STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Oak Rehabilitation and Healthcare Center	849 Big Oak Road Pittsgrove, NJ 08318

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37547 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain the resident's furnishings and living area in a clean and home like environment. This deficient practice was identified for 1 of 2 residents (Resident #66) on 1 of 2 nursing units (West Unit) reviewed for a clean, comfortable, home like environment and was evidenced by the following: 1. On 12/4/24 at 10:44 AM, the surveyor entered Resident #66's room and observed that the floor was visibly dirty and was soiled with both dried paint and debris. The resident's over bed table frame was rusty. The surveyor reviewed the medical record for Resident #66. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to: morbid (severe) obesity due to excess calories, osteomyelitis (bone infection) of vertebra, sacral (bottom of the spine) and sacrococcygeal (pertaining to both the sacrum and the coccyx (tailbone)) region, pressure ulcer of left heel stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle), pressure ulcer of other site stage 4 , type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular (relating to the eye) edema bilateral, and depression. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 11/8/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had one Stage 4 pressure ulcer that was present upon admission/entry or reentry to the facility and one surgical wound of the foot. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 5/29/24, that the resident wished to remain in the facility for Long Term Care. Goals included that the resident will state he/she is comfortable and verbalize satisfaction with care and services. Interventions included: .Follow resident's wishes as he/she expresses them. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/24 at 1:53 PM, the surveyor observed Resident #66 tearful and crying while lying in bed. The surveyor noted that the resident's flooring was heavily soiled with a black substance. Next to the resident's bed there was a red and pink substance on the floor. The surveyor noted that the wood around the resident's window frame was peeling and chipped in multiple areas. The resident's television was turned on, but was not in service. The resident stated that the television was not working and he/she had no remote control. The surveyor also noted that the protective cover on top of the resident's over bed table was chipped and had exposed wood around the edges. There were no personal effects or decor noted to personalize the resident's room or offer a home like environment. On 12/6/24 at 2:14 PM, the surveyor interviewed Housekeeping (HK) #1 who stated that she had already cleaned Resident #66's room and cleaned the counter tops, sills, high and low dusting, and the bathroom. The surveyor asked if the floor was mopped and the HK stated, yes. On 12/6/24 at 2:19 PM, the surveyor accompanied HK #1 and the Housekeeping Director (HD) into the resident's room. When the surveyor questioned the HD about the condition of the resident's flooring she stated that in 2022, the facility changed the whole floor on the nursing unit, but not Resident #66's room. The HD stated that the red substance on the floor next to the resident's bed was ketchup and should have been cleaned. The HD stated that the dried pink stuff on the floor was cranberry juice. The HD stated that HK had to clean it. At that time, the surveyor showed the HD the condition of the resident's over bed table. The HD stated, We have to report and replace it soon because the resident could be cut. The HD further stated that the table had to be replaced because it was a safety issue. The surveyor asked the HD if HK was responsible to clean the dirt and debris off of the outer heater cover, and the HK stated that the flooring and the heater cover were the responsibility of maintenance. The HK then proceeded to remove the resident's over bed table from the room and stated that she would get another table now. The HD stated they had new tables. The HK stated that the rusted table was not supposed to be in the room. Resident #66 then stated that the table had been like that since he/she arrived at the facility. The HD proceeded to call the Director of Maintenance (DM) to the room. On 12/6/24 at 2:29 PM, the surveyor interviewed the DM about the peeling paint and holes above the resident's television and around the resident's window frame and heater cover, and the condition of the flooring and over bed table. The DM stated that he did not know when the resident's room was painted. The DM stated that he reported the condition of the resident's flooring to the Licensed Nursing Home Administrator (LNHA) many times. The DM stated that no one had reported the holes in the wall. The DM stated they had to clear the room so that he could paint. The DM further stated that this was the only resident room that was like that. The DM further stated, That table ought to be in the trash can. The DM stated that he did not know if anyone told him. The DM stated that the facility did not provide television remotes, but agreed to give the resident a new one. The resident stated, Thank you. At that time, the HD provided the surveyor with documentation that indicated the resident's room was last carbolized (deep cleaned) on 10/30/24. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/24 at 2:38 PM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated that she had not noticed the condition of the resident's over bed table previously. The table wobbled as the HD pushed it down the hall. On 12/9/24 at 1:43 PM, the LNHA, in the presence of the Director of Nursing (DON) and the survey team, acknowledged that the resident's overhead table should have been maintained in good condition. The LNHA stated, we do environmental rounds rounds twice weekly. The LNHA stated it was an older building, but it should still be clean. The LNHA stated we changed chemical companies and thought it would be better to a certain degree. The LNHA stated that he rounded with the maintenance director and had a plan in place to go through each room, but things got pushed off due to emergencies, and planned to get back to it. On 12/11/24 at 10:50 AM, The LNHA stated that they took the resident's room out of service and closed it down until repairs were made. The LNHA stated that, the resident will return to the room when it is in better condition. The LNHA further stated that the the resident was very happy. The LNHA stated the resident wanted to hang up pictures in the room. The surveyor asked why the facility had not hung any pictures up in the room prior to surveyor inquiry, and the Nurse Consultant (NC) who was present stated that the resident was short term, and the family had not brought anything in to hang up on the wall. The NC stated that she did not know if the resident was offered assistance prior to hang his/her pictures to ensure a home like environment. On 12/11/24 at 11:00 AM, The LNHA stated that they did an audit the day prior and there were eight over bed tables that were removed from resident rooms. The surveyor asked if the over bed tables had rusted frames and chipped protective coating on the surface, and the Nurse Consultant stated that, the over bed tables were not cosmetically desirable or aesthetically pleasing. The Licensed Practical Nurse/Unit Manager #2/Infection Preventionist (LPN/UM #2/IP), who was present at that time, stated that it was an increased risk for infection to have the protective cover chipped away from the top of the over bed table because particles could get stuck in the exposed particle board and could not be properly cleaned and sanitized. A review of the facility's policy, Homelike Environment updated April 2024, included, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary and orderly environment; .inviting colors and decor; personalized furniture and room arrangements; clean bed and bath linens that are in good condition; . A review of the facility's policy, Cleaning and Disinfecting Residents' Rooms reviewed April 2024, included, Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visible soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Terminal Room Cleaning (fully cleaned and disinfectant surfaces in a patient room): Terminal room cleaning is done when the resident is transferred, discharged or expires . NJAC 8:39-31.4 (a), (f)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Based on interview, record review, and review of facility documents, it was determined that the facilty failed to ensure that an allegation of staff to resident abuse was immediately reported to a supervisor in accordance with the facility abuse policy to ensure the safety of all residents at the facility . This deficient practice was identified for 1 of 1 resident (Resident #33) reviewed for abuse and was evidenced by the following: On 12/6/24 at 9:04 AM, the surveyor completed a tour of the East Unit with Certified Nursing Assistant (CNA) #3. When interviewed, CNA #3 stated that on 12/5/24, Resident #65 reported that an aide twisted his/her roommate's fingers.(Resident #33) . The surveyor asked CNA #3 when she was supposed to report an allegation of abuse? CNA #3 stated that she was supposed to report any allegation of abuse to her supervisor right away. CNA #3 further stated that she did not report the allegation of abuse to the administration yet because Resident #65 stated that he/she wanted to speak with the state surveyor first. A review of Resident #65's most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated 11/26/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed that the resident had no behaviors. On 12/6/24 at 9:41 AM, the surveyor interviewed Resident #65 who stated that no one twisted Resident #33's fingers. Resident #65 then stated that Resident #33 twisted the staff's fingers. At that time, the surveyor observed Resident #33 lying in bed with their eyes closed and was unable to be interviewed at that time. A review of Resident #33's Admission Record, an admission summary, revealed the resident had diagnoses which included, Alzheimer's Disease, unspecified, unspecified dementia, unspecified severity with other behavioral disturbance, senile degeneration of the brain, not elsewhere classified, delusional disorders and anxiety disorder, unspecified. A review of Resident #33's quarterly MDS, dated [DATE], included the resident had a BIMS score of 4 out of 15, which indicated the resident's cognition was severely impaired. On 12/6/24 at 1:39 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON). The LNHA stated that any alleged abuse should be reported to a supervisor right away. The LNHA further stated that they were not aware of any allegations of abuse and would begin the investigation right away. On 12/9/24 at 2:49 PM, the surveyor interviewed the Nurse Consultant (NC) who stated that CNA #3 should have told Resident #65 that it was her obligation to report the allegation of abuse immediately. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 11:05 AM, the LNHA, in the presence of the DON and the survey team, stated that CNA #3 received abuse training on 11/28/24, and that their process should be revisited. A review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy updated April 2024, included: If a resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported NJAC 8:39-4.1(a) 5

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43308 Based on interview, record review, and review of facility documents, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of a resident hospitalization . This deficient practice was identified for 1 of 1 resident (Resident #20) reviewed for hospitalization and was evidenced by the following: On 12/4/24 at 10:22 AM, during the initial tour the surveyor observed Resident #20 lying in bed with their eyes closed. On 12/6/24 at 10:00 AM, the surveyor reviewed the medical record for Resident #20. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: cognitive communication deficit, chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), and muscle weakness. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 6/28/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had an admission reentry from the acute hospital. A review of the Progress Notes (PN) dated 6/5/24 at 11:34 PM, reflected the resident was admitted to the hospital for pneumonia, cellulitis (a bacterial infection that affects the skin and tissues beneath it), and acute kidney failure. On 12/6/24 10:09 AM, the surveyor interviewed the Nurse Consultant (NC) who stated that the notification to the State Long-Term Care Ombudsman (Ombudsman's office) was not completed. At that time, the surveyor requested a policy related to notification to the Ombudsman's office for transfers and discharges. On 12/9/24 at 11:44 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the Director of Social Work (DSW) was responsible for notifying the Ombudsman's office which was submitted monthly. The LNHA stated that he thought they were being sent monthly, but never obtained a copy to confirm it was being done. The LNHA stated that it was important to send a notification the Ombudsman's office because they were in partnership for care of the residents. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 11:55 AM, the surveyor interviewed the DSW who stated that he started at the facility in May 2024. He further stated that he was responsible for notifying the Ombudsman's office of the discharges and transfers and that he sent them monthly via email. The DSW confirmed Resident #20 was missed in June 2024, because he was still looking for the form and cleaning up the mess from the previous Social Worker. He stated that he did not start notifying the Ombudsman's office until September 2024 and did not go back and complete those prior to September. The DSW stated that it was important to notify the Ombudsman's office, so they know when the resident was transferred out to the hospital or discharged home. On 12/11/24 at 11:04 AM, the LNHA acknowledged in the presence of the Director of Nursing (DON), the Nurse Consultant (NC), and the survey team, that the notification to the Ombudsman's office should have been sent prior to surveyor inquiry. A review of the facility's Transfer or Discharge, Facility Initiated policy, dated October 2022, included, Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that include all notice content requirements). NJAC 8:39-4.1(a)3

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41260 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to develop an individual comprehensive care plan (ICCP) to include a.) a resident's use of anticoagulant medication (blood thinning medication) and, b.) a resident's hospice services. This deficient practice was identified for 1 of 5 residents (Resident #70) reviewed for medication regimen and 1 of 2 residents (Resident #37) reviewed for hospice and was evidenced by the following: 1.) On 12/5/24 at 12:21 PM, the surveyor observed Resident #70 eating lunch in his/her room. On 12/6/24 at 11:29 AM, the surveyor reviewed the medical record for Resident #70. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: atrial fibrillation (A-Fib; a heart condition that causes an irregular, rapid heart beat and increases the risk for blood clots). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/15/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS included the resident was taking an anticoagulant medication. A review of the Order Summary Report, dated as of 12/10/24, included the following Physician Orders (PO): A PO, dated 7/11/24, for apixaban (an anticoagulant medication) 5 milligrams by mouth every 12 hours for prophylaxis, observe for any bruising, dark urine, and black tarry stools. A PO, dated 8/1/24, for anticoagulant medication monitoring - monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, and nose bleeds. A review of the December 2024 Medication Administration Record (MAR) included the above PO for apixaban and anticoagulant monitoring. A review of the resident's individual comprehensive care plan (ICCP) did not include the resident's diagnosis of A-Fib or the use of anticoagulant medications. On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated nurses should monitor residents who were on anticoagulant medications for signs and symptoms of bleeding. The LPN further stated the unit managers were responsible for developing the resident's ICCP so that the staff know how to properly care for the resident safely. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 12:11 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated nurses should monitor residents who were on anticoagulant medications for bruising, bleeding, and bloody urine. The LPN/UM further stated that any nurse could develop the resident's ICCP because it is the map to the resident's care and tells staff what they need to know about the resident. On 12/9/24 at 1:19 PM, in the presence of the Nurse Consultant (NC), Licensed Nursing Home Administrator (LNHA), and the survey team, the surveyor interviewed the Director of Nursing (DON) who stated the unit managers and the DON were responsible for developing the resident's ICCP so that the proper plan of care is executed for the resident. At that time, the surveyor informed the DON of Resident #70's ICCP and the DON confirmed the ICCP should have included the resident's diagnosis of A-Fib and the use of anticoagulant medications. 43308 2.) On 12/4/24 at 10:01 AM, during the initial tour, the surveyor observed Resident #37 lying in bed awake. The surveyor interviewed the resident who stated they were on hospice. On 12/9/24 at 10:45 AM, the surveyor reviewed the medical record for Resident #37. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included: malignant neoplasm of brain (brain cancer), malignant neoplasm of prostate (prostate cancer), and malignant neoplasm of skin (skin cancer). A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 11/14/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated a moderate cognitive impairment. Further review of the MDS revealed the resident was on hospice. A review of the ICCP included a focus area, dated 11/8/24, that the resident had an advanced directive/wishes in place. Interventions included: code status do not resuscitate (DNR) and do no intubate (DNI). Further review of the ICCP did not include a hospice focus area or interventions. On 12/9/24 at 12:17 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated the care plan was in the resident's medical records. LPN #1 stated that the Unit Manager (UM) was responsible for developing the care plan. She stated that a care plan ensured the resident received the proper care from everyone. On 12/9/24 at 12:24 PM, the surveyor interviewed LPN #2 who stated the nurses were responsible for creating the care plans. She stated that a care plan was how staff knew how to care for the resident. She further stated that if a resident was on hospice there should be a care plan related to hospice because we still have to care for the resident. On 12/9/24 at 12:33 PM, the surveyor interviewed the LPN/UM #1 for the East Wing who stated the UMs updated the care plan, but any nurse could create one. She stated that the care plan was the guideline for resident specific plan of care. She further stated that the importance of the care plan was to ensure residents were receiving the specific and appropriate plan of care. LPN/UM #1 stated that if a resident was on hospice there should be a care plan. At that time, LPN/UM #1 confirmed Resident #37 was on hospice. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 12:39 PM, the surveyor and LPN/UM #1 reviewed the ICCP in the electronic medical record (EMR). LPN/UM #1 confirmed the resident did not have a focus area or interventions related to hospice. She stated that the care plan should have been developed within 72 hours of the resident being admitted on hospice. At that time, LPN/UM #1 stated she was going to develop the hospice care plan. On 12/11/24 at 11:15 AM, the Nurse Consultant (NC) stated, in the presence of the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), and the survey team, that the hospice care plan should have been developed prior to surveyor inquiry. A review of the facility's Care Plans, Comprehensive Person-Centered policy, updated April 2024, included, The interdisciplinary team (IDT) . develops and implements a comprehensive, person-centered care plan for each resident, and, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. Further review of the policy included, The comprehensive, person-centered care plan: . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . and, reflects currently recognized standards of practice for problem areas and conditions. A review of the facility's Hospice Program policy, updated April 2024, included, 13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by the facility. NJAC 8:39-11.2 (e), 27.1 (a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 40041 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain a professional standard of practice by ensuring a physician's order was in place for monitoring a resident's blood glucose levels. This deficient practice was identified during medication administration record review for 1 of 3 residents (Resident #25) on dialysis and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 12/4/24 at 10:12 AM, the surveyor observed that Resident #25 was not in their room. A review of the Admission Record, an admission summary, revealed that Resident #25 was readmitted from an acute care hospital and had diagnoses that included, but were not limited to: end-stage renal (kidney) disease, dependence on renal dialysis, chronic obstructive pulmonary disease (COPD) with acute exacerbation, and diabetes mellitus. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 9/8/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 6/8/22, that the resident was at risk for complications related to diabetes mellitus. The interventions included: Obtain finger sticks as indicated. A review of the physician's Progress Notes (PN) dated 11/9/2024 at 9:10 AM indicated to monitor blood sugars. A review of the Order Summary Report (OSR), active orders as of 12/3/2024, revealed no physician orders to monitor the resident's blood glucose levels. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 3:05 PM, the surveyor interviewed the Medical Director (MD), who stated that he saw Resident #25 yesterday (12/4/24). He further stated that the resident was on insulin, and he noticed that the resident did not have an order to monitor the blood glusose levels. The MD stated, he was going to order to montior the blood glucose levels and was unsure why it was not already ordered. He stated I am not going to lie, it probably was an oversight. The MD stated that the resident should have their blood glucose levels checks at least three (3) times per week. He emphasized I'll make sure, I put it in. On 12/11/2024 at 10:30 AM, the Nurse Consultant (NC) stated in the presence of the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), that if there was a discrepancy with monitoring the blood glucose levels after the resident returned from the hospital, her expectation would be for the nurse to ask the physician if they wanted to reorder to monitor the blood glucose levels. A review of the undated facility's Reconciliation of Medications on Admission policy did not include blood glucose monitoring. NJAC 8:39- 27.1(a)

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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. 37547 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to provide a wound treatment in accordance with the physician's orders, the facility policy, and professional standards of nursing practice. This deficient practice was identified for 1 of 3 residents (Resident #66) reviewed for pressure ulcers and was evidenced by the following: On 12/5/24 at 12:23 PM, the surveyor observed Resident #66 lying awake in bed on a large air mattress and the sheets were disheveled beneath the resident and left parts of the mattress uncovered. The resident had a gauze bandage that covered the resident's left ankle and shin that was dated 12/1/24. When interviewed, the resident stated that they also had a wound on their bottom. Certified Nursing Assistant (CNA) #1 was present and had begun to set the resident up to eat lunch. When interviewed, CNA #1 stated that she was only assigned to the resident today and floated throughout the facility. On 12/5/24 at 10:02 AM, the surveyor reviewed the medical record for Resident #66. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to: morbid (severe) obesity due to excess calories, osteomyelitis (bone infection) of vertebra, sacral (bottom of the spine), and sacrococcygeal (pertaining to both the sacrum and the coccyx (tailbone)) region, Pressure ulcer of left heel stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle), pressure ulcer of other site stage 4, type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular (relating to the eye) edema bilateral, and depression. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 11/8/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had one Stage 4 pressure ulcer that was present upon admission/entry or reentry to the facility and one surgical wound of the foot. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 6/4/24, that the resident was at risk for potential pressure injury development related to bladder and bowel incontinence, limited mobility, and was updated on 9/16/24, to include a stage 4 pressure ulcer to the sacrum (triangular bone at the base of the spine) and left heel. Interventions included: Follow facility policies and protocols for the prevention/treatment of skin breakdown. Further review of the resident's ICCP included a focus area, dated 9/15/24, that the resident was on IV (intravenous) antibiotics due to osteomyelitis of a stage 4 pressure ulcer of the sacrum. Interventions included: Dressing change as ordered, and monitor for signs and symptoms of infection (i.e. Redness swelling, increased pain, purulent (pus) discharge at exit sites of tubes). A review of the Order Summary Report (OSR), dated as of 11/3/24, included the following physian orders (PO): (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A PO, dated 11/3/24, for Povidone-Iodine Solution 10% Apply to left heel topically every day shift every Mon, Wed, Fri for wound care apply betadine soaked gauze ABD (abdominal, a type of dressing) pad and kling (type of gauze dressing). 2. A PO, dated 11/3/24, for Povidone-Iodine Solution 10% Apply to left heel topically every 8 (eight) hours as needed for wound care. Apply Betadine soaked gauze, ABD pad and kling. 3. A PO, dated 11/5/24, for Calcium Alginate-Silver External Pad 4 Calcium Alginate-Silver) Apply to sacrum topically every day shift for wound care. Cleanse with NSS (normal saline solution), pat dry, apply calcium alginate and bordered dressing. 4. A PO, dated 11/5/24, for Calcium Alginate-Silver External Pad 4 Apply to sacrum topically as needed for displacement/soilage. A review of the Progress Notes (PN) included a Skin/Wound Note (S/WN), dated 12/4/24 at 10:44 PM, which included the resident was seen by the wound Medical Doctor. Area to sacrum continued to improve. Ultrasonic mist treatment provided. Continue treatments as directed. Further review of PN indicated that there was no nursing note that referenced the resident's left heel wound dressing changes from 12/1/24 through 12/5/24. On 12/5/24 at 1:01 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that she had worked on both 12/3/24 and 12/4/24. She further stated she left before the end of her shift at 10:30 AM on 12/4/24, and did not get around to doing the resident's left heel wound treatment. At that time, the surveyor noted that the resident's left foot and heel was not covered by the dressing and the resident's heel was in direct contact with the resident's mattress which was not covered by the bed sheet. The surveyor noted a yellow substance at the base of the dressing. When interviewed, LPN #1 stated that there was a risk for infection if the resident's left heel dressing was not changed when it was ordered. At that time, the surveyor reviewed the Treatment Administration Record (TAR) with LPN #1 which revealed a PO for Povidone-Iodine Solution 10% Apply to left heel topically every day shift every Mon, Wed, Fri for wound care, apply Betadine soaked gauze ABD pad and kling that was signed out as administered on Monday 12/2/24 and was also signed out as administered on Wednesday 12/4/24 by LPN #1, though the dressing was observed as dated 12/1/24. The surveyor asked LPN #1 why she signed out the treatment as administered if she had not changed the dressing on 12/4/24, and LPN #1 stated that she may have signed the order out early and had forgotten to do the treatment. LPN #1 further stated that she had also forgotten to report off to the oncoming nurse who covered her shift that she had not completed the resident's left heel wound dressing change before she left the facility for the day. On 12/5/24 at 1:11 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager #2/Infection Preventionist (LPN/UM #2/IP) who stated that she believed that the resident's left heel dressing change was ordered every other day. The LPN/UM #2/IP stated that the wound was not treated effectively if it were not covered. She stated that it was improper documentation and a failure to do the treatment if the dressing was dated 12/1/24 and was documented as administered on both 12/2/24 and 12/4/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 2:03 PM, the surveyor interviewed the Director of Nursing (DON) who stated that a wound treatment should be rendered per the doctor's order and documented. The DON stated that if the resident's dressing was dated 12/1/24, the treatment was not done and two treatments were missed. The DON stated, That runs the risk of infection. The DON stated that it could also cause the wound to worsen if the wound was not covered. On 12/6/24 at 2:05 PM, the surveyor interviewed LPN #1 and asked if she had completed the resident's sacral wound dressing before she left her shift early on 12/4/24 as she had documented on the resident's TAR, and LPN #1 stated no, unfortunately. LPN #1 stated that when she changed the wound dressing the day prior, on 12/5/24, she could not tell who changed it last because it had a lot of brown stuff on it and it was nasty. On 12/9/24 at 2:11 PM, the DON, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, acknowledged that it was her expectation that the resident's wound treatments were rendered as ordered and documented accordingly. A review of the facility's undated Wound Care policy, included: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. .The following information should be recorded in the resident's medical record: The date and time the wound care was given. The type of wound care given. The name and title of the individual performing the wound care. Any changes in the resident's condition. Any problems or complaints made by the resident related to the procedure. If the resident refused the treatment, the reason for the refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal. The signature and title of the person recording the data. .Notify the supervisor if the resident refuses the wound care. Report other information in accordance with the facility policy and professional standards of practice. NJAC 8:39-27.1(e), 27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 40041 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) adjust medication administration times to accommodate for scheduled dialysis times and b.) notify the physician that the resident missed medications during dialysis times. This deficient practice was identified for 1 of 3 residents (Resident #25) reviewed for dialysis and was evidenced by the following: On 12/4/24 at 10:12 AM, the surveyor observed that Resident #25 was not in their room. A review of the Admission Record, an admission summary, revealed the resident had diagnoses that included, but were not limited to: end-stage renal (kidney) disease, dependence on renal dialysis, chronic obstructive pulmonary disease (COPD) with acute exacerbation, and diabetes mellitus. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 9/8/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident received dialysis while a resident at the facility. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 6/8/22, that the resident needed dialysis related to renal failure and that the resident went to dialysis on Mondays, Wednesdays, and Fridays, with a chair time (appointment time) of 5:15 AM. The ICCP did not include any interventions to schedule medications around the resident's scheduled dialysis times. A review of the Order Summary Report (OSR), dated as of 12/3/24, included the following physician orders (PO): A PO, dated 10/13/24, for hemodialysis on Mondays, Wednesdays, and Fridays with a chair time of 5:30 AM. A PO, dated 10/13/24, for budesonide suspension 0.5 milligrams (mg) orally via nebulizer two times a day for COPD which was scheduled to be administered at 9:30 AM and 9:30 PM. A PO, dated 10/13/24, for Humalog Kwik Pen subcutaneous 4 units, three times a day for diabetes, scheduled to be administered at 7:30 AM, 11:30 AM, and 4:30 PM. A review of the October 2024 Medication Administration Record MAR revealed that Resident #25 missed five doses of budesonide at 9:30 AM, on their scheduled dialysis days as follows: 10/16, 10/18, 10/21, 10/25, 10/28. Further review of the MAR revealed that Resident #25 missed six doses of Humalog at 7:30 AM, on their scheduled dialysis days as follows: 10/16, 10/18, 10/21, 10/25, 10/28, and 10/30. There was no documented evidence that the physician was not notified of the missed doses in October. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the November 2024 MAR revealed that Resident #25 missed a total of nine doses of budesonide at 9:30 AM on their scheduled dialysis days as follows:11/4, 11/6, 11/8, 11/11, 11/13, 11/15, 11/24, 11/26, and 11/29. Further review of the MAR revealed that Resident #25 missed a total of 10 doses of Humalog at 7:30 AM on their scheduled dialysis days as follows: 11/4, 11/6, 11/8, 11/11, 11/13, 11/15, 11/18, 11/24, 11/26, and 11/29. There was no documented evidence that the physician was not notified of the missed doses in November. A review of the December 2024 MAR revealed that Resident #25 missed a total of three doses of budesonide at 9:30 AM on their scheduled dialysis days as follows: 12/2, 12/6, and 12/11. Further review of the MAR revealed the resident missed two doses of Humalog at 7:30 AM on the following dialysis days: 12/2 and 12/4. There was no documented evidence that the physician was not notified of the missed doses in December. On 12/5/24 at 2:38 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM#2), who stated Resident #25's medications should be adjusted around their dialysis schedule. She further stated that if a resident was out of the facility and the medication was not given, the physician should be notified of the missed doses. On 12/6/24 at 11:28 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the medication times should accommodate the dialysis times. She further stated that the physician should be notified if the medication times did not accommodate the resident's dialysis times and of any missed doses. A review of the facility's Dialysis policy, updated April 2024, did not include accommodating the resident's medication administration times. A review of the facility's Medication Administration policy, updated April 2024 did not include missed doses. NJAC 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. 40041 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to store medications properly. This deficient practice was observed in 1 of 4 medication carts reviewed for medication storage and labeling and was evidenced by the following: On 12/5/24 at 2:14 PM, the surveyor observed the East Wing high treatment cart in the hallway next to the conference room. A tube of Santyl ointment 250 grams (gm) and a bottle of Nystatin External Powder 100000 UNIT/GM were left on the treatment cart, unattended by a licensed nurse. The surveyor knocked on the Nursing Office door to notify a licensed nurse. Licensed Practical Nurse/Unit Manager (LPN/UM) #1 confirmed that the medication was on the cart and immediately removed the medication. At that time, LPN/UM #1 stated that the medication should be stored in a plastic bag and secured in the treatment cart. On 12/6/24 at 11:41 AM, the surveyor interviewed the Director if Nursing (DON) who stated that the medications should be stored inside the locked cart. A review of the facility's Storage of Medications policy, updated April 2024, included, 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. NJAC 8:39-29.4(h)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 40041 Based on observation, interview, and record review, it was determined that the facility failed to ensure adaptive dining equipment was provided to a resident during meal service as ordered by the physician and indicated on the resident's individual comprehensive care plan (ICCP). This deficient practice was identified for 1 of 1 resident (Resident #35) reviewed for adaptive dining equipment and was evidenced by the following: On 12/4/24 at 12:32 PM, during a lunch meal observation, the surveyor observed Resident #35's clothes contained droppings of pudding. The diet slip on the resident's lunch tray indicated that the resident should have built-up utensil handles, a sippy cup, and a curved spoon. The resident's lunch tray had a built-up fork, a standard spoon and knife, and the cranberry juice and milk were in their original containers with no sippy cup. On 12/5/24 at 12:07 PM, during a lunch meal observation, the surveyor observed the resident had a built-up spoon, built-up fork, and a sippy cup. The spoon was not curved. The surveyor reviewed the medical record for Resident #35. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: cerebral palsy, psoriatic arthritis mutilans (a rare, severe, and disabling form of psoriatic arthritis that causes joint inflammation and damage), dysphagia, dysarthria, and anarthria. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 11/2/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated a severely impaired cognition. Further review of the MDS revealed the resident depended on staff for the set-up or clean-up for eating. A review of the individual comprehensive care plan (ICCP), initiated 8/9/22, included a focus that the resident was at risk for unavoidable nutritional decline due to progressive disease, oropharyngeal dysphagia from the cerebrovascular accident (CVA - stroke), mechanically altered diet, history of weight loss. Interventions included: Assistive Feeding Devices: sippy cup, high sided dish, curved spoon. A review of the Order Summary Report (OSR) of active orders as of 9/24/24, included the follwing physician orders (PO): A PO, dated 8/25/24, of Assistive Feeding Devices: sippy cup, high-sided dish, and curved spoon. On 12/4/24 at 1:01 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #5, who stated that the Certified Nurse Assistant (CNA) ensured the resident had the right utensils. LPN #5 walked over to Resident #35's tray and confirmed that he/she did not have the appropriate adaptive equipment. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 12:40 PM, the surveyor interviewed the Director of Rehabilitation (DOR), who stated that Resident #35 had spastic movements and poor fine motor coordination, and she noticed over the past few months that he/she has had a decline. The DOR looked at the resident's diet slip and confirmed that according to the diet slip, the resident should have had a curved spoon, built-up utensils, and a sippy cup. At that time, she was unaware that a curved spoon was listed on the resident's diet slip. She further stated that should a resident require special equipment, the rehabilitation therapist would fill out a communication form, and copies would go to the dietary department, nursing, and dietician. On 12/5/24 at 2:16 PM, the surveyor interviewed the Food Service Director (FSD) who confirmed that according to the diet slip, Resident #35 should have had a curved spoon, built-up utensils, and a sippy cup during meals. On 12/6/24 at 11:49 AM, the surveyor interviewed the Director of Nursing (DON) who stated that when the food carts arrived on the unit, the nurses and CNAs passed them out. She further stated the nurses, CNAs, and anyone passing trays were supposed to check the diet slip and that adaptive equipment should be provided. The DON stated that if they do not have the adaptive equipment on the meal tray, the kitchen should be contacted so it can be obtained. A review of the facility's Assistance with Meals policy, revised March 2022, included 1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. 2. Assistance will be provided to ensure than [sic] residents can use and benefit from special eating equipment and utensils if needed. NJAC 8:39-27.5 (b)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41260 Complaint #: NJ176956 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 12/4/24 at 9:45 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. When the surveyor and the FSD approached the designated handwashing sink, a dietary staff member removed items from the sink. When asked what the items were, the FSD stated the dietary staff member removed a fork and spatula from the sink that was used to make sandwiches. The FSD further stated that there should not be food prep items in the designated handwashing sink. There was no signage to indicate the sink was to be used for handwashing purposes only. 2. In the walk-in refrigerator, there were three metal shelving units used to store food items. The three shelving units had rust on the shelves. 3. In the dish washing area, there was a build-up of black substance in the calking between the counter and the wall. The FSD stated the area was cleaned daily, but the dietary staff had not gotten to cleaning the area yet. 4. In the area identified by the FSD as the storage area for plates to be used for meal service, there were four ceramic meal plates that were chipped. The FSD stated the chipped plates should be thrown away and removed them from the storage area. On 12/5/24 at 9:57 AM, the surveyor interviewed the FSD who stated the dietary staff were unable to remove the black substance from the dish washing area and would have to contact maintenance for assistance. The FSD further stated the dish washing area should be kept clean to prevent contamination. When asked about the shelving units in the walk-in refrigerator, the FSD stated they should not have rust because rust is a possible contaminate. When asked about the chipped ceramic plates, the FSD stated chipped dishware should not be used for the safety of residents. On 12/9/24 at 1:27 PM, in the presence of the Nurse Consultant (NC), the Director of Nursing (DON), and the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) of the concerns in the kitchen. The LNHA stated used utensils should not be stored in the designated handwashing sink. The LNHA further stated that if there was rust on the shelving units in the walk-in refrigerator, the dietary staff should have reported it to maintenance and not stored food on those shelves until the rust was addressed. The LNHA also stated the dietary staff should have cleaned the black substance in the dish washing area or notified housekeeping and maintenance for further assistance. The LNHA added that the dietary staff should have thrown away any chipped dishware. (continued on next page)

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Big Oak Rehabilitation and Healthcare Center	849 Big Oak Road Pittsgrove, NJ 08318

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Handwashing, Kitchen policy, updated 4/2024, included, Hand washing facilities should be readily accessible and equipped with hot and cold running water, paper towels, soap, trash cans, and signage notifying employees to wash their hands. Review of the facility's Food Receiving and Storage policy, revised November 2022, included, Food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times. Review of the facility's Sanitization policy, revised November 2022, included, All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris. Further review of the policy included, All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning, and, Plastic ware, china and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded. NJAC 18:39-17.2(g)

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 41260 Based on observation, interview, and review of facility documents, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to a.) keep the dumpster area free of garbage and debris and b.) have a cover over the opening of 2 of 3 dumpsters. This deficient practice was evidenced by the following: On 12/4/24 at 10:30 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the facility's designated garbage disposal area. There were three garbage dumpsters that each contained two lids. Two of the garbage dumpsters each had one lid open, exposing trash bags inside. There was also garbage on the ground between the two open garbage dumpsters which included single-use gloves, plastic water bottles, plastic packaging, single-serve juice containers, plastic cup lids, paper debris, and cardboard. The surveyor interviewed the FSD at that time who stated the garbage dumpster lids should be closed and there should not be loose trash surrounding the garbage dumpsters. On 12/9/24 at 12:18 PM, the surveyor interviewed the Housekeeping Director (HD) who stated dietary, housekeeping, and maintenance take their own trash to the dumpsters. The HD further stated that the dumpster lids should be kept closed and that there should not be trash and debris surrounding the dumpsters for infection control reasons. On 12/9/24 at 12:23 PM, the surveyor interviewed the Director of Maintenance (DM) who stated housekeeping and dietary maintained the dumpster area when they dispose of trash, but maintenance would pick up trash and debris when it was observed. The DM further stated the dumpster lids should be kept closed and there should not be trash and debris surrounding the dumpsters to prevent pests from the area. On 12/9/24 at 1:27 PM, in the presence of the Nurse Consultant (NC), the Director of Nursing (DON), and the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) of the dumpster area. The LNHA stated the dumpster area should be kept clean with the dumpster lids closed. Review of the facility's Sanitization policy, revised November 2022, included, Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered), and, Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pests. Review of the facility's Food-Related Garbage and Refuse Disposal policy, updated April 2024, included, Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. NJAC 18:39-19.3(b)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 43308 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure the required committee members, specifically the Licensed Nursing Home Administrator (LNHA), was present for 1 of 4 Quality Assurance and Performance Improvement (QAPI) quarterly meetings reviewed. This deficient practice was evidenced by the following: On 12/4/24 at 10:10 AM, during the entrance conference with the LNHA and the Nurse Consultant (NC), the surveyor requested the last four quarters of the QAPI sign-in sheets. On 12/5/24 at 10:15 AM, the NC provided the last four quarters of the QAPI sign-in sheets. At that time, the surveyor requested the NC to identify the staff members that signed the sheets. On 12/5/24 at 10:24 AM, the NC provided the updated sign-in sheets, which revealed the LNHA did not sign in for the January 2024 QAPI meeting. A review of the QAPI book and the QAPI minutes reflected there was no documented evidence the LNHA was in attendance for the January 2024 meeting. On 12/9/24 at 11:33 AM, the LNHA stated, in the presence of the survey team, that QAPI met monthly with quarterly goals. He stated the Medical Director (MD) and/or a physician, the Director of Nursing (DON), the LNHA, and the department heads attended the QAPI meetings. When asked if the LNHA was required to attend, he stated it was always good for the LNHA to be there. On 12/9/24 at 11:38 AM, the LNHA reviewed the January 2024 QAPI sign-in sheet and confirmed there was no LNHA signature. The LNHA stated he could not speak to the missing signature as he was not the LNHA at that time. He stated that it was important for the LNHA to attend QAPI because the LNHA was the chairperson of the committee and ensured all concerns were followed through and presented at QAPI. The LNHA confirmed that the LNHA should have signed in. He emphasized he did not know what a QAPI would be without the LNHA present. On 12/11/24 at 11:10 AM, the LNHA stated he did not have any additional information and was unable to comment on the previous LNHA's attendance for the January 2024 QAPI meeting. A review of the facility's Quality Assurance and Performance Improvement (QAPI) Program - Governance Leadership policy, updated April 2024, included, 1. The administrator, whether a member of the QAPI committee or not, is ultimately responsible for the QAPI program, and for interpreting its results and findings to the governing body. 6. The following individuals serve on the committee: a. Administrator. NJAC 8:39-33.1(b)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to a.) follow appropriate infection control practices by not performing hand hygiene during the meal pass for 1 of 2 units (West Wing) observed, and b.) have a water management program in place to prevent the growth of Legionella (a waterborne pathogen). The deficient practice was evidenced by the following: On 12/5/24 at 12:09 PM, the surveyor observed the following during the meal pass on the [NAME] Wing unit: Certified Nursing Assistant (CNA) #2 picked up a tray from the meal cart, brought it to room [ROOM NUMBER]-B, and set up the tray for the resident. The CNA then left the room without performing hand hygiene and picked up another tray from the meal cart, brought it to room [ROOM NUMBER]-A, and set up the tray for the resident. The CNA then left the room without performing hand hygiene and picked up another tray from the meal cart, brought it to room [ROOM NUMBER]-A, and set up the tray for the resident. The CNA then left the room without performing hand hygiene and picked up another tray from the meal cart. The CNA entered Resident #34's room, put the tray on the overbed table, moved the overbed table closer to the resident with ungloved hands, put on gloves to assist the resident to a sitting position by holding the resident's hand, set up the resident's tray, and tore open a sweetener packet for the resident's coffee while still wearing gloves used to assist the resident. Wearing those same gloves, the CNA then went to the roommate's (Resident #61) meal tray, opened the resident's coffee, tore a sweetener packet to put in the coffee, and touched the resident's eating utensils to cut up the resident's food. The CNA then disposed of her gloves, left the room without performing hand hygiene, and went to the meal cart to pick up another tray. At that time, before the CNA picked up another tray from the meal cart, the surveyor interviewed CNA #2. The CNA stated that staff were supposed to perform hand hygiene between each meal tray that was passed out to prevent the transfer of germs between residents. The CNA confirmed that she did not perform hand hygiene during the surveyor's observation of the meal pass. On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated staff should perform hand hygiene between each meal tray that is passed out to prevent the spread of germs from resident to resident. On 12/9/24 at 12:11 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2, who was also the Infection Preventionist (IP), who stated staff should perform hand hygiene before picking up the next meal tray to deliver to the next resident to prevent contamination and spreading any potential infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/9/24 at 1:19 PM, in the presence of the Nurse Consultant (NC), Licensed Nursing Home Administrator (LNHA), and the survey team, the surveyor interviewed the Director of Nursing (DON) who stated staff should perform hand hygiene when exiting each resident's room during meal pass for infection prevention. At that time, the surveyor informed the DON of the meal pass observation and the DON confirmed that CNA #2 should have performed hand hygiene after passing out each meal tray and should not have worn the same gloves for Resident #34 and Resident #61. A review of the facility's Handwashing/Hand Hygiene policy, updated April 2024, included to use an alcohol-based hand rub, or soap and water, for the following situations: before and after assisting a resident with meals. 43308 2.) On 12/4/24 at 10:10 AM, during the entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Nurse Consultant (NC), the surveyor requested the facility's water management program with evidence of monitoring. On 12/6/24 at 10:26 AM, the surveyor interviewed the Infection Preventionist (IP). When asked if there had been a case of Legionella or other waterborne pathogen illness in the facility, the IP stated the facility did not have any cases. On 12/6/24 at 12:09 PM, the surveyor interviewed the LNHA who stated they hired an outside company for the well water (water that comes from a well, which is a hole dug into the ground to access groundwater) system. The LNHA stated he thought the outside company completed the Legionella testing, but confirmed it was not tested . He further stated that the facility was constantly cleaning to ensure there was no still water. The LNHA stated that the outside company informed him that the chemicals used helped with preventing Legionella. He further stated the Director of Maintenance (DM) oversaw the water management program and could not fully speak to what was done. On 12/6/24 at 12:23 PM, the surveyor interviewed the DM, in the presence of the LNHA and survey team, who stated that the process for the water management was the facility had an outside company that came in and treated the water. He stated that they came to test the water every two weeks to ensure the levels, which included the salt, chlorine, nitrate, and pH for the well water, were good. When asked if there was a process for monitoring waterborne pathogens such as Legionella, the DM stated there was no process and that they did not monitor for Legionella. He further stated that he did ensure there was no stagnate water and that he kept a report of it. A review of the records indicated the facility monitored the lead and copper levels. There was no documented evidence for the monitoring of waterborne pathogens. On 12/11/24 at 10:30 AM, the LNHA stated, in the presence of the Nurse Consultant (NC), the Director of Nursing (DON), the Infection Preventionist (IP), and the survey team, that the testing that was provided did not specifically include Legionella. He further stated that he spoke with the outside company that tested their well water and they informed him the usage of the chemicals would take away Legionella. The LNHA then emphasized he just scheduled an official testing for Legionella. The LNHA confirmed that he created the water management program over the weekend (12/7/24, after surveyor inquiry) since they did not have one prior. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's Water Supply policy, reviewed April 2024, included, Purpose: to maintain a sanitary water supply and control the spread of waterborne microorganisms. NJAC 8:39-19.1 NJAC 8:39-19.4 (m)(n)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 43308 Based on interview, record review, and review of facility documents, it was determined that the facility failed to accurately utilize an infection assessment tool for 7 of 7 residents (Resident # #11, #39, #54, #65, #70, #328, #329) reviewed that were prescribed antibiotic medications in the facility. This deficient practice was evidenced by the following: A review of the facility's Antibiotic Stewardship line list for September, October and November 2024, revealed the following residents were prescribed antibiotics while at the facility: 1. Resident #328 was prescribed an antibiotic on 9/4/24 for seven (7) days for a skin infection. The line list further indicated that in infection assessment tool was completed with antibiotic use criteria not met. 2. Resident #11 was prescribed an antibiotic on 9/18/24 for five (5) days for a tooth infection. The line list further indicated that an infection assessment tool was completed with antibiotic use criteria not met. 3. Resident #329 was prescribed an antibiotic on 9/28/24 for 7 days for a urinary tract infection (UTI). The line list further indicated that an infection assessment tool was completed with antibiotic use criteria not met. 4. Resident #54 was prescribed an antibiotic on 9/20/24 for 5 days for a UTI. The line list further indicated that an infection assessment tool was completed with antibiotic use criteria not met. 5. Resident #39 was prescribed an antibiotic on 10/20/24 for 7 days for a skin infection. The line list further indicated that an infection assessment tool was completed with antibiotic use criteria not met. 6. Resident #65 was prescribed an antibiotic on 10/22/24 for 5 days for a UTI. The line list further indicated that an infection assessment tool was completed with antibiotic use criteria not met. 7. Resident #54 was prescribed an antibiotic on 10/6/24 for 3 days and then another antibiotic on 10/15/24 for 5 days both for a UTI. The line list further indicated that an infection assessment tool was completed with antibiotic use criteria not met. 8. Resident #70 was prescribed an antibiotic on 11/4/24 for 5 days for a UTI. The line list further indicated that an infection assessment tool was completed with antibiotic use criteria not met. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/24 at 10:26 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that she worked full time as a Licensed Practical Nurse (LPN) and was the Unit Manager (UM) for the [NAME] Wing and the IP. She stated that she contributed at least 20 hours a week for her role as the IP. The IP stated that she used the McGeer for infection surveillance which determined if an antibiotic was appropriate. She further stated that she reviewed the diagnostics testing and the nurses and physician's documentation to determine if the criteria was met. She stated that if the criteria was not met then she would notify the physician to see if they want to continue the antibiotic. When asked how the data was analyzed, the IP stated she tracked it on the Infection Log monthly and the surveillance checklist. The IP further stated that she did not notice any trends, but if she did, then she would notify the physicians and explain to them that the criteria was not met. On 12/6/24 at 11:10 AM, the IP provided a copy of the Infection Logs and the infection surveillance checklist. At that time, the surveyor continued to interview the IP who stated that if a resident was started on an antibiotic while at the facility and criteria was not met then the nurse should called the physician and would document it in the electronic medical record (EMR). The surveyor and the IP reviewed the Infection Log and she confirmed the 7 residents were prescribed an antibiotic even though the criteria was not met. The IP acknowledged there should be documentation, but there was no documentation that physician was notified that the antibiotic did not meet the criteria for the 7 residents that were at the facility and started on an antibiotic. The IP stated the importance of following the criteria was to prevent antibiotic resistant and for the risk of Multidrug Resistant Organisms (MDRO - bacteria that is resistant to many antibiotics). On 12/11/24 at 10:57 AM, the Nurse Consultant (NC) stated, in the presence of the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the survey team, that for the antibiotic stewardship they were going to revamp it and ensure it was followed. The NC stated that it was important to follow the criteria and that it was met so they are not overusing the antibiotic. A review of the facility's Antibiotic Stewardship policy, updated April 2024, included, 1. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. A review of the facility's Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes policy, reviewed April 2024, included, 2. The IP or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. a. Therapy may require further review and possible changes if: (4) therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. 3. At the conclusion of the review, the provider will be notified of the review findings. NJAC 8:39-19.4(d)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the pneumococcal vaccination or the influenza vaccination was offered to residents upon admission to the facility for 4 of 5 residents (Resident #14, #66, #69, and #70) reviewed for immunizations. This deficient practice was evidenced by the following: Reference: Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report Pneumococcal Vaccine for Adults Aged >[AGE] years: Recommendations of the Advisory Committee on Immunization Practices (ACIP), United States, 2023 Recommendations and Reports / September 8, 2023 / 72(3);1-39 Adults aged >[AGE] years who have received PCV13 only are recommended to receive a single dose of PCV20 at an interval >1 year after receipt of the PCV13 dose or to receive >1 dose of PPSV23 to complete their pneumococcal vaccine series. -When PPSV23 is used instead of PCV20, the minimum recommended interval between PCV13 and PPSV23 administration is >8 weeks for adults with an immunocompromising condition, a CSF leak, or a cochlear implant and >1 year for adults without these conditions. Either PCV20 or a second PPSV23 dose is recommended >5 years after the first PPSV23 dose for adults aged 19-[AGE] years with specified immunocompromising conditions but not for adults with a CSF leak or a cochlear implant. In addition, those who received both PCV13 (at any age) and PPSV23 (no PCV20) but have not received a dose of PPSV23 at age >[AGE] years are recommended to receive either PCV20 or a single and final dose of PPSV23 at age >[AGE] years and >5 years since the previous PPSV23 dose. Reference: Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP) - United States, 2024-25 Influenza Season Recommendations and Reports / August 29, 2024 / 73(5);1-25 Routine annual influenza vaccination of all persons aged >6 months who do not have contraindications continues to be recommended. All persons should receive an age-appropriate influenza vaccine (one that is approved for their age) 1.) On 12/6/24 at 10:19 AM, the surveyor reviewed the medical record for Resident #14. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: urinary tract infection, extended spectrum beta lactamase (ESBL) resistance, and chronic viral hepatitis C. A review of the resident's Immunization Audit Report, as of 12/5/24, did not include any documentation related to the pneumococcal vaccine. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/16/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS included the resident was offered, but declined, the pneumococcal vaccine. On 12/6/24 at 10:39 AM, in the presence of the survey team, the surveyor interviewed the Infection Preventionist (IP) who confirmed administration or declination of vaccinations was documented in the immunization tab (Immunization Audit Report) of the resident's electronic medical record. On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the unit managers offered the residents their vaccines and obtained the consents or declinations. The LPN confirmed that immunization information was documented in the resident's electronic medical record and stated it was important to offer residents vaccines to help prevent sickness such as the flu, pneumonia, or COVID-19. On 12/9/24 at 1:19 PM, in the presence of the Nurse Consultant (NC), the Licensed Nursing Home Administrator (LNHA), and the survey team, the surveyor interviewed the Director of Nursing (DON) who stated upon admission, the resident's immunization information was included in the admission packet to determine if the resident received or would like to receive immunizations. The DON further stated that any of the nurses could obtain consent or declination for the vaccines and that consents/declinations were documented in the resident's medical record. The DON added that the importance of offering immunizations was so the resident can be vaccinated for anything that is possibly harmful. At that time, the surveyor informed the DON of the missing pneumococcal vaccine information for Resident #14, and the DON confirmed the resident should have been offered a pneumococcal vaccine. On 12/11/24 at 9:30 AM, the DON provided the surveyor with Resident #14's pneumococcal vaccine declination which was signed on 12/9/24, after surveyor inquiry. On 12/11/24 at 10:30 AM, in the presence of the NC, DON, LNHA, and the survey team, the surveyor interviewed the IP who stated the pneumococcal vaccine consents and declinations should have been obtained upon admission. 2.) On 12/6/24 at 10:23 AM, the surveyor reviewed the medical record for Resident #70. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: immunodeficiency due to drugs. A review of the resident's Immunization Audit Report, as of 12/5/24, included a historical immunization record that the resident received the pneumococcal conjugate vaccine 13 (PCV13) on 6/18/18. There was no other documentation of a pneumococcal vaccination after 2018. (continued on next page)

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	315014	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Oak Rehabilitation and Healthcare Center	849 Big Oak Road Pittsgrove, NJ 08318

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/15/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS included the resident was offered, but declined, the pneumococcal vaccine. On 12/6/24 at 10:39 AM, in the presence of the survey team, the surveyor interviewed the Infection Preventionist (IP) who confirmed administration or declination of vaccinations was documented in the immunization tab (Immunization Audit Report) of the resident's electronic medical record. On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the unit managers offered the residents their vaccines and obtained the consents or declinations. LPN #1 confirmed that immunization information was documented in the resident's electronic medical record and stated it was important to offer residents vaccines to help prevent sickness such as the flu, pneumonia, or COVID-19. On 12/9/24 at 1:19 PM, in the presence of the Nurse Consultant (NC), the Licensed Nursing Home Administrator (LNHA), and the survey team, the surveyor interviewed the Director of Nursing (DON) who stated upon admission, the resident's immunization information is included in the admission packet to determine if the resident received or would like to receive immunizations. The DON further stated that any of the nurses could obtain consent or declination for the vaccines and that consents/declinations were documented in the resident's medical record. The DON added that the importance of offering immunizations was so the resident can be vaccinated for anything that is possibly harmful. At that time, the surveyor informed the DON of Resident #70's pneumococcal immunization status, and the DON confirmed the resident should have been offered a pneumococcal vaccine. On 12/11/24 at 9:30 AM, the DON provided the surveyor with Resident #70's pneumococcal vaccine consent which was signed on 12/9/24, after surveyor inquiry. On 12/11/24 at 10:30 AM, in the presence of the NC, the DON, the LNHA, and the survey team, the surveyor interviewed the IP who stated the pneumococcal vaccine consents and declinations should have been obtained upon admission. 43308 3.) On 12/5/24 at 12:01 PM, the surveyor reviewed the medical record for Resident #69 A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: high blood pressure, pneumonia, and chronic respiratory failure with hypoxia (the body is not receiving enough oxygen). A review of the resident's Immunization Audit Report, as of 12/5/24, did not include any documentation related to the pneumococcal vaccine. A review of the resident's admission Minimum Data Set (MDS), an assessment tool, dated 9/25/24, included the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS included the resident was offered, but declined, the pneumococcal vaccine. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 9:30 AM, the DON provided the surveyor with Resident #69's pneumococcal vaccine consent which was signed on 12/10/24, after surveyor inquiry. 37547 4.) On 12/5/24 at 9:59 AM, the surveyor reviewed the medical record for Resident #66. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: morbid (severe) obesity due to excess calories, osteomyelitis (bone infection) of vertebra, sacral (bottom of the spine), and sacrococcygeal (pertaining to both the sacrum and the coccyx (tailbone)) region, pressure ulcer of left heel stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle), pressure ulcer of other site stage 4, type 2 (two) diabetes mellitus with mild nonproliferative diabetic retinopathy without macular (relating to the eye) edema bilateral, and depression. A review of the resident's Immunization Audit Report, as of 12/5/24, did not include any documentation related to the influenza or pneumococcal vaccination administration. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated 5/28/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed that both the influenza and pneumococcal vaccines were not administered and were not offered. A review of the resident's quarterly MDS, dated [DATE], included the resident had a BIMS score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed that both the influenza and pneumococcal vaccines were offered and declined. On 12/5/24 at 1:19 PM, the surveyor interviewed the Infection Preventionist (IP), who stated that she had worked at the facility since September 2024. The IP stated that she reviewed the resident's admission assessments and their medical records to determine the resident's immunization status. The IP stated that she had called the resident's responsible party to determine if the resident had previously received the influenza and pneumococcal vaccines, but did not document the call and had not heard back. The IP stated that she was unable to find any immunization history for the resident in the immunization data base, hospital records or under the immunization tab in the resident's EHR. The IP stated there was no data to be found for the resident to indicate that the resident's immunization status was previously assessed or if the resident was offered the pneumococcal or influenza vaccines upon admission/readmission or when they were offered at the facility during vaccine clinics. The surveyor reviewed the resident's past four Admission/Readmission Evaluations and the Immunization sections were incomplete and failed to indicate if the resident had previously received the influenza or pneumococcal vaccines. On 12/5/24 at 2:08 PM, the surveyor interviewed the Director of Nursing (DON) who stated the admission nurse was responsible to determine if the resident had already received the influenza or pneumococcal vaccines. The DON stated the IP was responsible to ensure that the resident's immunization status was accurately reflected on the Immunization Audit Report. The DON further stated the IP should have documented attempts to contact the resident's family in the resident's EHR. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/24 at 11:42 AM, the surveyor interviewed the MDS Coordinator, via telephone, who stated that she worked at the facility since 10/1/24. The MDS Coordinator stated she reviewed the resident's historical immunization history in the resident's EHR and only noted a historical tuberculosis testing. The MDS Coordinator stated that she documented that the influenza and the pneumococcal status as offered and declined, and, unfortunately, I did just copy the information from the previous MDS. The MDS Coordinator stated that she should have looked in the resident's EHR and attempted to find a vaccination refusal. On 12/9/24 at 1:24 PM, The surveyor interviewed the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated that it was important to be vaccinated in order to prevent anything that may be hurtful to the resident. The DON stated the resident should have been offered the influenza and the pneumococcal vaccines if they were a resident during the time they were offered. On 12/11/24 at 9:31 AM, the DON provided the surveyor with an Informed Consent for Influenza Vaccination and Pneumococcal Vaccinations and both consents were refused by the resident on 12/9/24, after surveyor inquiry. A review of the facility's Pneumococcal Vaccine policy, updated February 2024, included, Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series unless medically contraindicated or the resident has already been vaccinated, and, Administration of the pneumococcal vaccines or revaccination will be made in accordance with current Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) recommendations at the time of the vaccination. A review of the facility's Influenza Vaccine policy, updated April 2024, included, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote benefits associated with vaccinations against influenza. .Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. .Administration of the influenza vaccine will be made in accordance with current centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) recommendations at the time of vaccination. NJAC 8:39-19.4 (i)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to offer residents an updated COVID-19 vaccine for 4 of 5 residents (Resident #14, #66, #69, and #70) reviewed for immunizations. This deficient practice was evidenced by the following: Reference: Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report Use of COVID-19 Vaccines for Persons Aged >6 Months: Recommendations of the Advisory Committee on Immunization Practices (ACIP) - United States, 2024-2025 Weekly / September 19, 2024 / 73(37);819-824 On June 27, 2024, the Advisory Committee on Immunization Practices recommended 2024-2025 COVID-19 vaccination with a Food and Drug Administration (FDA)-authorized or approved vaccine for all persons aged >6 months. In August 2024, the FDA approved and authorized the Omicron JN.1 lineage (JN.1 and KP.2), 2024-2025 COVID-19 vaccines by Moderna and Pfizer-BioNTech (KP.2 strain) and Novavax (JN.1 strain). Persons aged >[AGE] years without moderate to severe immunocompromise need 1 dose of 2024-2025 COVID-19 vaccine (Moderna, Novavax, or Pfizer-BioNTech) to be up to date. Persons aged >[AGE] years who have not previously received any COVID-19 vaccines and choose to get Novavax should receive 2 doses of the 2024-2025 Novavax vaccine. 1.) On 12/6/24 at 10:19 AM, the surveyor reviewed the medical record for Resident #14. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: urinary tract infection, extended spectrum beta lactamase (ESBL) resistance, and chronic viral hepatitis C. A review of the resident's Immunization Audit Report, as of 12/5/24, included a historical immunization record that the resident received a COVID-19 vaccination on 8/15/21 (Step 1), 9/12/21 (Step 2), and 9/28/22 (Booster). There was no documentation that the resident received or declined an updated COVID-19 vaccination after 2022. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/16/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/24 at 10:39 AM, in the presence of the survey team, the surveyor interviewed the Infection Preventionist (IP) who confirmed administration or declination of vaccinations was documented in the immunization tab (Immunization Audit Report) of the resident's electronic medical record. On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the unit managers offered the residents their vaccines and obtained the consents or declinations. The LPN confirmed that immunization information was documented in the resident's electronic medical record and stated it was important to offer residents vaccines to help prevent sickness such as the flu, pneumonia, or COVID-19. On 12/9/24 at 1:19 PM, in the presence of the Nurse Consultant (NC), the Licensed Nursing Home Administrator (LNHA), and the survey team, the surveyor interviewed the Director of Nursing (DON) who stated upon admission, the resident's immunization information is included in the admission packet to determine if the resident received or would like to receive immunizations. The DON further stated that any of the nurses could obtain consent or declination for the vaccines and that consents/declinations were documented in the resident's medical record. The DON added that the importance of offering immunizations was so the resident can be vaccinated for anything that is possibly harmful. At that time, the surveyor informed the DON of Resident #14's COVID-19 immunization status, and the DON confirmed the resident should have been offered an updated COVID-19 vaccine. On 12/11/24 at 9:30 AM, the DON provided the surveyor with Resident #14's COVID-19 vaccine declination which was signed on 12/10/24, after surveyor inquiry. On 12/11/24 at 10:30 AM, in the presence of the NC, DON, LNHA, and the survey team, the surveyor interviewed the IP who stated the COVID-19 vaccine consents and declinations should have been obtained upon admission. 2.) On 12/6/24 at 10:23 AM, the surveyor reviewed the medical record for Resident #70. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: immunodeficiency due to drugs. A review of the resident's Immunization Audit Report, as of 12/5/24, included a historical immunization record that the resident received a COVID-19 vaccination on 4/9/21 (Step 1), 4/30/21 (Step 2), 3/1/22 (Booster), and 10/4/22 (Booster). There was no documentation that the resident received or declined an updated COVID-19 vaccination after 2022. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/15/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. On 12/6/24 at 10:39 AM, in the presence of the survey team, the surveyor interviewed the Infection Preventionist (IP) who confirmed administration or declination of vaccinations was documented in the immunization tab (Immunization Audit Report) of the resident's electronic medical record. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 12:03 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated the unit managers offered the residents their vaccines and obtained the consents or declinations. LPN #1 confirmed that immunization information was documented in the resident's electronic medical record and stated it was important to offer residents vaccines to help prevent sickness such as the flu, pneumonia, or COVID-19. On 12/9/24 at 1:19 PM, in the presence of the Nurse Consultant (NC), the Licensed Nursing Home Administrator (LNHA), and the survey team, the surveyor interviewed the Director of Nursing (DON) who stated upon admission, the resident's immunization information is included in the admission packet to determine if the resident received or would like to receive immunizations. The DON further stated that any of the nurses could obtain consent or declination for the vaccines and that consents/declinations were documented in the resident's medical record. The DON added that the importance of offering immunizations was so the resident can be vaccinated for anything that is possibly harmful. At that time, the surveyor informed the DON of Resident #70's COVID-19 immunization status, and the DON confirmed the resident should have been offered an updated COVID-19 vaccine. On 12/11/24 at 9:30 AM, the DON provided the surveyor with Resident #70's COVID-19 vaccine consent which was signed on 12/9/24, after surveyor inquiry. On 12/11/24 at 10:30 AM, in the presence of the NC, the DON, the LNHA, and the survey team, the surveyor interviewed the IP who stated the COVID-19 vaccine consents and declinations should have been obtained upon admission. 43308 3.) On 12/5/24 at 12:01 PM, the surveyor reviewed the medical record for Resident #69 A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, high blood pressure, pneumonia, and chronic respiratory failure with hypoxia (the body is not receiving enough oxygen). A review of the resident's Immunization Audit Report, as of 12/5/24, did not include any documentation related to the COVID-19 vaccine. A review of the resident's admission Minimum Data Set (MDS), an assessment tool, dated 9/25/24, included the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident's cognition was intact. On 12/11/24 at 9:30 AM, the DON provided the surveyor with Resident #69's COVID-19 vaccine declination which was signed on 12/10/24, after surveyor inquiry. 37547 4.) On 12/5/24 at 9:59 AM, the surveyor reviewed the medical record for Resident #66. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: morbid (severe) obesity due to excess calories, osteomyelitis (bone infection) of vertebra, sacral (bottom of the spine), and sacrococcygeal (pertaining to both the sacrum and the coccyx (tailbone)) region, pressure ulcer of left heel stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle), pressure ulcer of other site stage 4, type 2 (two) diabetes mellitus with mild nonproliferative diabetic retinopathy without macular (relating to the eye) edema bilateral, and depression. A review of the resident's Immunization Audit Report, as of 12/5/24, did not include any documentation related to the COVID-19 vaccine administration. A review of the resident's quarterly MDS, dated [DATE], included the resident had a BIMS score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed that the resident's COVID-19 vaccination was not up to date. The surveyor reviewed the resident's past four Admission/Readmission Evaluations and the Immunization sections were incomplete and failed to indicate if the resident had previously received the SARS-COV-2 (COVID-19) vaccine. On 12/5/24 at 2:08 PM, the surveyor interviewed the Director of Nursing (DON) who stated the admission nurse was responsible to determine if the resident had already received the COVID-19 vaccine. The DON stated the IP was responsible to ensure that the resident's immunization status was accurately reflected on the Immunization Audit Report. The DON further stated the IP should have documented attempts to contact the resident's family in the resident's EHR. On 12/5/24 at 1:19 PM, the surveyor interviewed the Infection Preventionist (IP), who stated that she had worked at the facility since September 2024. The IP stated that she reviewed the resident's admission assessments and their medical records to determine the resident's immunization status. The IP stated that she had called the resident's responsible party to determine if the resident had previously received the COVID-19 vaccine but did not document the call and had not heard back. The IP stated that she was unable to find any immunization history for the resident in the immunization data base, hospital records, or under the immunization tab in the resident's EHR. The IP stated there was no data to be found for the resident to indicate that the resident's immunization status was previously assessed or if the resident was offered the COVID-19 vaccine upon admission/readmission. On 12/6/24 at 11:42 AM, the surveyor interviewed the MDS Coordinator, via telephone, who stated that she worked at the facility since 10/1/24. The MDS stated she reviewed the resident's historical immunization history in the resident's EHR and only noted a historical tuberculosis testing. The MDS Coordinator stated, unfortunately, I did just copy the information from the previous MDS. The MDS Coordinator stated that she should have looked in the resident's EHR and attempted to find vaccination information. On 12/9/24 at 1:24 PM, the surveyor interviewed the DON in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated that it was important to be vaccinated in order to prevent anything that may be hurtful to the resident. The DON stated the resident should have been offered the COVID-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 9:31 AM, the DON provided the surveyor with a COVID-19 Vaccination consent with documented resident refusal that was signed by the resident on 12/9/24, after surveyor inquiry. A review of the facility's COVID-19 Vaccination policy, updated April 2024, included, When COVID-19 vaccine is available to the facility, each resident and staff member who has not already been immunized and does not have medical contraindications will be offered the vaccine. Further review of the policy included, Prior to vaccination, informed consent will be obtained, and, The resident, resident representative, or staff member has the opportunity to accept or refuse the COVID-19 vaccine and change their decision about vaccination at any time. Refusal of the vaccine shall be documented. NJAC 8:39-19.4(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40041 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain a safe and sanitary medication storage room. This deficient practice was identified in 1 of 2 medication storage rooms (West Wing med room) and was evidenced as follows: On 12/5/2024 at 9:04 AM, the surveyor entered the medication (med) storage room located on the [NAME] Wing, accompanied by Licensed Practical Nurse (LPN) #1; upon entering, there was a musty odor and the following was observed: The floor tile was discolored with stains and small particles in various areas. The floor was raised and buckled in the area closest to the left wall. There was a crack extending across the ceiling. There was piping that was detached piping laying on the floor in front of the sink. In the cabinet under the sink, there was a moist soiled white blanket containing brown stains and debris. The lower bilateral sides of the interior of the cabinet were discolored grayish black. On 12/5/2024 at 10:54 AM, the surveyor interviewed the Director of Maintenance (DM), who stated he was responsible for repairing the med room piping and floor. He stated that the pipes in the med storage room broke about three weeks ago and that he ordered the parts. He further stated he was not at work for about a week after he ordered the parts and that while he was out nothing was done since he was the only maintenance person on staff. On 12/05/24 at 2:29 PM, the surveyor conducted a follow-up visit to the [NAME] Wing med storage room, accompanied by LPN #3 and LPN/UM #2. When LPN#3 turned on the faucet, water came out of the pipe under the sink and onto the white blanket. There was no signage indicating that the sink was not in working condition. At that time, LPN/UM #2 stated that the med room sink was nonfunctional. When asked if there was any hand sanitizer, she replied, no there was no hand sanitizer in the med storage room. On 12/6/2024 at 12:14 PM, the surveyor interviewed LPN/UM#1 , who stated the sink has been nonfunctional for about a month. She further stated something under the sink was cracked or broken because when she washed her hands she could hear water dripping under the sink. She also stated that the facility knew that the floor was pushing in and squishy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Oak Rehabilitation and Healthcare Center	849 Big Oak Road Pittsgrove, NJ 08318

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/2024 at 1:25 PM, the surveyor conducted a follow-up interview with LPN #1, who stated when she washed her hands at the sink in the med storage room, she would hear water dripping under the sink. She then stated that the floor had been soft and wet for months. She further stated that the DM was informed, but she did not recall when he was notified. On 12/6/24 at 1:33 PM, the surveyor interviewed LPN #3, who stated that she has not been washing her hands in the med room for about one month due to the sink being out of order. She further stated that she was unsure of when the water leaked onto the floor. On 12/6/2024 at 1:39 AM, the surveyor conducted an interview with LPN/UM #2, who stated that since September there has been a leak onto the med storage floor and the damage progressed. She further stated, You can tell it was wet in there, and you could see that the tiles had obviously gotten wet. She also stated that there was a maintenance log and and all issues where documented on the maintenance log. On 12/9/2024 at 9:03 AM, the surveyor conducted a follow-up interview with the Licensed Nursing Home Administrator (LNHA). When asked if the condition of the med storage room floor was reported to him, he stated that he received reports related to some water on the floor. The LNHA further stated that the floor, the faucet and the cabinet should be maintained in good repair. On 12/9/2024 at 2:26 PM, the surveyor interviewed the Consultant Pharmacist (CP), who stated that medications should be stored in a clean, dry, organized, temperature-controlled, and sanitary environment. She stated that she toured the medication storage rooms once per month and her last visit was on 12/5/24. She further stated when she toured the [NAME] Wing med storage room this month, she noticed that there was something going on and told the facility that it was unacceptable. When asked, what would be her recommendation if the med storage room had a leak, she replied that the facility would have to rectify that immediately, because if an air quality test were to be done, it would not be considered a dry cool room. A review of the facility's Storage of Medications policy updated April 2024 included 3. The nursing staff is responsible for maintaining medication storage and preparation areas clean, safe, and sanitary. A review of the facility's Maintenance Service undated policy included, Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards. NJAC 8:39-31.4(a)