNHA, DON, and Regional Registered Nurse Consultant (RRNC). The surveyor notified the facility management of the above findings and concerns regarding dining and laundry observations. A review of Policy: Laundry Washing and Drying Procedures dated June 2024 that was provided by the LNHA revealed: Policy: To establish procedures and protocols for the proper and efficient laundering of soiled linen articles. All linens and personal clothing are processed under Standard Precautions protocols and considered infectious. Note: Staff personal effects (i.e., refreshments such as water, soda, coffee; purses, cellphones, keys, etc.) are to be secured safe from contact with work surfaces and linens/garments in the washroom and folding area. A review of the facility's Policy: Infection Control Management dated June 2024 that was provided by the LNHA showed: Purpose: To effectively provide processes and cleaning supplies to maintain surfaces from harmful germs, viruses, etc. Procedure: Note: Staff shall be informed that personal effects (cell phones, refreshments, purses, lunch bags/boxes, food items, etc.) are not allowed: . Personal effects shall be stored secure and safe from all work areas and surfaces. 46049 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 8/14/24 at 10:55 AM, during tour on a unit, the surveyor observed the door to the room of Resident #164 had a EBP signage. EBP indicated that PPE such as gloves and gown should be worn while providing high-contact care activating with a resident to reduce the spread of MDROs. The surveyor observed a hospice agency's certified home health aide (CHHA) exit the room of Resident #164. The CHHA was wearing disposable gloves and carried in one hand a plastic bag of linens. The CHHA walked down the hallway to the soiled utility room, then opened the door of the room with her gloved hands. The CHHA disposed of the bag of linens in the soiled utility room, removed her gloves, disposed them in the room, closed the soiled utility room, and proceeded to walk back down the hallway. The surveyor interviewed the CHHA who stated gloves should not be worn in the hallway upon exiting a room. The surveyor informed the CHHA of the above observations. The CHHA replied that she removed her gloves when throwing out the soiled linen and acknowledged she should have not worn the gloves in the hallway after exiting the resident's room. On 8/14/24 at 11:03 AM, the surveyor interviewed the Charge Nurse/Registered Nurse (CN/RN) about glove use in hallway. The CN/RN stated gloves should not be worn in the hallway especially when exiting a resident's room. The surveyor informed the CN/RN of the observation of the CHHA. The CN/RN replied the CHHA should not have worn gloves in the hallway and would talk with her. On 8/21/24 at 01:03 PM, the surveyor informed the LNHA and the DON about the observed concern with CHHA. On 8/22/24 at 11:07 AM, the LNHA, DON, RRNC, [NAME] President (VP) of Clinical Services, and VP of Skilled Nursing Division met with survey team. The LNHA stated the facility had communicated with the hospice agency about the concerns and that the CHHAs who came to the facility were re-educated about hand hygiene and glove use. A review of the facility's policy titled Enhanced Barrier Precautions (EBP) with a updated date of 4/12/2024, under Procedure read: .Soiled linen and trash bins will be placed inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room, or before providing care for another resident in the same room . On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, Assistant Director of Nursing, IP/RN, and RRNC for an Exit Conference and there was no additional information provided by the facility management. N.J.A.C. 8:39-19.4(a)(1,2),m,n

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on interview, and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's QAPI (quality assurance and performance improvement) program for five (5) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education. This deficient practice was evidenced by the following: On 8/22/24 the surveyor reviewed the annual in-service education hours for five randomly selected CNA files, which were provided by the facility. The Employee In-service Record showed the following: CNA#1 had a hire date of 7/30/18. According to the Topic on the Inservice Record and Certificates of Completion, CNA #1 did not have QAPI training. CNA#2 had a hire date of 5/22/23. According to the Topic on the Inservice Record and Certificates of Completion, CNA #2 did not have QAPI training. CNA#3 had a hire date of 3/15/23. According to the Topic on the Inservice Record and Certificates of Completion, CNA #3 did not have QAPI training. CNA#4 had a hire date of 6/6/11. According to the Topic on the Inservice Record and Certificates of Completion, CNA #4 did not have QAPI training. CNA#5 had a hire date of 7/5/16. According to the Topic on the Inservice Record and Certificates of Completion, CNA #5 did not have QAPI training. On 8/22/24 at 01:07 PM, the surveyor in the presence of another surveyor interviewed the Assistant Director of Nursing (ADON). The ADON stated she started at the facility 02/01/24 and her responsibilities included but were not limited to collaboration with the Director of Nursing (DON) and perform in-service education to the staff. The ADON confirmed that she was the only person who was responsible for staff education. The ADON stated there was a hybrid system for monthly education, they were scheduled on-line courses and some in-person group education. The surveyor asked the ADON about the 12-hour competency for CNAs. The ADON stated that she can only speak to the education provided from February 2024 to present and can not say what was earlier as the previous ADON was responsible. The ADON stated she was only made aware of using the CNA date of hire as an anniversary date for CNA education. During the interview with the ADON, the DON provided the surveyor with education competencies for five CNAs that were previously requested. On 8/22/24 at 01:17 PM, the surveyor in the presence of other surveyors interviewed the DON. The DON was asked if the competencies that were just provided everything for those 5 CNAs. The DON stated that he cannot confirm what was being provided as complete proof of mandatory in-services as the ADON was not responsible for it. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24 at 01:31 PM, the survey team asked the ADON to provide everything she had for annual mandatory education to the team. On 8/23/24 at 10:07 AM, the surveyor in the presence of the survey team interviewed the ADON. The survey team asked if there was a list of mandatory in-services. The ADON provided a list of education protocols. The ADON stated that the Licensed Nursing Home Administrator (LNHA) and the DON have a list for QAPI education and the Infection Preventionist (IP) has a list for infection control education. The surveyor reviewed the list titled NJ (New Jersey) Mandatory CNA and Nurse Education Requirements (undated) that was provided by the ADON. The list reflected on line 15. QAPI, with a notation of mandatory for CNA renewal. On 8/23/24 at 10:14 AM, the survey team interviewed the DON in the presence of the Regional Registered Nurse Consultant (RRNC). The DON confirmed the NJ mandatory education list provided by the ADON. The surveyor asked if the DON does QAPI education. The DON stated he could not provide a formal sign in sheet for QAPI education and confirmed responsibility for QAPI education. On 8/23/24 at 10:20 AM, the survey team interviewed the LNHA who confirmed the NJ mandatory education list provided by the ADON. The LNHA could not provide sign in sheets for QAPI education. On 8/23/24 at 10:25 AM, the surveyor in the presence of another surveyor interviewed CNA#6 who stated she worked at the facility for five months. The surveyor asked CNA#6 if she got any education on QAPI. The CNA stated she was unsure as there are many different in-services. On 8/23/24 at 10:33 AM, The surveyor in the presence of another surveyor interviewed CNA#7 who stated she worked at the facility for [AGE] years. The surveyor asked CNA#7 if she got any education on QAPI. The CNA stated she was unsure. The CNA asked the surveyors what was QAPI about. On 8/23/24 at 10:45 AM, The surveyor in the presence of another surveyor interviewed CNA#8 who stated she worked at the facility for [AGE] years. The surveyor asked CNA#8 if she got any education on QAPI. The CNA stated she had many different in-services but was not sure if that was one. On 8/23/24 at 10:54 AM, The surveyor in the presence of another surveyor interviewed the Staffing Coordinator (SC) who was also a CNA. The surveyor asked the SC if she got any education on QAPI. The SC stated she did not know. On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, ADON, IP, RRNC for an Exit Conference. There was no additional information provided by facility management. N.J.A.C 8:39-33.1

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on interview, and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's Compliance and Ethics training for five (5) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education. This deficient practice was evidenced by the following: On 8/22/24, the surveyor reviewed the annual in-service education hours for five randomly selected CNA files, which were provided by the facility. The Employee In-service Record showed the following: CNA#1 had a hire date of 7/30/18. According to the the Inservice Record and Certificates of Completion, CNA #1 did not have Compliance and Ethics training. CNA#2 had a hire date of 5/22/23. According to the Inservice Record and Certificates of Completion, CNA #2 did not have Compliance and Ethics training. CNA#3 had a hire date of 3/15/23. According to the Inservice Record and Certificates of Completion, CNA #3 did not have Compliance and Ethics training. CNA#4 had a hire date of 6/6/11. According to the Inservice Record and Certificates of Completion, CNA #4 did not have Compliance and Ethics training. CNA#5 had a hire date of 7/5/16. According to the Inservice Record and Certificates of Completion, CNA #5 did not have Compliance and Ethics training. On 8/22/24 at 01:07 PM, the surveyor in the presence of another surveyor interviewed the Assistant Director of Nursing (ADON). The ADON stated she started at the facility 02/01/24 and her responsibilities included but were not limited to collaboration with the Director of Nursing (DON) and perform in-service education to the staff. The ADON confirmed that she was the only person who is responsible for staff education. The ADON stated there was a hybrid system for monthly education, they were scheduled on-line courses and some in-person group education. The surveyor asked the ADON about the 12-hour competency for CNAs. The ADON stated that she can only speak to the education provided from February 2024 to present and can not say what was earlier as the previous ADON was responsible. The ADON stated she was only made aware of using the CNA date of hire as an anniversary date for CNA education. During the interview with the ADON, The DON provided the surveyor with education competencies for five CNAs that were previously requested. On 8/22/24 at 01:17 PM, the surveyor in the presence of other surveyors interviewed the DON. The DON was asked if the competencies that were just provided everything for those 5 CNAs. The DON stated that he cannot confirm what is being provided as complete proof of mandatory in-services as the ADON was not responsible for it. (continued on next page)

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24 at 01:31 PM, the survey team asked the ADON to provide everything she had for annual mandatory education to the team. On 8/23/24 at 10:07 AM, the surveyor in the presence of the survey team interviewed the ADON. The survey team asked if there was a list of mandatory in-services. The ADON provided a list of education protocols. The ADON stated that other topics like ethics could be done by an outside contractor the facility used. The surveyor reviewed the list titled NJ (New Jersey) Mandatory CNA and Nurse Education Requirements (undated) that was provided by the ADON. The list did not reflect any Compliance or Ethics requirements. On 8/23/24 at 10:14 AM, the survey team interviewed the DON in the presence of the Regional Registered Nurse Consultant (RRNC). The DON confirmed the NJ mandatory education list provided by the ADON. The surveyor asked if the DON does Compliance and Ethics Training education. The DON stated that Ethics education was done annually. The DON stated that there were posters by the time clock that reference Ethics and he could not provide any sign in sheets. On 8/23/24 at 10:20 AM, the survey team interviewed the Licensed Nursing Home Administrator (LNHA) who confirmed the NJ mandatory education list provided by the ADON. On 8/23/24 at 10:25 AM, the surveyor in the presence of another surveyor interviewed CNA#6 who stated she worked at the facility for five months. The surveyor asked CNA#6 if she got any education on Ethics and Compliance. The CNA stated she was unsure as there are many different in-services. On 8/23/24 at 10:33 AM, The surveyor in the presence of another surveyor interviewed CNA#7 who stated she worked at the facility for [AGE] years. The surveyor asked CNA#7 if she got any education on Ethics and Compliance. The CNA stated she was unsure what that topic was. On 8/23/24 at 10:45 AM, The surveyor in the presence of another surveyor interviewed CNA#8 who stated she worked at the facility for [AGE] years. The surveyor asked CNA#8 if she got any education on Ethics and Compliance. The CNA stated she had many different in-services but could not recall exactly if one was ethics. On 8/23/24 at 10:54 AM, The surveyor in the presence of another surveyor interviewed the Staffing Coordinator (SC) who was also a CNA. The surveyor asked the SC if she got any education on Ethics and Compliance. The SC stated she was not sure. On 8/23/24 at 12:51 PM, the survey team met with the LNHA, DON, ADON, Infection Preventionist, and RRNC for an Exit Conference. There was no additional information provided by facility.