STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315037	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Family of Caring at Teaneck LLC	1104 Teaneck Road Teaneck, NJ 07666

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure a.) the bed hold-policy that was provided to the Resident or Resident's Representative (RR) included information about the reserve bed payment policy plan for 2 of 2 residents (Residents #3 and #113) reviewed for hospitalizations and b) completion of a physician's discharge summary for 1 of 1 residents (Resident #115) reviewed for discharge to the community. The deficient practice was evidenced by the following: 1.Surveyor #1 (S #1) reviewed the electronic medical record (EMR) for Resident #3 for hospitalization and revealed: A review of the admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses including but not limited to essential hypertension (also called primary hypertension, or idiopathic hypertension) is a form of hypertension without an identifiable physiologic cause) and type 2 diabetes (a condition where the body does not use insulin properly and results in high blood sugar). A review of the comprehensive Minimum Data Set (cMDS), an assessment tool, with an assessment reference date (ARD) of 11/7/25, reflected a brief interview for mental status (BIMS) score of 6 out of 15, indicating that the resident had severe cognitive impairment. A review of the Census List which reflected dates the resident was admitted to the facility. A review of the Progress Notes reflected dates of assessment when the resident was readmitted to the facility. The Licensed Nursing Home Administrator (LNHA) provided, upon request, the notice of transfer, Notification of Bed Hold Policies, and admission Agreement for Resident #3. S #1 reviewed the facility provided documentation, and the documentation did not reflect any reserve bed rates or Bed Hold rates. 2. On 11/24/25 at 8:59 AM, Surveyor #2 (S #2) reviewed the EMR of Resident #113. A review of the AR revealed Resident #113 had diagnoses which included, but were not limited to; vascular dementia, hypertension (high blood pressure), and type 2 diabetes mellitus. A review of the MDS revealed two Discharge Return Anticipated MDS assessments which indicated the resident had unplanned transfers to an acute care hospital in September 2025. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/24/25 at 9:54 AM, S #2 reviewed the closed paper record for Resident #113 provided by the LNHA which consisted only two documents. The two documents were the New Jersey Universal Transfer forms for the resident's two discharges to the hospital dated 9/1/25 and 9/10/25. On 11/24/25 at 12:35 PM, S #2 interviewed the Director of Social Services (DSS) about notifications for resident's emergency transfer. The DSS stated social services provided the ombudsman's office notification of a resident's emergency transfer and were not responsible for bed hold policy notification. The DSS stated it may be the Director of Admissions (DA) who was responsible for providing bed hold policy notification. S #2 requested to speak with the DA. On 11/24/25 at 1:31 PM, S #2 requested from the LNHA and the Director of Nursing (DON) the bed hold policy notifications for Resident #113's two emergency transfers. The LNHA stated it would be provided and confirmed the DA's responsibility. On 11/24/25 at 2:09 PM, S #2 interviewed the DA, who stated he was responsible for sending bed hold policy notification. He further stated the bed hold policy was sent via an electronic online system which allowed direct messages to RR and reviewed the process with S #2. S #2 requested from the DA the bed hold policy notification for Resident #113's two unplanned discharges. On 11/24/25 at 2:29 PM, the LNHA provided documentation of messages sent to the RR about bed hold policies. The two message receipts were dated 9/8/2025 and 9/11/2025. The documents indicated the recipient [the RR] contact phone number which the message was delivered to and no resident information. The content of the message was not attached with the documentation provided. On 11/25/25 9:30 AM, S#2 requested from the LNHA the message content of the bed hold policy notification sent to the Resident #113's RR. On 11/25/25 10:04 AM, the LNHA provided the bed policy notification for the resident's 9/10/25 unplanned emergency transfer which included a document titled Notification of Bed Hold Policies. The document did not detail reserve bed payment and was unsigned where it indicated I have received notification of the bed hold policy and choose for the above-named person (check one) .Yes to be placed on bed hold.Not to be place on bed hold. On 11/25/25 at 10:21 AM, S #2 interviewed the DA, who stated that after written bed hold policy notification was sent to the RR, he also called to follow up about receipt of the notification and would make multiple attempts to speak with the RR. S #2 asked the DA if reserve bed payment policy was included in the bed hold policy notice. The DA stated the bed hold policy notice did not specifically include the reserve bed payment. The DA further explained if the RR called the facility, the reserve bed payment would be discussed, and they would decide whether to hold the resident's bed. S #2 asked the DA if discussion with the RR were documented and if there was any additional documentation to indicate reserve bed payment included with bed hold policy notification, and the DA replied there was no additional documentation. On 11/25/25 at 11:41 AM, S #2 notified the DON and the LNHA about the concern for bed hold notification upon emergency transfer which did not detail the bed reserve payment policy. On 11/25/25 at 12:23 PM, the LNHA provided the facility's admission agreement sample. The LNHA stated the bed hold policy including the reserve bed payment was detailed in the admission agreement. The bed hold policy section included attachment with bed reserve payment for Medicaid, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medicare, and private pay residents. The bed hold policy provided at the time of the resident's transfer did not include the information provided in the bed hold policy section of the admission agreement. There was no additional information provided by the facility's management. Additional review of the message receipt dated 9/8/2025, provided by the facility revealed the recipient's contact phone number which the message was delivered to was not listed for Resident #113. A review of the facility's Policy: Bed Hold Policy which had a last reviewed date of January 2025, under Purpose revealed:.Center Representative will send notification to families for emergency discharges and to the OMBUDSMAN. A review of the facility provided policy titled Transfer and Discharge, which had a last reviewed date of October 2025, under Emergency Transfers/Discharges revealed, .Provide a notice of the resident's bed hold policy to the resident and representative at time of transfer, as possible, but no later than 24 hours of the transfer. There was no additional information regarding the details of bed hold policy notification upon a resident's emergency transfer in the policies. 3. On 11/19/25 at 1:01 PM, S #2 reviewed the EMR of Resident #115. The AR revealed Resident #115 had diagnoses which included, but were not limited to congestive heart failure and hypertension. A Discharge Return Not Anticipated MDS with an ARD of 8/28/2025, indicated the resident's discharge (d/c) was unplanned and to home/community. The resident's EMR included an interdisciplinary d/c summary. Additional review of the EMR and closed paper chart revealed there was no physician d/c summary documented. On 11/24/25 at 1:31 PM, S #2 requested from the DON and the LNHA the physician d/c note for Resident #115. On 11/25/25 at 11:41 AM, S #2 notified the DON and the LNHA of the concern that there was no physician d/c note found in the medical records for Resident #115. On 11/25/25 at 12:35 PM, the DON provided to S #2 a late entry note dated 8/28/25 by a nurse practitioner (NP) for Resident #115's d/c. The DON acknowledged the note was completed after surveyor inquiry. The surveyor reviewed the facility provided policy titled Discharge Summary and Plan of Care with a last review date of October 2025. Under Policy Explanation and Procedures revealed, The discharge plan should include.The physician's assessment of the resident's discharge and rehabilitation potential at the time of admission, as documented in admission physician's orders. The physician should update the assessment of potential as, appropriate. NJAC 8:39-5.1(a); 5.4(c)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and review of facility-provided documents, it was determined that the facility failed to ensure that meals were consistently provided in a dignified and homelike manner. The deficient practice was observed in the recreation dining area for 2 of 2 residents (Residents #87 and #91). The deficient practice was evidenced by the following:On 11/21/2025 at 12:09 PM, the surveyor observed the lunch meal service in the dining room, Residents #87 and #91 were seated at table #9. Resident #91 had been served a tray of food and was independently eating. Resident #87, seated across from Resident #91 was not served a tray. The surveyor observed staff in the room that included but were not limited to the Director of Activities (DA) and Certified Nurse Aides (CNAs) that distributed meal trays and assisted residents to eat.At that time, the surveyor interviewed the DA who was monitoring the dining area and tray distribution to residents. The surveyor asked the DA if it was common practice for a resident not to have a tray while other residents at the same table were eating. The DA stated, no, it was not a common practice, and resident #87 normally took meals in their room. The DA then asked a CNA to get resident #87's meal tray from a cart located in the hallway across from the dining room after surveyor's inquiry. On 11/24/25 at 1:31 PM, the survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), and the surveyor notified them of the above concerns. The surveyor asked the DON if it was common practice for one resident at a dining table to be served a meal tray and be eating while another resident did not get serve. The DON stated, no, it was not a common practice. The DON also stated that the staff should accommodate the resident's choice daily, not just what they thought the resident wanted.On 11/25/25 at 11:42 AM, the survey team met with the LNHA and DON, and the DON stated that the staff was educated on dining room services and to be sure residents at a table were all served together. The DON also stated that the incident was a one off event. The surveyor asked the DON if the staff should adapt to the resident's needs even, they normally do not eat in the dining room. The DON stated that the staff should adapt to resident needs.The facility did not provide any further relevant information.A review of the electronic medical records (EMR) for Resident #87 and Resident #91 revealed:Resident #87 EMR revealed an admission Record (AR; an admission summary), which reflected that the resident was admitted with diagnoses which included but were not limited to, dementia (a loss of cognitive function that interferes with daily life) and depression. A review of the comprehensive Care Plan reflected a focus that the resident was at risk for malnutrition or unplanned weight loss. A review of the dietician progress note dated 11/4/25, reflected that the resident reported that they had a fair appetite.Resident #91 EMR revealed an AR which reflected that the resident was admitted with diagnoses which included but were not limited to essential hypertension (also called primary hypertension, or idiopathic hypertension) is a form of hypertension without an identifiable physiologic cause) and type 2 diabetes (a condition where the body does not use insulin properly resulting in high blood sugar).A review of the facility's Food, Dining Service an HS Snacks Policy with a reviewed date of 6/2025, reflected under Eating Environment: -All residents seated at a table will be served together.A review of the facility's Resident Rights Policy, dated 10/2025, reflected under 3.assure the resident is always treated with respect, kindness and dignity.NJAC 8:39-4.1(a),12,28;27.1(a);27.3(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to; a.) clarify the physicians' orders for 1 of 5 residents, (Resident #23), observed during medication administration, according to the standard of clinical practice and facility policy and b) follow appropriate tuberculosis (TB) testing and documentation according to standards of clinical practice and facility protocol for 1 of 5 residents (Resident #30) reviewed for unnecessary medications. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1.On 11/21/25 at 9:31 AM, during the medication (med) pass observation, Surveyor #1 (S #1) observed the Registered Nurse (RN) passing medications (meds) to Resident #23. S #1 observed a med labeled Probiotic Saccharomyces boulardii administered to the resident. The label on the med reflected a strength of 500 mg (milligram) per 2 capsules (caps) and 10 billion CFU per 2 caps. The resident's electronic Med Administration Record (eMAR) reflected Saccharomyces boulardii Oral Capsule (cap) (Saccharomyces boulardii) give one cap by mouth two times a day for supplement as the med order. The order did not reflect any strength. S #1 asked the RN if this was the usual med given to a resident with the order reflected on the eMAR. The RN stated yes, it was a house stock bottle. On 11/21/25 at 11:39 AM, S #1 inspected the stock meds cabinet located in the center nurse station. The inspection revealed a bottle labeled Probiotic Formula. The ingredients reflected Bacillus Coagulans 1 billion CFU and Inulin 250 mg. The inspection did not reveal any bottles of Saccharomyces boulardii. A review of the manufacturer information for the available dosages of Saccharomyces boulardii revealed that the med was available in many different strengths by multiple manufacturers. S #1 reviewed the electronic medical record (EMR) for Resident #23, and revealed: A review of the admission Record (AR; an admission summary), which reflected that the resident was admitted with diagnoses which included but were not limited to essential hypertension (also called primary hypertension, or idiopathic hypertension) is a form of hypertension without an identifiable physiologic cause) and heart failure (a condition where the heart can not pump enough blood). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 8/20/25, had a brief interview for mental status (BIMS) score of 13 out of 15, indicating that the resident had no cognitive impairment. A review of the Order Summary Report (OSR) reflected an order for Saccharomyces boulardii oral cap, give one cap by mouth two times a day for supplement as the med order. On 11/24/25 at 1:31 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and S #1 notified them of the above findings and concerns. S #1 asked the DON if a med order had no strength listed but could be available in different strengths could the order cause confusion and a possible med error. The DON stated that the order should be clarified to include a strength. On 11/25/25 at 11:42 AM, the survey team met with the LNHA and DON, and the LNHA stated that the Saccharomyces order was clarified to include a strength, and the house stock meds were adjusted to only have one type of probiotic to avoid confusion. The facility did not provide any further pertinent information. A review of the facility's Administering Medications Using Electronic System Policy, with a review date of 1/2025, the policy did not reflect any mention of clarification of orders. 2. On 11/24/25 at 10:16 AM, Surveyor #2 (S #2) reviewed the EMR of Resident #30. A review of the AR documented that the resident had diagnoses that included but were not limited to; generalized muscle weakness, dysphagia (difficulty swallowing), and urinary tract infection. A review of the comprehensive MDS), with an ARD of 10/22/25, indicated a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. A physician's order (PO) dated 10/15/25, documented Tuberculin PPD [purified protein derivative] Solution 5 UNIT/0.1milliliter (ml) Inject 0.1 ml intradermally one time only for House Protocol until 10/15/2025 11:59 PM, PPD Step (1) Administration. Repeat in (14) days if results of 1st PPD is negative. A PO dated 10/15/25, documented Tuberculin PPD Solution 5 UNIT/0.1 ml Inject 0.1 ml intradermally one time only for House Protocol until 10/29/2025 11:59 PM, PPD Step (2) Administration. Repeat (14) days after Step 1 if results of 1st PPD is negative. A PO dated 10/15/25, indicated Read PPD: 2 step one time only for House Protocol until 10/17/2025 11:59 PM; Read in 72 hours after Step (1) administration and document in millimeter (mm). A PO dated 10/15/25, indicated Read PPD: 2 step one time only for House Protocol until 10/24/2025 11:59 PM; Read in 72 hours after Step (2) administration and document in mm. A review of the immunization section of the EMR revealed results were pending for the 2 Step PPD test. A review of the October 2025 eMAR revealed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/25 at 12:45 AM, the Step 1 PPD was documented as administered. On 10/17/25 at 10:05 PM, the Step 1 PPD result was documented as read with a result of 0 mm. The order indicated the PPD was to be read 72 hours after Step 1. On 10/25/25 at 12 AM, the Step 2 PPD result was documented as read with a result of 0 mm. The order indicated the PPD was to be read 72 hours after Step 2. There was no documentation of Step 2 being administered to the resident. On 10/29/25 at 9:51 AM, the Step 2 PPD was documented as administered. There were no additional entries in the October 2025 eMAR for PPD. A review of November 2025 eMAR revealed no entries to read the Step 2 PPD results. On 11/24/25 at 11:45 AM, S #2 interviewed the Licensed Practical Nurse Unit Manager (LPN/UM), who stated it was facility protocol for a 2 step PPD to be administered according to a PO. The LPN/UM further explained the Step 1 PPD would be given and then the results read after 72 hours; If the results were negative the Step 2 PPD would be given 14 days after the Step 1 PPD. S #2 reviewed with the LPN/UM Resident #30's eMAR. The LPN/UM acknowledged the concern that Step 1 was not read after 72 hours and for Step 2, there was documentation to indicate Step 2 results were read after 72 hours. The LPN/UM stated he would review to provide any additional information. On 11/24/25 at 1:31 PM, S #2 notified the LNHA, and the DON of the concern for Resident #30's PPD order not being transcribed and administered according to facility protocol and the PO. The DON confirmed the PPD result was expected to be read 72 hours after its administration and the 2nd step was to be given 14 days after the 1st step. On 11/25/25 at 11:41 AM, the LNHA, and the DON met with the surveyors. The DON stated the nurses should have clarified the order to adjust the timeframe to the appropriate days for it to be completed as ordered and the nurses were provided in-service education. There was no additional information provided by the facility's administration. A review of the facility's Tuberculosis, Screening Residents for, with a last reviewed date of January 2025, under the Policy Statement revealed, This facility shall screen all residents for tuberculosis infection and disease (TB). The policy did not address documentation for PPD administration. A review of the facility's Administering Meds Using Electronic System., with a last reviewed date of January 2025, under the Policy Statement revealed, Meds shall be administered in a safe and timely manner, and as prescribed. NJAC 8:39-11.2(b); 29.2 (d)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Complaint #2666131Based on observation, interview, and record review, it was determined that the facility failed to: a.) transcribed a physician order to ensure that a resident receive treatment and care in accordance with professional standards of practice and facility policies and procedures and b.) ensure that an incident report was documented in the resident's electronic health record (EHR) timely for 1 of 21 residents (Resident #97) reviewed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 11/19/25 at 11:36 AM, during the initial tour, the surveyor interviewed Resident #97 in their room and observed the resident lying in bed with lower left (L) arm covered in bandages. Resident #97 stated they were in the hospital, was brought in the facility to get therapy. The resident further stated that there was an incident that during breakfast, the tea was knocked down onto resident's L arm and L abdomen. The resident stated that they did not have pain but it burns sometimes, and the nurse gave them something to help the pain and it was getting better. On 11/19/25 at 1:00 PM, the surveyor requested from the License Nursing Home Administrator (LNHA) all accidents and investigations for the last four months for Resident #97. On 11/20/25 at 1:00 PM, the LNHA provided a facility reportable event (FRE) investigation, dated 11/9/25. The surveyor reviewed the FRE investigation which revealed the facility staff reported the incident to the Department of Health (DOH) on 11/11/25. The FRE revealed on 11/9/25 at 8:10 AM, the Certified Nursing Assistant (CNA) and the License Practical Nurse (LPN) were assisting Resident #97 for breakfast. The resident requested for the tea to be heated up and the CNA returned with the tea and placed it on the overbed table which was in front of the resident. The LPN witnessed the resident reach for the oatmeal and accidentally spilled the tea over their L arm and abdomen. The LPN assessed the resident who presented with a reddened area measuring 4.5 cm (centimeters) x 1 cm to L arm and upper abdomen measuring 8 cm x 2.5 cm; treatment was rendered to L arm and abdomen immediately; physician and Resident Representative (RR) were made aware. The reddened areas presented as closed blisters on 11/11/25, and the resident denied pain. All staff were in-serviced not to heat up beverages in the microwave but to replace from the thermos that kitchen will provide. The facility staff determined a conclusion that the incident was an isolated accident. On 11/20/25 at 4:23 PM, the surveyor called the CNA who was assigned to Resident #97 during the incident. The CNA stated that she and the nurse pulled up the resident in bed for breakfast. She further stated that the resident asked for the tea to be heated because it was cold, and the CNA maybe heated it up in the microwave for 60 seconds. The CNA placed the tea on the tray and saw that there was no milk, turned to get the milk in another tray and then heard the resident yell, and saw the resident's arm with the water. The nurse was in the room by the bed and witnessed the incident. The CNA stated that she took the tray away and cleaned up after the incident, the RR was made aware. She further stated that the Director of Nursing (DON) provided in service about the incident. The surveyor reviewed the medical records of Resident #97, and revealed: A review of the admission Record (an admission summary) reflected diagnoses that included but not limited to type 2 diabetes mellitus without (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complications and malignant neoplasm of unspecified site of unspecified female breast. A review of the physician orders (PO) revealed: -11/11/25 order for Silver External Gel (Silver) apply to L arm/abdomen upper quadrant topically every day shift for skin redness/blisters that was discontinued on 11/11/25. -Silver External Gel (Silver) apply to L arm/abdomen upper quadrant topically every day shift for skin redness/blisters-Start Date11/12/25. -11/11/25 Cleanse L arm (lower) satellite wound with NS (normal saline), pat dry, apply Silvadene cream with cotton tipped wood applicator, and cover with tender band bordered gauze daily. one time a day for wound care. -11/11/25 Cleanse L upper abdominal area with NS, pat dry, apply Silvadene cream with cotton tipped wound applicator and cover with tender band bordered gauze daily one time a day for wound care. A review of the comprehensive Minimum Data Set (MDS), a facility assessment tool to facilitate the plan of care, revealed a Brief Interview of Mental Status (BIMS) score of 15 out of 15 indicating intact cognition; the resident eating was set up or clean up assistance. A review of the Progress Notes (PN) revealed a late entry, incident note, effective date 11/9/25 at 9:45 AM, that was electronically signed by the LPN, with a note text: measurements done; L upper abdomen with 8 cm X 2.5 cm (closed blister), satellite wound to L lower arm with measurement 4.5 cm x 1 cm (open/ closed blisters), no s/s (signs/symptoms) infection noted, able to move L upper extremity independently, denied pain, will continue to observe. A review of the PN with an effective date 11/11/25 at 2:08 PM, that was electronically signed by the LPN with a note text: This writer was assisting resident to set up breakfast tray, resident requested to heat up tea, this writer asked CNA to heat tea up while this writer stayed with resident. CNA returned placed hot tea on table resident attempted to reach for oatmeal and accidentally spill tea over L arm and abdomen. Resident c/o feeling arm warm redness noted on L arm . Neosporin ointment applied to L arm . pain medication given as per PRN order . Orders received as followed: Cleanse L arm satellite wound with NS, pat dry, apply Silvadene cream with cotton tipped wood applicator, and cover with tender band bordered gauze daily.Cleanse L upper abdominal area with NS, pat dry, apply Silvadene cream with cotton tipped wound applicator and cover with tender band bordered gauze daily. On 11/21/25 at 11:40 AM, the surveyor reviewed, the electronic Medication Administration Records (eMAR) and electronic Treatment Administration Records (eTAR) in the EHR for November 2025, which revealed there was no order entered or signed treatment administered for 11/9/25 and 11/10/25. Further review of the EHR revealed that there was no documented evidence that the incident on 11/9/25 was documented in the PN. The PN revealed, the LPN entered a late entry created on 11/11/25, with an effective date of 11/9/25, and an incident note entered on 11/11/25. On 11/21/25 at 12:15 PM, the surveyor interviewed the LPN, in the DON's office, in the presence of the Regional DON and DON. The LPN stated that they were setting up the resident for breakfast and the resident asked for tea to be heated up. The CNA heated it up, while the LPN was setting up tray, opening containers and the resident tried to reach for oatmeal, spilled the tea all over, we removed everything and provided care. At that moment the resident had nothing except redness, I only saw blisters, and the LPN did not know what happened the next day. The LPN further stated that she applied the Neosporin that the doctor ordered that day until she got a new order for Silvadene. She also stated that the doctor ordered the Neosporin and we had a backup of the silver nitrate. The LPN stated that it was an expectation that the treatment provided and order of the physician would documented in the eMAR as administered. The LPN confirmed that if there was an order for a treatment it would be entered as a PO and signed in the eMAR. On that same date and time, the LPN confirmed that the incident should have been documented in the PN that same day it happened. The LPN had no response when she was asked why the treatment was not entered and why she did not document timely on 11/9/25. The LPN confirmed she received in-service about heating beverages. On 11/24/25 at 9:57 AM, the DON provided a typed attestation note from the LPN regarding obtaining a telephone order from Nurse Practitioner (NP), to administer Neosporin ointment for dates 11/9 and 11/10/25. The LPN further stated, I acknowledged that I neglected to put the order that I received into the computer. On 11/24/25 at 1:30 PM, the surveyor met with the LNHA and the (continued on next page)

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Family of Caring at Teaneck LLC	1104 Teaneck Road Teaneck, NJ 07666

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON regarding concerns of PN, treatment order not entered, and treatment not signed for two days. The DON confirmed the nurse should have documented on what happened on the day of the incident. The DON further stated, the nurse documented on the incident report which did not run into the PN, It should have been documented and when we noticed on 11/11/15, we asked her to do a late entry. The DON further stated that the Doctor's orders should have been transcribed and signed on the eTAR. The surveyor asked the DON if the incident report was part of the resident's medical records, and she stated No. A review of the facility's Accidents and Incidents-Investigating and Reporting Policy dated 1/5/25, revealed under Policy Interpretation and Implementation, . shall promptly initiate and document investigation of the accident or incident. A review of the facility's Charting and Documentation Policy dated 10/2025, revealed under Policy Interpretation and Implementation, #3. All incidents, accidents, or changes in the resident's condition must be recorded . #6 Documentation of procedures and treatments shall include care-specific details and shall include at a minimum; a) The date and time the procedure/treatment was provided A review of the facility's Physician Services Policy dated August 2006, revealed under Policy Interpretation and Implementation #3. Physician orders and PN shall be maintained in accordance with current regulations and facility policy. On 11/25/25 at 12:52 PM, the LNHA informed the survey team that there was no additional information to provide. 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. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident received care consistent with professional standards of practice by failing to; a.) clarify the physician order for sacrum wound, b.) follow the physician order and care plan for weekly skin assessment, and c.) properly assess and document wound assessments for 1 of 2 residents, (Resident #14), reviewed for facility acquired pressure injury.The evidence was as follows:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 11/19/25 at 9:51 AM, the surveyor asked the Director of Nursing (DON) the list of residents with facility acquired wounds and she responded that she would get back to the surveyor. On 11/19/25 at 10:30 AM, the surveyor observed Resident #14 lying on air mattress with eyes closed. On 11/19/25 at 11:54 AM, during phone interview of the surveyor with the Resident's Representative (RR), the RR informed the surveyor that the resident had facility acquired wound to the sacrum. The surveyor reviewed the medical records of Resident #14, and revealed:The admission Record (an admission summary) revealed that the resident was admitted to the facility with the following medical diagnoses that were not limited to; Alzheimer's disease unspecified, unspecified dementia, unspecified severity with other behavioral disturbance, type 2 diabetes mellitus without complications, and essential (primary) hypertension. A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 9/4/25, revealed a cognitive skills for daily decision making was coded 3, which reflected that the resident's cognition was severely impaired. The qMDS indicated that the resident had no skin impairment. A review of the Skin Observation Tool that was electronically signed by the Licensed Practical Nurse/Wound Nurse (LPN/WN) on 10/27/25, reflected that Resident #14 had stage 1 (pressure injury characterized by intact skin with non-blanchable redness, indicating localized damage due to prolonged pressure, often over bony prominences) with measurement of 4 centimeters (cm) x 7 cm. The notes section was left blank. A review of the Progress Notes (PN), dated 10/27/25 at 8:30 AM, that was electronically signed by the LPN/WN, included that the resident was noted with 4 cm x 7 cm stage 1 to the sacrum, MD (medical doctor) was made aware with order to cleanse the sacrum with NSS (normal saline solution, pat dry, apply skin prep, and cover with dry dressing daily and PRN (as needed). The PN also included that the RR was notified of the wound and new orders. A review of the Wound Care PN, with an effective date of 11/5/25 at 12:11 PM, electronically signed by the APN (Advance Practice Nurse), Resident #14 was seen for an initial wound evaluation. The wound assessment included sacral stage 2 pressure injury (a partial thickness skin injury characterized by a shallow, open wound that affects both the epidermis and part of the dermis) not present on admission (facility acquired wound), 4 cm x 5 cm x 0.1 cm, 100% pink dermal base, no odor, no undermining/tunneling, small amount of serosanguinous drainage (a type of wound exudate that appears as a light pink or pale red fluid, indicating a mixture of serum and red blood cells, commonly seen during the healing process), attached edges, and peri wound intact. The assessment/plan, the resident had delayed wound healing due to (d/t) the following factors: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extensive co-morbidities, impaired functional status, and impaired mobility. Recommended to cleanse with NSS, apply xeroform (sterile wound dressing that is nonadherent), cover with dry dressing, change daily and PRN. Further review of the Wound Care PN, revealed a follow up note, with an effective date of 11/19/25 at 11:51 AM, electronically signed by APN, reflected wound assessment included sacral stage 2 pressure injury improving, 3.5 cm x 4.3 cm x 0.1 cm, 100% pink dermal base, no odor, no undermining/tunneling, small amount of serosanguinous drainage, attached edges, and peri wound intact. The assessment/plan, the resident had delayed wound healing d/t the following factors: extensive co-morbidities, impaired functional status, and impaired mobility. Recommended to cleanse with NSS, apply xeroform, cover with dry dressing, change daily and PRN.A review of the Order Summary Report revealed the following physician order (PO):Ordered on 10/27/25, MD made aware with order to cleanse sacrum with NSS, pat dry, apply skin prep, and cover with dry dressing daily and prn; every day shift. The order was discontinued (dc' d) on 10/31/25.Ordered on 10/31/25, cleanse sacrum with NSS, pat dry, apply xeroform and cover with dry dressing daily and prn; every day shift for wound care.Ordered on 11/4/25, Weekly Skin assessment every day shift every Monday. A review of the October 2025 and November 2025 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) revealed:The above order on 10/31/25 for sacrum wound and xeroform daily and PRN dressing were plotted as one and not separated to determine if daily or PRN was administered and signed by nurses.The above order on 11/4/25 for weekly skin assessment was signed on 11/6/25, 11/13/25, 11/20/25, and 11/27/25 by the Licensed Practical Nurse (LPN). A review of the personalized care plan (CP) with a focus on potential for impairment of skin integrity related to diagnosis of diabetes mellitus, limited physical mobility, and incontinence, on 10/27/25-noted with stage 1 sacral wound 11/5/25-sacrum stage 2 pressure injury, that was revised on 11/5/25. Interventions included but not limited to, weekly skin assessment RN (Registered Nurse), created on 9/28/22. Further review of the above PN and medical records, there was no documented evidence that the PO for weekly skin assessment and CP by an RN was followed. The sacral wound was assessed by an RN not until 11/5/25, when the APN saw the resident for initial wound evaluation. On 11/20/25 at 8:50 AM, the Licensed Nursing Home Administrator (LNHA) provided the list of wound round date 11/12/25, included Resident #14 with facility acquired wound to sacrum stage 2, measurement: 4 cm x 5 cm, stable with treatment of xeroform. Initial date wound identified was on 10/27/25. On 11/19/25, sacrum stage 2, measurement: 3.5 cm x 4.3 cm x 0.1 cm, seen in weekly wound rounds. On 11/20/25 9:32 AM The surveyor observed the LPN/WN assisted by LPN during sacrum wound treatment. The surveyor observed the sacral wound with whitish color in the middle area, other areas of wound bed was reddish. There was another open wound, reddish, in the left side of the sacrum/buttock. The surveyor asked the nurses to describe the wounds. The LPN informed the surveyor that the sacrum wound was reddish in color, and she was the one who did the wound treatment yesterday. The surveyor then asked if there were whitish color in the sacrum when she did the wound care yesterday. The LPN/WN responded that the sacrum wound had whitish color and was present at the time of wound rounds with the APN on 11/19/25. On that same date and time, the surveyor asked the nurses about the other site with open wound, and the LPN/WN stated that it looks like a new wound, open, and raw, and about 1 cm x 1 cm. The LPN/WN approximate the new wound for measurement and did not use a measuring device. He further stated that he would call the physician for a new order probably it would be the same order for xeroform. The LPN informed the surveyor in the presence of the LPN/WN that the other open wound was not present yesterday when she did the wound treatment. At that same time, the surveyor interviewed the LPN/WN and asked to check again the order for the sacrum wound. The LPN/WN checked the eTAR and read the order for the sacrum which included PRN order. The surveyor asked how the nurse will be able to sign for PRN order that was included in the routine order. The LPN/WN responded that the order should have been clarified and acknowledged that the order for the sacrum should have been separated for routine order and PRN order, he also added that he would contact the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician. On 11/21/25 at 10:29 AM, the surveyor reviewed the resident's medical records and revealed that the LPN/WN documented in the PN with a created date of 11/20/25 at 12:13 PM, Resident #14 was noted with denuded skin to right lateral sacrum, APN was made aware with recommendation to cleanse right lateral right sacrum with NSS, pad dry, apply xeroform and cover with dry dressing daily and PRN. The LPN/WN also documented that MD agreed with recommendation and RR was notified of new changes and orders. A review of the Skin Observation Tool that was initiated and not completed by the LPN/WN on 11/20/25 at 12:19 PM, revealed, a note of right lateral sacrum denuded skin, 1 cm x 1 cm. Further review of the medical records revealed that there was no documented evidence that the resident's sacrum wound, and new wound was assessed by another nurse except for LPN/WN. There was no documented evidence that the sacrum wound assessment was updated to include the whitish area observed during wound treatment with the surveyor. On 11/21/25 at 12:41 PM, the surveyor interviewed the LPN/WN, who informed the surveyor that he called the APN to notify of the denuded skin to the part we saw, and the APN stated that she would see the resident next week during wound rounds. He further stated that for now cover with xeroform and dry dressing, and I spoke to the MD who agreed with the recommendations. He also stated that he followed the facility's practice and protocol to notify the RR, placed the order of the physician, made a skin assessment observation, and documented in the electronic medical records, everything done yesterday. On that same date and time, the LPN/WN informed the surveyor that I'm basically the daily nurse that assess the wound, if the wound was above the knee, like the sacrum, it would be the responsibility of the APN to assess the wound. The LPN/WN confirmed that there were no other doctors or nurses who assessed the resident's wound as of yesterday except for him. He also stated that I usually refer to MD or APN for wound staging. The surveyor asked about the sacrum wound observed yesterday with whitish color in the middle of the wound, the LPN/WN stated that it was an epithelial wound and acknowledged did not inform the APN about it because there was no changes from 11/19/25 wound rounds. On 11/21/25 at 1:01 PM, the surveyor notified the DON of the above findings and concerns about wound assessments of the sacrum and physician orders. The DON stated that she would check and assess the resident's sacrum wound and would get back to the surveyor. She stated that she was not able to see the wound and would want to check it first before providing information. On 11/21/25 at 1:11 PM, the DON informed the surveyor that the sacrum wound after her assessment, had possible sloughed and it was an expectation that the LPN/WN should have called him yesterday for her to see the wound and properly assess them to get an appropriate wound treatment. She further stated that the epithelial wound would not develop overnight and from LPN/WN description that rounded with the APN on 11/19/25, the sacrum wound was the same. She further stated that the wound APN did not properly assess the wound because she continued to document 100% pink dermal tissue. On 11/24/25 at 8:44 AM, the DON in the presence of the survey team informed the surveyor that the little white area in the sacrum wound was fibrin not sloughed, and the new wound area we think it was the tear from diaper. She further stated that she did an assessment and the APN should document completely the description of the wound so we could follow through with it. She also stated that sometimes fibrin and sloughed mimic each other and that was why wound should be continuously assessed. The DON added that the APN acknowledged that was fibrin saw on 11/19/25 wound follow up consult, the bridge which could not develop overnight, and this should be part of what the APN's notes on 11/19/25. At that same time, the DON stated that she was made aware and the Manager in the unit by the LPN/WN of the sacral wound condition on that same date (11/20/25), and we are both RN. The surveyor then asked the DON, if the LPN/WN notified the Manager and the DON of the sacral wound status, why there was no assessment done on that same date by an RN. The DON confirmed that they were aware that assessment should be done by an RN in New Jersey, but the LPN/WN had certification and credential for wound care. Furthermore, the DON provided a copy of the AD-HOC (also known as Quality Assurance Performance Improvement or QAPI) Committee Meeting Minutes dated 11/21/25 for skin assessments. The provided copy of Skin & (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Evaluation by the DON was done with date of 11/22/25 00:13 (12:13 AM), and lock date of 11/24/25 07:44 (7:44 AM), for the left lateral buttock abrasion type of wound 0.5 cm x 0.3 cm x 0.1 cm, acquired exact date 11/20/25, pink in color, with light serous, with notes: left lateral buttock was new abrasion, possible caused by tape from diaper or shearing that caused skin stripping, wound doctor orders were placed, Wound APN consulted and aware and will be seen on next visit. On 11/24/25 at 1:30 PM, the survey team met with the LNHA and DON, and the surveyor notified the LNHA and DON of the above concerns with Resident #14's wounds. The surveyor asked the LNHA and DON if that was the facility's practice to approximate the wound, and the DON responded, we have a measuring device to use and the nurse should measure the wound. A review of the facility's Wound Care Policy that was provided by the LNHA, with a procedure revised on 10/2025, revealed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation:1. Verify that there is a PO for this procedure.2. Review the resident's CP to assess for any special needs of the resident.Documentation: The following information should be recorded in the resident's medical record: 5. Any change in the resident's condition.6. All assessment data (that is, wound bed color, size, drainage, etc.) obtained when inspecting the wound.Reporting: 2.Report other information in accordance with facility policy and professional standards of practice. A review of the facility's Skin Assessment Policy that was provided by the LNHA, with reviewed date of 10/2025, revealed that it was facility's policy to perform a full body skin assessment as part of facility's systematic approach for pressure ulcer prevention and for the promotion of healing of various skin conditions, including pressure ulcers.Policy Explanation and Procedures:1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after newly identified pressure ulcer. On 11/25/25 at 12:59 PM, the survey team met with the LNHA, DON, two Regional DONs, and Chief Operations Officer for an exit conference and there was no additional information provided by the LNHA. NJAC 8:39-11.2(b); 27.1 (a)(e)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate treatment and services for a resident receiving enteral (tube) feedings. This deficient practice was identified for 1 of 2 residents (Residents #81), reviewed for enteral tube feeding.This deficient practice was evidenced by the following: On 11/19/25 at 10:03 AM, the surveyor observed Resident #81 lying in bed with their head of the bed elevated. The resident was alert and verbally responsive. Resident #81 stated they had a tube feeding (TF; delivery of nutrients through a feeding tube directly into the stomach), received enteral feedings, and recently started a diet to eat food by mouth. On 11/20/25 at 10:20 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #81. A review of the admission Record (an admission summary) documented the resident had diagnoses that included but were not limited to; dysphagia (difficulty swallowing), respiratory failure, and generalized muscle weakness. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 10/9/25, reflected a Brief Interview Mental Status (BIMS) score of 12 out of 15, which indicated the resident had moderate cognitive impairment. In Section K (Swallowing/Nutritional Status), Resident #81 was coded as receiving nutrition through a TF while a resident. A review of the physician's order (PO) dated 11/19/25, indicated to administer Glucerna 1.5, 237 milliliters (ml) via gastrostomy tube (GT; a surgical placed tube through the abdominal wall into the stomach to provide nutrition and fluids). A PO dated 11/19/25, indicated to flush the GT with 60 ml of free water before and after each bolus feeding. A PO dated 11/19/25, indicated to flush GT with 200 ml free water two times a day for hydration. A review of the November 2025 electronic Medication Administration Record (eMAR) for the order entry related to flushing the GT with 60 ml of water before and after each bolus feeding revealed, the nurses signed and documented 200 ml as the total amount administered for the 4 of 4 entries from 11/19/25 to 11/20/25. The documented ml amount did not total the amount to be administered as per the PO. On 11/20/25 at 1:32 PM, the surveyor interviewed the Registered Nurse (RN) who was assigned to care for the resident. The RN stated the nurses followed the PO regarding enteral feeding and water flushes. The RN with the surveyor reviewed Resident #81's enteral feeding and water flush orders. The RN stated for the order entry of administering 60 ml before and after the bolus feeding, the total amount of water flushed would be 120 ml. The RN reviewed the entries which indicated total amounts of 200 ml for the 4 of 4 entries. The RN acknowledged the entry amounts were not correct and that the PO should be followed. On 11/20/25 at 1:52 PM, the surveyor interviewed the Director of Nursing (DON) who stated the nurses were to follow PO and clarify them with the physician as needed. The DON further explained the enteral feedings and water flushes were determined by the PO. The surveyor reviewed Resident #81's eMAR. The DON acknowledged the total documented as administered did not reflect the PO and it should be 120 ml documented as administered. The DON stated she would follow up. The surveyor requested the TF policy. On 11/24/25 at 1:31 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the DON of the above concerns regarding the nurses total documented as administered not reflecting the PO. The DON stated the nurses did not tally the total correctly and in-service education was provided to the nurses. A review of the facility's Care and Treatment of Feeding Tubes Policy, with a reviewed date of October 2025, under policy revealed: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. NJAC 8:39-25.2(c)2; 27.1 (a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to store food in a consistent manner to prevent foodborne illness for 2 of 10 refrigerators and freezers reviewed. This deficient practice was evidenced by the following: On 11/20/25 at 1:47 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1), who stated the refrigerator (ref) to store resident food items for the entire floor was on the central nurses' station. The ref had signage which indicated food items should be labeled, dated, and kept in the ref for no more than three days. The surveyor with LPN #1 checked the nutrition ref and observed the following:1. A ricotta cheese manufacturer container which had a written date of 11/2/25 and a room number. The manufacturer expiration date of the container was in January 2026. There was no resident name on the item. LPN #1 acknowledged the item was dated being in ref more than three days and should be removed. 2. A white bag contained a food item in a plastic container. The bag had a written date of 11/12/25, and no resident name. LPN #1 acknowledged the item was dated being in ref more than three days and should be removed. On 11/20/25 at 1:52 PM, the surveyor interviewed the Director of Nursing (DON), who stated nursing was responsible for the labeling of resident food items brought in and stored in the ref. The DON stated items were allowed to be stored for 72 hours and after that would be discarded. The surveyor notified the DON of the above observed concerns. The DON stated items longer than three days should not be in ref and should be discarded, even if food items were not expired. On 11/24/25 at 11:03 AM, the surveyor conducted a follow up on the nutrition ref at the nurses' station. The signage was posted which indicated resident outside food items would not be stored in the ref. Registered Nurse #1(RN #1) explained that the ref would only store house stock items from the kitchen and that there was another ref for resident food items on the north unit. The surveyor with RN #1 checked the nutrition ref at the central nurses' station which revealed the following:The freezer compartment which was empty had frost build up on the bottom and sides of the freezer. The frost on the left side of the freezer bottom was soiled with a pink to red colored substance. The left, back wall of the freezer was splattered with the same-colored substance. On 11/24/25 at 11:08 AM, the surveyor interviewed a Housekeeper who stated housekeeping was responsible for cleaning refrigerators (refs) on the unit. The housekeeper further explained the refs were checked daily by housekeeping to ensure they were clean. On 11/24/25 at 11:10 AM, the surveyor with LPN #2, who was assigned to work on the north unit, checked the nutrition ref at the nurses' station which revealed the following: - A food container with a written date of 11/18/25 and room number with no resident name. LPN #2 acknowledged the food item should not be in the ref as it was more than three days. -A ricotta cheese container with a written date of 11/2/25 and room number with no resident name. The container was the same item observed on 11/20/25 in the central nurses' station ref. -A [brand name] broccoli-cheddar soup container had a written resident name, [Resident #50], room number and no written date. The manufacturer's use by date was 11/17/25 on the container. LPN #2 verified there was no written date, and the use by date had passed. LPN #2 acknowledged the item should have been discarded. - A [brand name] ice cream container had a written resident name and room number, and there was no written date. -The freezer section of ref had frost build up. LPN #2 acknowledged identified items should not be in the ref for more than three days from their written date. LPN #2 was not sure who was responsible for defrosting and checking the ref and could ask to find out. On 11/24/25 at 11:19 AM, the DON accompanied the surveyor to observe the above concerns with the ref. The DON acknowledged the items should not be in there and the ref should be de-frosted. The DON stated that the ref in the north unit had always been used as a nutrition ref. She further explained that last week they designated it as the residents outside food ref for the entire floor and the central nurses' station ref was designated as the house stock item ref. On 11/24/25 at 1:31 PM, the surveyor notified the Licensed (continued on next page)

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	315037	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Family of Caring at Teaneck LLC	1104 Teaneck Road Teaneck, NJ 07666

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Home Administrator (LNHA) and the DON about the above concerns. The DON acknowledged the refs should have been checked and the identified items should have been removed from the ref. The DON stated if the resident had manufactured food items that were good for a prolonged period, the labeled date should be updated after the three days to indicate the item in the ref was checked. On 11/24/25 at 1:31 PM, the surveyor met with the DON and the LNHA. The DON and the LNHA acknowledged the food items should have been removed from the refs. The DON stated staff were in-serviced and the refs would be checked daily. A review of the facility's Food Brought in for Patients and Residents Policy with an effective date of 1/5/2025, under procedure revealed:.1.2 Food items that require refrigeration must be labeled with the patient/resident's name and the date the food was brought in.1.5 Food will be held in the ref for three days following the date on the label and will be discarded by staff upon notification to patient/resident. NJAC 8:39-17.2(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for 5 of 8 staff (1 Certified Nursing Aide, 3 Licensed Practical Nurses, and 1 non-licensed staff) and follow appropriate infection control practices to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 revealed.Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications:Immediately before touching a patient .Before moving from work on a soiled body site to a clean body site on the same patient .After touching a patient or the patient's immediate environmentAfter contact with blood, body fluids, or contaminated surfacesImmediately after glove removal. According to the CDC information on how to safely remove PPE: There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials.Remove all PPE before exiting the patient room.discard to appropriate receptacle. 1.On 11/19/25 at 10:19 AM, the surveyor observed Resident #8's room with a posted sign for Enhanced Barrier Precautions (EBP) and a PPE box outside the door. The posted EBP sign included an instructions that everyone must clean their hands, including before entering and when leaving the room. The surveyor observed the Administrator in Training (AIT) entered the resident's room without performing hand hygiene and responded to resident's call light. The AIT also touched the resident's curtain, took the yogurt from the resident's breakfast tray and stirred it, and left the room without performing hand hygiene. Afterward, Licensed Practical Nurse #1 (LPN #1) entered the resident's room without performing hand hygiene, responded to the call light, drawn the curtain, talked to the resident, and left the room with resident's tray without performing hand hygiene. On 11/19/25 at 10:27 AM, during an interview of the surveyor with LPN #1, she confirmed that she was inside resident's room to attend to resident's call bell and because the resident had concern with their throat. The surveyor asked what the posted signs outside the resident's room were, and LPN #1 confirmed that the resident was on EBP due to use of urinary catheter. On 11/19/25 at 10:43 AM, LPN #1 informed the surveyor that the posted sign for EBP should be followed including the hand hygiene before entering and before leaving the resident's room. LPN #1 confirmed that she went inside the resident's room to respond to the resident's call bell, had picked up the resident's breakfast tray, and touched the curtain. She further stated that she was rushing and forgot to perform hand hygiene. 2. On 11/20/25 at 10:48 AM, the surveyor observed the Certified Nursing Aide (CNA) in the hallway with double surgical mask in use. On 11/20/25 at 10:53 AM, the surveyor observed the CNA went inside a resident's room with double surgical mask and confirmed to the surveyor that she should not use double mask. On 11/20/25 at 10:55 AM, the surveyor notified Regional Director of Nursing #1 (RDON #1) who was covering as an Infection Preventionist (IP) of the facility of the above concern with the CNA. RDON #1 immediately followed the CNA and afterward informed the surveyor that the CNA was still using the double mask. She also stated that she would educate the CNA later after care of the resident on proper use of PPE. RDON #1 stated that the CNA should not use double mask. 3. On 11/24/25 at 6:24 AM, the surveyor observed upon exiting the elevator, on the second floor, the Licensed Practical Nurse Supervisor (LPNS) in the hallway with gloves in used while pushing a cart. The top cart shelf with respiratory supplies, the second shelf of the cart with meal trays, and the LPNS removed her gloves upon seeing the surveyor. The LPNS then went to the center nursing station and provided the surveyor with assignments for 11-7 shift. The LPNS did not perform hand hygiene after removal of gloves. 4. On 11/24/25 at 6:37 AM, the surveyor observed Licensed Practical Nurse #2 (LPN #2) from South unit nursing station in the computer and agreed to accompany the surveyor for incontinence round. The surveyor observed LPN #2 entered a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's room without performing hand hygiene, donned (put on) gloves, checked Resident #59's incontinence brief, LPN #2 doffed off (removed) used gloves, and exited the room without performing hand hygiene. LPN #2 walked away from Resident #59's room, walked in the hallway, and the surveyor asked LPN #2 about hand hygiene. LPN #2 stated that she did not want to wash her hands in the resident's room, she would do it in the nursing station. On 11/24/25 at 7:39 AM, the surveyor interviewed RDON #1 (covering IP), who informed the surveyor that the EBP process of facility was applicable for those residents with tube feeding, wounds, tubes including catheters, we put purple dot and EBP posted signs. The IP stated that if staff not providing the direct care listed below of the posted sign (dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing), staff not required to perform hand hygiene before and after going to resident's room. She also stated that their (staff) training if they touched the resident, dirty areas like the overbed table that was not clean and went to another resident, staff should wash their hands. On that same date and time, the surveyor notified RDON #1 of the above findings and concerns with staff hand hygiene and PPE use. RDON #1 confirmed that the AIT also known as the facility's Assistant Administrator. The surveyor also asked RDON #1 if staff allowed to use gloves in the hallway, and she responded no. RDON #1 confirmed that, it was the best practice to perform hand hygiene before leaving the room because sometimes you would be called to another room or assisting another resident. On 11/24/25 at 1:30 PM, the survey team met with the LNHA and DON, and the surveyor notified them of the above findings and concerns with hand hygiene and PPE use. On 11/25/25 at 11:41 AM, the survey team met with the LNHA and DON, and the DON stated that we in service everyone for hand hygiene and mask. The LNHA stated that it was the oxygen tubing being changed and distributed by the LPNS that were on top of the cart. A review of the facility's Handwashing/Hand Hygiene Policy that was provided by the LNHA, with a revised date of April 2010, revealed, this facility considers hand hygiene the primary means to prevent the spread of infections.Policy Interpretation and Implementation:.5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: c. Before and after direct resident contact;.f. Before and after eating or handling food;g. Before and after assisting a resident with meals;.u. After removing gloves or aprons;.7. Hand hygiene is always the final step after removing and disposing of PPE.8. The use of gloves does not replace handwashing/hand hygiene. On 11/25/25 at 12:59 PM, the survey team met with the LNHA, DON, RDON #1, RDON #2, and Chief Operations Officer for an exit conference and there was no additional information provided by the LNHA. NJAC 8:39-19.4(a)(1)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a clean, safe, and sanitary environment for: a.) 1 of 2 shower rooms and b.) 1 of 2 eyewash stations. This deficient practice was evidenced by the following: Onn 11/20/25 at 10:40 AM, the surveyor asked the Licensed Practical Nurse/Wound Nurse (LPN/WN) where the shower rooms of the residents were, and he accompanied the surveyor to the south shower room. Both the surveyor and the LPN/WN observed a plastic cover in the south shower room. He stated that he just came back from vacation, and the room was on renovation. The LPN/WN then asked the Director of Nursing (DON), who informed the surveyor that the south shower room was on renovation, and the north unit shower room was being used by the residents. On that same date and time, the LPN/WN accompanied the surveyor to the north shower room, and both observed the ceiling lights not working, with one fluorescent light dimmed. The surveyor observed also two shower cubicles with no privacy curtains. The 1st shower cubicle, near the door, soap dispenser was empty. The 2nd shower cubicle had a broken soap dispenser, two sharp metal edges on the wall, shelf on the floor, and some metal parts on the floor. The shower room floor was dirty, with accumulation of whitish substances. The LPN/WN stated that he did not know why there were on the floor, and it should not be on the floor. He further stated that the metal parts were probably was part of the shower head. The LPN/WN stated that he would notify the Maintenance Staff (MS). On 11/20/25 at 10:45 AM, the LPN/WN called and notified the MS, and the MS went inside the north shower room. The MS informed the surveyor that the white wood and metal parts were from the wall shelf in the second shower cubicle, and should have been disposed. The surveyor then asked the MS about the lights on the ceiling, and he said that it was not busted, the other light was just dimmed. The MS further stated that it should have been replaced. On 11/20/25 at 11:05 AM, the surveyor and the DON went inside the north shower room. The DON stated that should not left like that. The DON acknowledged safety concerns with the metal part on the wall. 2.On 11/20/25 at 10:59 AM, the surveyor asked Regional DON #1 (RDON #1) about the facility's eyewash station, and she showed the south nursing unit. Both the surveyor and RDON #1 observed accumulation of whitish substances on top of the eyewash container and the board where the eyewash solution was placed on the wall, RDON #1 confirmed it was an accumulation of dust, and should have been cleaned. On 11/24/25 at 1:30 PM, the survey team met with the Licensed Nursing Home Administration (LNHA) and DON, and the surveyor notified them of the above findings and concerns. On 11/25/25 at 11:41 AM, the survey team met with the LNHA and DON, and the LNHA stated that the eyewash station was cleaned, the north shower station lights were replaced, the shower room was cleaned with bleach, and the metal pieces holding the shelf were removed. The surveyor also notified the LNHA and DON of the privacy curtain concerns with two shower cubicles. A review of the facility's Quality of Life-Homelike Environment Policy that was provided by the LNHA, with a revised date of 10/2025, revealed, residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible.Policy Interpretation and Implementation:.2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:a. Cleanliness and order;.4. Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment. On 11/25/25 at 12:59 PM, the survey team met with the LNHA, DON, RDON #1, RDON #2, and Chief Operations Officer for an exit conference and there was no additional information provided by the LNHA. NJAC 8:39-31.4 (a)(f)