STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Park Renaissance	521 Pine Brook Road Lincoln Park, NJ 07035

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 2 of 38 residents reviewed for accommodation of needs (Resident #59 and #127), and was evidenced by the following: On 10/1/24 at 11:34 AM, the surveyor observed Resident #59 in bed on a specialty mattress, with his/her eyes open. Resident #59 did not respond to the surveyor's greeting. The surveyor observed the resident's call bell (a bell used to summon staff for assistance) was intertwined with their roommates call bell cord and entangled in the bed electrical cords, not within his/her reach. The surveyor reviewed the medical record for Resident #59. A review of Resident #59's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to hemiplegia (mild or partial weakness or loss of strength on one side of the body) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body, dysphagia and gastrostomy status (surgical procedure creating an opening into the stomach through the abdominal wall to provide nutrition). A review of Resident #59's Annual Minimum Data Set (MDS) an assessment tool dated 7/25/24 revealed Resident #59 had a long- and short-term memory problem and had a severe cognitive impairment. The MDS further revealed that the resident was dependent on staff for personal hygiene, and he/she was always incontinent of bowel and bladder. A review of Resident 59's individualized comprehensive care plan (ICCP) initiated on 2/5/20, with a revision date of 9/12/24 included the resident had a communication problem r/t history of intercranial hemorrhage with aphasia, she is non-verbal. The interventions included but were not limited to; ensure/provide a safe environment: keep call light in reach. On 10/1/24 at 11:34 AM, the surveyor observed Resident #127 in bed. The resident did not respond to the surveyor's greeting. The surveyor observed the resident's call bell was intertwined with their roommates call bell and twisted together in the bed electrical cords not within his/her reach. A review of Resident #127's Admission Record reflected that the resident was admitted to the facility with diagnoses which included dementia, insomnia and dysphagia. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent quarter MDS dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 3 out of 15, which indicated a severe cognitive impairment. A further review indicated they required supervision and contact guard from staff for transfers and toileting. A review of the ICCP initiated 6/26/23 revised 7/12/24 reflected, resident has potential for activities of daily living (ADL) self-care performance deficit r/t cognitive deficits secondary to dementia with interventions that included but not limited to: encourage resident to use bell to call for assistance. On 10/4/24 at 8:00 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who had Resident #59 and Resident #127 on their assignment on 10/1/24. The CNA acknowledged that the call bells should be kept within the resident's reach at all times and could not speak to why she did not ensure that the resident's call bells were within their reach. On 10/7/24 at 10:35 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Regional Director of Nursing (RDON) and DON acknowledged that all residents should have their call bells within reach. A review of the facility's Call Light Use policy revised 1/5/24 included .the purpose is to respond promptly to resident's call for assistance .when providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light .be sure call lights are placed on the bed as all times never on the floor or bed side. A review of the facility's Certified Nursing Assistant job description included .answers all call bells and places them in reach of the resident . NJAC 8:39- 31.8 (c)(9)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on interview and record review, it was determined that the facility failed to start, complete and transmit the Minimum Data Set (MDS) for a Death in facility and a Discharge Return not Anticipated in accordance with federal guidelines. This deficient practice was identified for two (2) of 38 residents reviewed for Resident Assessment (Resident #144, and 54) and was evidenced by the following: 1. The surveyor reviewed the closed medical record for Resident #144. A review of the resident's Admission Record (an admission summary) reflected that Resident #144 was admitted to the facility with diagnoses that included but was not limited to heart failure. On [DATE] at 10:14 AM, the surveyor reviewed the electronic Medical Record, Minimum Data Set (MDS) tab that reflected a Death in the facility tracking discharge was not completed and was 102 days overdue. On [DATE] at 10:28 AM, during an interview with the surveyor, the MDS-Director stated that the facility had 14 days to submit the death in the facility tracking. At that time the MDS- Director confirmed Resident #144 expired on [DATE] and the Death in the facility was not started, and was over 102 days overdue. A review of the facility provided policy Resident Assessment Instrument (RAI), dated [DATE], reflected that the Assessment Coordinator was responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: within 14 days of the resident's admission; when there is a significant change; at least quarterly, and once every 12 months. 19106 2. Resident #54 was discharged from the facility to home on [DATE] as noted in a [DATE] electronic Nurses Note and the electronic Census. The resident was not expected to return to the facility. A review of the completed MDS assessments revealed the following submissions: A [DATE] Entry and a [DATE] Admission/Medicare 5 Day assessment. The surveyor interviewed the RN Assessment Coordinator on [DATE] at 11:50 AM. She stated the MDS Discharge/Return Not Anticipated assessment should be done within 14 days of the discharge date . She stated the assessment was not done and was late. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:44 AM, during a meeting with the survey team, the Licensed Nursing Home Administrator, and the Regional Nurse, and the DON, the surveyor discussed the concern Regarding the Death in the facility tracking discharge for Resident #144 that was not started and was 102 days overdue. A review of facility policies regarding resident MDS assessments failed to address discharge assessment, however the RN Assessment Coordinator stated the facility follows the Resident Assessment Instrument (RAI) 3.0. NJAC 8:39 - 11.1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19106 Based on observation, interview, and record review it was determined that the facility failed to accurately assess: a) a resident's oral health; b) a resident's use of a hand splint; c) a resident's use of an indwelling urinary catheter; and d) a resident's skin condition in the Minimum Data Set (MDS) assessment tool. The deficient practice was identified for 4 of 38 residents reviewed for MDS accuracy (Resident #88, 77, 129, 25) and evidenced by the following. 1. The surveyor interviewed Resident #88 on 10/2/24 at 9:53 AM. The resident was observed with multiple broken and missing teeth. The surveyor interviewed the Registered Dietician (RD) on 10/4/24 at 8:46 AM regarding the resident's oral health. The RD referred the surveyor to the Speech Language Pathologist's (SLP) admission evaluation. The surveyor reviewed the 9/12/24 Speech Therapy SLP Evaluation and Plan of Treatment. In the document, the SLP noted pt with poor natural dentition, many missing/broken teeth. The 9/17/24 Admission MDS assessment, Section L - Oral/Dental Status failed to identify broken or missing teeth. The surveyor interviewed the RN Assessment Coordinator on 10/4/24 at 12:00 PM. She stated the broken or missing teeth should have been triggered in the Admission MDS. 2. The surveyor observed Resident #77 on 10/1/24 at 11:19 AM. The resident had a blue hand splint on the over bed table. A review of the electronic medical record revealed a 1/10/24 physician's order for a right-hand roll with a wrist support (an orthopedic device used for muscle contractures). The 8/9/24 Annual MDS assessment, Section O - Special Treatments, Procedure, and Programs failed to address the daily placement of a splint or brace. The surveyor interviewed the RN Assessment Coordinator on 10/04/24 at 12:00 PM. She stated the splint should have been identified in Section O. 3. Resident #129 was admitted to the facility with an indwelling urinary catheter for chronic urinary bladder outlet obstruction as noted by the nurse in the 7/2/24 electronic Admission Summary Note. The 7/8/24 Admission MDS assessment Section H failed to identify that the resident used an indwelling urinary catheter. The surveyor interviewed the RN Assessment Coordinator on 10/4/24 at 12:00 PM. She stated the catheter should have been coded in the Admission MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Certifying Accuracy of the Resident Assessment, revised 12/2009, contained the following Policy Statement: All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. 45449 4. On 10/1/24 at 11:45 AM, during the initial tour, Resident #25 was not in their room. A staff member identified Resident #25 in the dayroom asleep, not roused by the surveyor's voice, seated on a geri chair (geriatric chair or medical recliner; a large, padded chair with wheels, designed to assist seniors with limited mobility) with legs elevated and heels off-loaded (practice of reducing or removing pressure on a part of the body to help with healing or prevent wounds). The surveyor reviewed the medical record for Resident #25 According to the electronic Medical Record, Resident #25 had diagnoses which included, but were not limited to, unstageable pressure ulcer of unspecified site. Review of the quarterly Minimum Data Set, an assessment tool dated 6/28/24, reflected a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated a severely impaired cognition. Further review of the qMDS revealed Resident #25 had an unstageable deep tissue injury (DTI) that was not present upon admission. Review of the Admission MDS dated [DATE], under section M. Skin Conditions revealed the resident had 1 unstageable DTI that was present upon admission. Review of the Wound Physician's Note dated 8/16/22, reflected Resident #25 had an unstageable DTI of the right heal. On 10/4/24 at 12:37 PM, the surveyor interviewed the Registered Nurse /MDS Director (RN/MDS-D) who stated she signed the submissions for the MDS and that the signature was an attestation that she had checked all the areas for accuracy to the best of her knowledge. At that time, the surveyor and the RN/MDS-D reviewed Resident #25's medical record. The RN/MDS-D confirmed that the MDS submitted was inaccurate and that the accuracy of the MDS was important because the assessment can affect the care given to the resident. On 10/4/24 at 1:26 PM, during a meeting with the survey team, the Director of Nursing (DON), Licensed Practical Nurse/Infection Preventionist (LPN/IP) and the Regional Nurse, the surveyor discussed the concern regarding the inaccuracy of the MDS for Resident #25. On 10/7/24 at 10:44 AM, during a meeting with the survey team, the License Nursing Home Administrator, and the DON, the Regional Nurse, stated the MDS coding should be accurate. A review of the facility provided policy, Certifying Accuracy of the Resident Assessment, dated /revised on 1/5/24 included: All personnel who complete any portion of the MDS assessment, tracking form or correction request form must sign a hard copy of such assessment certifying the accuracy of that portion of that assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-11.2(e)1

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 51226 Based on observation, interview, record review, and review of other facility's documentation, it was determined that the facility failed to ensure a.) the Professional Standards of Practice to assess a resident's pain at least each shift for significant changes in levels of chronic pain, b.) a physician order for administration with parameters was followed (Resident #131) and c.) a narcotic medication for pain was administered when documented as administered (Resident #367). The deficient practice was identified for one (1) of one (1), Resident #14, reviewed for pain management, one (1) of (4) four residents administered by one (1) of four (4) nurses observed during the medication administration, and for one (1) of (5) medication carts observed during the medication storage and labeling inspection. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. The evidence was as follows: 1.) On 10/01/24 at 11:20 AM, the surveyor observed Resident#14 lying in bed, alert, awake and oriented able to make needs known. The resident did not appear to be in distress. The resident complained of chronic aching pain on the right hip upon movement. On 10/03/24 at 10:00 AM, the surveyor reviewed the following records: Review of Admission Records revealed the following Diagnosis which include but not limited to Encounter for Palliative Care, Alcoholic Cirrhosis of Liver, Chronic Pain Syndrome and Pain , unspecified. Review of Quarterly Pain Interview Assessment record dated 8/29/2024 revealed severe frequent pain. A review of Pain Level Summary revealed that there were only pain assessments done on the following month of August: 8/26/2024, month of May: 5/23/2024, and month of February: 2/26/2024. Review of Care plan for chronic pan, initiated on 12/23/19, and revised on 11/23/2020, revealed that Resident # 14 had chronic pain related to non-healing right hip surgical wound, impaired mobility and diabetic neuropathy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Medication Order for Resident # 14 revealed the following pain management regimen which included but was not limited to Acetaminophen (a non-steroidal anti-inflammatory drug used for pain management) Tablet 325 milligram (mg) give 2 tablets by mouth every 6 hours as needed for pain. Celebrex (a non-steroidal anti-inflammatory drug used for pain management) Oral Capsule 100 mg give 1 capsule by mouth in the morning for chronic pain. Gabapentin (a medication used for nerve pain) Oral Tablet 600 mg, give 1 tablet by mouth three times a day for neuropathy and chronic pain. Morphine Sulfate ER (a non-synthetic narcotic medication used for pain; Extended Release) Oral Tablet 30 mg, give 1 tablet by mouth three times a day for chronic pain. On 10/02/24 at 10:30 AM, the surveyor interviewed the Unit Manager (UM) Licensed Practical Nurse (LPN) working full time in the facility about pain management for Resident #14. She described the Resident # 14 is on palliative care due to poor prognosis. She further explained that the floor nurses were the ones doing pain assessment and were responsible for monitoring the effectiveness of the pain regimen. When the surveyor requested documentation related to pain, the UM/LPN showed the surveyor a list of pain levels which were not consistent and did not show pain assessments done every shift. On 10/7/24 at 11:05 AM, the surveyor discussed the concern with the Director of Nursing (DON), who acknowledged that the pain assessments were not done every shift. The surveyor reviewed the Pain Assessment and Management Protocol policy, revised on 6/24/2024, which revealed to assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain. 45449 2.) On 10/3/24 at 8:23 AM, the surveyor observed the Registered Nurse (RN) prepare medications for Resident #131 that included a physician order for Losartan 25 milligram (mg) tablet, one (1) tablet by mouth in the morning for hypertension. Hold for systolic blood pressure (SBP) less than 110. On 10/3/24 at 8:36 AM, the surveyor observed the Certified Nursing Assistant (CNA) and the RN use an alcohol-based hand rub (ABHR), then put on their personal protective equipment prior to entering the resident's room. The RN informed, the surveyor that they will adjust the resident to a seated position prior to the administration of the medications. The surveyor observed the RN enter the resident's room with the resident's medication in a medication cup. The resident was adjusted to a seated position, the RN was about to administer the medications, and the surveyor requested to speak with the RN outside the room. At 8:37 AM, during an interview with the surveyor, the RN stated she took Resident #131's blood pressure reading at 8:00 AM and confirmed she did not take the SBP prior to entering the resident's room for medication administration. At that time, the RN stated that the parameters should have been taken immediately prior to the medication administration of the high blood pressure medicaiton, Losartan. 3.) On 10/4/24 at 11:04 AM, the surveyor and RN #2 began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart (narcotic box) located in 2A. RN #2 stated her cart was called 2A split. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, in the presence of RN #2, the surveyor observed Resident #367's bingo card (blister packet which contains the medication) with a pharmacy label for Methadone 5 mg (narcotic medication; a controlled-dangerous substance medications, that due to their high potential for abuse, are tracked with a degree of detail and attention). The bingo card contained two (2) tablets. At that time, in the presence of RN#2 the surveyor compared the bingo cared against Resident #367's Individual Patient's Controlled Drug Record (IPCDR; declining inventory sheet used to track removal of a controlled drug from inventory) for Methadone 5 mg. The IPCDR log reflected a documented quantity of one (1). At that time, during an interview with the surveyor, RN #2 stated that she did not administer the medication but had signed the IPCDR. The surveyor and the RN reviewed Resident #367's electronic Medication Administration Record (eMAR) which revealed the RN's initials attesting the resident had consumed the medication. On 10/4/24 at 11:15 AM, the surveyor and the RN entered Resident #367's room. The resident informed, the surveyor that she had pain every day and stated that she took her methadone that morning and was feeling a little better. The RN informed the resident that she made an error and had not administered the Methadone and informed the resident that she would be administering it at that time. The surveyor and the RN exited the resident's room. On 10/4/24 at 11:20 AM, during a follow-up interview with the surveyor the RN stated that she would call the physician and inform her supervisor. The surveyor reviewed the medical record for Resident #367. According to the Admission Record, Resident #367 was admitted to the facility with diagnosis that included but was not limited to pulmonary hypertension (a chronic condition that occurs when blood pressure in the lungs is higher than normal). Review of the incomplete Admission Minimum Data Set (MDS), an assessment tool with an Assessment Record Date of 9/25/23, reflected a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident was cognitively impaired. The pain asssessment section of the MDS was incomplete. Review of the eMAR for Resident #367 included a physician order for Methadone 5mg, give 1 tablet by mouth every 12 hours for pain management. The administration was scheduled at 9:00 AM and 21:00 [9:00 PM]. On 10/8/24 at 1:45 PM, during an interview with the surveyor, the MDS-Director stated that the MDS for Resident #367 was incomplete, the section for pain assessment was incomplete and the comprehensive person-centered care plan for pain was also incomplete. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/4/24 at 1:26 PM, in the presence of the survey team, the Licensed Practical Nurse/ Infection Preventionist (LPN/IP), the DON, and the Regional Nurse, the surveyor discussed the concern regarding RN #1 who failed to obtain a parameter for Resident #131 prior to administration of the high blood pressure medication, in accordance with the physician's order and professional standards of practice. At that time, the surveyor also discussed the concern regarding Resident #367's routine Methadone physician's order that was documented as administered, but was not and was documented removed from the IPCDR, but was not. On 10/7/24 at 10:44 AM, during a meeting with the survey team, the Licensed Nursing Home Administrator, and the Regional Nurse, the DON stated that education was given to the nurses for medication administration, parameters, and an investigation was conducted for the missed administration of the Methadone. The resident was assessed, and the physician was notified. A review of the provided facility policy, Medication Pass dated/revised 6/24/24, included the following: -Medication Preparation; Hold parameters: Check blood pressure and/or pulse rate immediately prior to pouring. -Signing for Medications; Sign the MAR/eMAR immediately after the administration of the medication to each resident. NJAC 8:39-27.1(a), 29.2(d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 3 of 10 residents (Resident #59, #82 and #29), observed for incontinence care on 1 of 2 units (B1 Unit). This deficient practice was evidenced by the following: On 10/1/24 at 11:34 AM, the surveyor observed Resident #59 in bed on a specialty mattress, with his/her eyes open. Resident #59 did not respond to the surveyor's greeting. The surveyor observed a strong unpleasant odor in the resident's room. On 10/1/24 at 11:40 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who had been assigned to Resident #59's care for the 7AM-3:00 PM shift. During the interview, the CNA stated that she had 10 residents on her assignment and that this was the first opportunity she had to provide care to Resident #59. The surveyor asked the CNA how often she provided incontinence care to the residents on her assignment. The CNA replied she would usually provide incontinence care 3 x daily, but today it would be only twice since it was already so late. On 10/1/24 at 11:45 AM, the CNA exposed Resident #59's incontinence brief. The surveyor and CNA observed that the Resident's incontinence brief had a bladder absorbency pad inserted within the adult brief. The adult brief, pad and pad under the resident were all saturated with urine. A review of Resident #59's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to hemiplegia (mild or partial weakness or loss of strength on one side of the body) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body, dysphagia and gastrostomy status (surgical procedure creating an opening into the stomach through the abdominal wall to provide nutrition). A review of Resident #59's Annual Minimum Data Set (MDS) an assessment tool dated 7/25/24 revealed Resident #59 had a long- and short-term memory problem and had a severe cognitive impairment. The MDS further revealed that the resident was dependent on staff for personal hygiene, and he/she was always incontinent of bowel and bladder. A review of Resident 59's Individualized Care Plan (ICP) initiated on 2/5/20, with a revision date of 9/12/24 included the resident was totally dependent on staff with activities of daily living (ADLs) with Interventions which included but were not limited to: providing incontinence care every 2 hours and as needed. On 10/4/24 at 7:20 AM, the surveyor completed an incontinence tour on the B1 Unit and observed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/24 at 7:26 AM, the surveyor accompanied by the CNA observed Resident #82 in bed. The surveyor and CNA noted a strong urine odor in the resident's room. The surveyor observed that Resident #82's incontinence brief was saturated with urine and feces. The pad under the resident was also saturated with urine. The CNA acknowledged the brief and under pad were saturated with urine and feces and stated that the resident could not have received incontinence care recently due to the extent of the saturation. A review of Resident #82's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to bipolar disorder, dementia, and dysphagia. A review of Resident #82's Quarterly MDS dated [DATE] revealed Resident #82 had a had a long and short-term memory problem and had a severe cognitive impairment. The MDS further revealed that the resident required staff assistance for personal hygiene, and he/she was always incontinent of bowel and bladder. A review of Resident 82's ICP initiated on 12/5/22, with a revision date of 8/12/24, revealed the resident had an ADL self-care performance deficit with interventions which included but were not limited to the resident required extensive assistance of 1 staff for personal hygiene; and to keep skin clean and dry. On 10/4/24 at 7:38 AM, the surveyor accompanied by the CNA observed Resident #29 in bed with a strong unpleasant odor in the resident's room. The CNA exposed Resident #29's incontinence brief which was saturated with urine and feces. At that time when the CNA exposed the incontinence brief the surveyor observed that the Resident's gown and bed pad were also saturated. The CNA stated that the resident could not have received incontinence care at 5:00 AM, due to the saturated brief, gown and pad. On 10/4/24 at 7:40 AM, the unit manager accompanied the surveyor to Resident #29's room. The unit manager acknowledged that the resident was saturated with urine and feces and stated that it was unacceptable. A review of Resident #29's Admission Record revealed Resident #29 was admitted to the facility with diagnoses which included but were not limited to Alzheimer's disease, acute kidney failure, psychosis and major depressive disorder. A review of Resident #29's Annual MDS dated [DATE] revealed Resident #29 had a Brief Interview for Mental Status (BIMS) of 3 of 15 indicating a severe cognitive impairment. MDS further assessed Resident #29 was dependent on staff for personal hygiene and was always incontinent of bowel and bladder. A review of Resident #29's ICP initiated on 12/24/19 with a revision date of 9/19/24 revealed that the resident had an ADL self-performance deficit and required extensive assistance of staff for personal hygiene. On 10/4/24 at 12:35 PM, the survey team met with the administration to discuss the above observations and concerns. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 6:50 AM, the surveyor attempted an interview with the assigned 11 PM-7 AM CNA for Resident's #82 and #29. The Registered Nurse (RN) stated that the 11-7 CNA had called out. The surveyor attempted a phone interview and left a message, with no return call. The surveyor asked the Director of Nursing (DON) to contact the CNA. On 10/7/24 at 7:00 AM, the surveyor interviewed the RN who stated that the CNAs should perform incontinence rounds and provide incontinence care 3 times per shift at 11:30 PM, 2:30 AM and again between 4:30-5:00 AM. The RN/UM stated that on 10/4/24 one of the CNAs left their shift early around 6:00 AM and there was only 1 CNA on the floor from 6:00 AM-7:00 AM. On 10/7/24 at 10:35 AM, in the presence of the survey team, the DON stated that despite the number of residents the CNAs have on their assignments, incontinence care should be provided to the residents 3 times on the night shift and every 2 hours on the day shift. On 10/7/24 at 11:30 AM, the DON stated that the 11-7 CNA did not return her call and therefore was not available for an interview. A review of the facility's Urinary and Fecal Incontinence Care policy dated as revised 6/24/24 reflected . residents must be cleaned after each episode of incontinence. NJAC 8:39-27.1 (a), 27.2 (h)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Complaint NJ 177694, NJ 176286 Based on interviews and record review and review of pertinent facility documentation, the facility failed to ensure an abnormal urine lab result was communicated to the physician, received treatment and care, in a timely manner, and in accordance with professional standards of practice that meet the resident's physical, mental and psychosocial needs. This deficient practice was identified for one (1) of two (2) residents reviewed for abuse and neglect, (Resident #319) and was evidenced by the following: The surveyor reviewed the closed record for Resident #319. According to the Admission Record, Resident #319 was admitted to the facility with diagnoses which included but were not limited to chronic kidney disease (gradual loss of kidney function), heart failure (a condition when the heart does not pump enough blood to meet the body's needs) and hyperparathyroidism (excessive secretion of parathyroid hormone resulting in abnormally high levels of calcium). Review of the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 8/11/23, reflected the resident's Brief Interview for Mental Status (BIMS) score of three (3) out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident did not exhibit behaviors associated with rejection of care. Resident #319 had occasional urinary and fecal incontinence. Review of Resident #319's person-centered care plan (CP) included a focus that the resident had a potential for impairment to skin related to impaired mobility, incontinence, and poor safety awareness. The interventions included to provide prompt toileting needs for incontinence care, that was initiated on 11/9/22. Further review of the CP for activities of daily living reflected the resident required a Hoyer lift (mechanical lift) with two (2) to three (3) staff member assistance. The CP did not reflect an intervention to monitor for signs and symptoms of urinary tract infection (UTI). Review of the facility provided, Antibiotic Order Listing Report for October 2023, reflected Resident #319 had a physician order on 10/26/23, for a facility acquired cystitis (a type of UTI that causes inflammation of the bladder). Review of the Nurse's progress notes (NPN), dated 11/29/23 at 12:22 PM, included that a urinalysis (UA; a test to detect urinary tract infection, kidney disease or diabetes), with culture and sensitivity (C&S; a test to identify the cause of an infection) was collected from Resident #319. Review of the NPN, dated 11/30/23 at 1:03 AM, reflected Resident #319 received intravenous (IV) hydration (formulated liquid injected into the vein) and that the UA C&S was pending. Review of the NPN note dated 11/30/23 at 2:36 PM included that the UA/C&S was still pending. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the abnormal urine lab report, with a reported date of 11/30/23 at 9:07 PM, included a preliminary report of gram-negative rods, and colony count of over 100,000. Review of the final abnormal urine lab report for Culture and Sensitivity, with a final report date on 12/2/23, included the following: Colony count 100,000+ Gram negative rods Organism identification: Pseudomonas Aeruginosa Review of the Infectious Disease Note, dated 12/6/23 at 4:22 PM, included that the resident was seen for UTI evaluation of reported positive urine culture. The assessment plan included an order for renal ultrasound and an antibiotic, IV Cefepime that was renally dosed. On 10/8/24 at 8:45 AM, during an interview with the surveyor, the Licensed Practical Nurse/Infection Preventionist (LPN/IP) stated that if a resident had frequency in urination, with or without a fever, and an altered mental status, a UA/C&S was ordered by the physician. When the UA result showed colony counts greater than (>) 100,000, and either gram positive (+) or gram negative (-). The physician usually orders an antibiotic when the culture and sensitivity report is available. At that time, the LPN/IP also stated that any abnormal labs were reported to the physician, by any of the nurses or the supervisors. The standard of practice was to document the communication into the electronic medical record (eMR). On 10/8/24 at 9:24 AM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) could not provide evidence that the physicians were made aware of the final abnormal urine lab report for culture and sensitivity result that returned on 12/2/24. The communication was not documented in the eMR. The LPN/UM stated she would look into the matter further, discuss with the supervisors and care team regarding the surveyor's concern. On 10/8/24 at 11:49 PM, during an interview with the surveyor, the NP stated that he did not treat infections until the culture and sensitivity came back. In the case of Resident #319, who had renal failure, the NP stated he had to involve the infectious disease ID/physician or the ID/NP to renally dose the resident. At that time, the NP stated that the expectation was the ID prescriber would see the resident within 2 to 3 days of the requested consult. The NP was asked if it was an acceptable standard of practice for Resident #319 not to be evaluated, and treated until 12/6/23, four (4) days from when the culture and sensitivity was available on 12/2/24. The NP stated that it was not an acceptable standard of practice however he had no control of when the ID prescriber saw the resident. On 10/8/24 at 12:52 PM, during a follow-up interview with the surveyor, the LPN/UM stated that she was on vacation prior to 12/6/23 and was the one who called the ID/NP to see Resident #319 that day. At that time, the LPN/UM stated that the nurses or the supervisors should have followed-up preliminary result and communicated with the NP when the finalized abnormal urine lab culture and sensitivity results was available and documented into the eMR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the provided policy, Facility assessment dated [DATE], reflected: It is the policy of [name redacted] to conduct, document and annually review a facility-wide assessment, which included both resident population and the resources the facility needs to care for the residents. Review of the provided policy, Test Results dated 2/5/24, included that Attending physicians will be notified promptly of the the test results provided to the facility. NJAC 8:39-27.1 (a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 19106 Based on observation, interview, and record review it was determined that the facility failed to consistently follow a physician's order for placement of an orthopedic device for 1 of 3 residents reviewed for positioning and mobility, Resident #77. The deficient practice is evidenced by the following. The surveyor observed the door to Resident #77's room was closed on 10/1/24 at 11:19 AM. The surveyor knocked and entered the room to see the resident had completed receiving morning care from the Certified Nursing Assistant (CNA). The CNA stated she was done with care and left the room. The surveyor observed a blue hand splint placed on the over bed table. The surveyor returned to the resident's room later the same day at 1:03 PM. The splint was observed on the over bed table. The resident was seated in a geri-chair (a reclining lounge-type chair) at the bedside. A review of the electronic medical record revealed the following information. An Admission Record noting the resident was admitted with a diagnosis of a right-hand contracture. A 4/26/24 Physician's Order for the application of a right-hand roll with a wrist support (an orthopedic device used for muscle contracture) to be placed on the resident during AM care and removed during PM care daily. A 10/1/24 Treatment Administration Record (TAR) contained a nurse signature indicating the splint was placed at AM care and removed at PM care on 10/1/24. The surveyor interviewed the nursing Unit Manager on 10/4/24 at 8:36 AM. She stated if the splint was not put on the resident during AM care, the nurse should not have documented that it was in place. The Regional Registered Nurse stated on 10/7/24 at 11:04 that if the nurse documented the placement of the splint, it should have been on. The facility policy titled Orthotic Devices, revised 4/2007, included the Standard as follows: Residents receive appropriate services and interventions in response to physical and functional needs. NJAC 8:39-27.1(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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer oxygen therapy according to the physician's order for 2 of 4 residents, (Resident #29 and #136). This deficient practice was evidenced by the following: 1. On 10/1/24 at 12:46 PM, the surveyor observed Resident #29 in bed. The resident did not respond to the surveyor. The surveyor observed Resident #29 wearing a nasal cannula (NC) with a portable oxygen tank on and the gauge was set at 2 liters per minute (LPM). On 10/4/24 at 7:38 AM, the surveyor observed Resident #29 in bed with the head of the bed positioned at approximately 45 degrees with a tube feeding running via a machine at 65 mililiters (mls) per hour. The resident did not respond to the surveyor. The surveyor observed Resident #29 was wearing a NC with a portable oxygen tank on and the gauge was set at 1 LPM. A review of Resident #29's Admission Record revealed Resident #29 was admitted to the facility with diagnoses which included but were not limited to Alzheimer's disease, acute kidney failure, psychosis and major depressive disorder. A review of Resident #29's Annual Minimum Data Set (MDS), an assessment tool, dated 6/7/24 revealed Resident #29 had a Brief Interview for Mental Status (BIMS) of 3 of 15 indicating a severe cognitive impairment. A review of the resident's comprehensive person-centered care plan initiated on 10/3/24 reflected that Resident #29 had altered respiratory status/difficulty breathing related to hypoxia (low levels of oxygen in body tissues.) The interventions included Oxygen via nasal cannula at 2 LPM continuously. A review of the September 2024 Order Summary Report (OSR) revealed an active physician order (PO) with an order date of 9/30/24 for Oxygen 2 LPM via NC for hypoxemia. On 10/4/24 7:40 AM, the surveyor asked the UM/LPN to accompany her to Resident #29's room. The surveyor and the UM/LPM entered Resident #29's room, and both observed the resident in the bed at approximately 45 degrees with tube feeding running via a machine. The resident was wearing a NC and the oxygen tank was on with the gauge set at 1LPM. The UM/LPN confirmed the oxygen tank was on and the gauge was set at 1LPM. On that same day at the same time, the surveyor and the UM/LPN reviewed the electronic medical record (EMR) for the resident's order for oxygen. The UM/LPN stated that the resident's PO was for 2LPM, not 1LPM and she did not know who changed the oxygen to 1LPM. The UM/LPN acknowledged the order should have been followed. On 10/4/24 at 12:35 PM, the survey team met with the administration to discuss the above observations and concerns. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45449 2. On 10/1/24 at 10:53 AM, the surveyor observed Resident #136 in bed asleep, wearing a nasal cannula with the oxygen (O2) concentrator (a medical device used for delivering oxygen) set at 1.5 liters per minute (LPM) and the head of the bed was elevated. On 10/2/24 at 9:12 AM, the surveyor observed Resident #136 asleep, who did not rouse from the surveyor voice. The resident was wearing a nasal cannula and the O2 concentrator was on and set to 1.5 LPM. The surveyor reviewed the medical record for Resident #136. According to the Admission Record, an admission summary, the resident was admitted to the facility with diagnoses that included but was not limited to palliative care. The significant change Minimum Data Set (SCMDS), an assessment tool used to facilitate the management of care, dated 8/22/24, reflected a Brief Interview for Mental Status (BIMS) score that was blank, and that the resident was rarely/never understood. Further review of the SCMDS reflected the resident required respiratory treatment. A review of the residents comprehensive person-centered care plan reflected Resident #136 had altered respiratory status/difficulty breathing related to hypoxia (a condition when the respiratory system cannot adequately provide oxygen to the body). The interventions included Oxygen via nasal cannula at 2 LPM continuously, initiated on 4/17/24. The goal reflected that the resident would maintain normal breathing [NAME] as evidenced by normal respirations, normal ski color and regular respiratory rate/pattern through the review date. A review of the Treatment Administration Record (TAR) reflected an order for October 2024 included a physician's order for O2 at 2 LPM via nasal every shift. The O2 order start date was on 8/15/24. Further review of the TAR revealed the administration of oxygen was signed on all three shifts on 10/1/24 and on the day shift of 10/2/24. On 10/2/24 at 12:40 PM, during an interview with two surveyors, the Licensed Practical Nurse (LPN) informed the surveyors that he was assigned to Resident #136. The LPN stated that Resident #136 was on hospice and had a hospice aide, but the aid did not provide care involving the resident's oxygen. The LPN also stated that he checked the resident's oxygen that morning and ensured the head of the bed was elevated. On 10/2/24 at 12:42 PM, the surveyor and the LPN entered the Resident #136's room who was asleep and observed the O2 concentrator was on and set at 1.5 LPM. The LPN observing the O2 concentrator was set at 1.5 LPM, the surveyors and the LPN exited the resident's room. On 10/2/24 at 12:44 PM, the surveyor and the LPN reviewed the electronic medical record for Resident #136 which reflected the physician's order for O2 saturation was 2 LPM. At that time, the LPN acknowledged the order should have been followed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 12:47 PM, the surveyor and the Licensed Practical Nurse/Unit Manager (LPN/UM) entered Resident #136's room. Resident #136 was awake, conversant and did not want to eat. The LPN/UM adjusted the setting on the O2 concentrator to 2 LPM while speaking with the resident. The LPN/ UM explained to the resident that she needed to use a pulse oximeter to measure the amount of oxygen in their blood. The resident was agreeable, and pulse oximeter reading was 99, which indicated the O2 saturation was normal. On 10/2/24 at 12:55 PM, the LPN/UM stated the physician's order should have been followed. The LPN/UM informed the surveyor that she would check the functionality of the machine and provide education to the nurses. All nurses on all shifts were responsible to ensure the O2 saturation for Resident #136 was correct. A review of the facility provided policy for Oxygen Administration, dated/revised on 5/13/24, included the following: The purpose of this procedure is to provide guidelines for safe oxygen administration. NJAC 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 19106 Based on observation, interview, and record review it was determined that the facility failed to assess residents' vital signs and dialysis access site for complications upon return from the renal dialysis (RD) center for 2 of 2 residents reviewed for dialysis care, Resident #90 and 134. Evidence of the deficient practice is as follows. 1. The surveyor interviewed Resident #90 on 10/1/24 at 1:09 PM. The resident stated they had RD appointments on Monday, Wednesday, and Friday at 5:30 AM. The resident stated they are not assessed promptly when returning from RD. A review of the electronic medical record revealed the following information. The 8/15/24 quarterly Minimum Data Set (MDS) assessment tool, Section C - Cognitive Patterns, indicated the resident was cognitively intact (Brief Interview for Mental Status score 15 of 15). Section I - Active Diagnoses triggered for renal disease. Section O - Special Treatments, Procedures, and Programs indicated the resident received RD. The physician's 10/2024 Order Summary Report included the following RD-related orders. RD Monday, Wednesday, Friday chair time 5:30 AM. Enhanced Barrier Precautions related to the presence of an arterio-venous fistula (RD access site). Monitor left arm fistula for signs and symptoms of infection and active bleeding. The surveyor interviewed the nurse Unit Manager (UM) on 10/04/24 at 8:02 AM. The UM stated the nurses should be documenting promptly in the electronic progress notes vital signs and assessment of the RD access site when the resident returns from RD. The UM was unable to locate the documentation in the electronic record when asked to do so by the surveyor. The Director of Nursing (DON) spoke with the surveyor on 10/07/24 at 10:41 AM. The DON stated the post dialysis assessments were not done consistently on the resident. She stated the vital signs and the access site monitoring must be done post dialysis and documented in the progress notes. 45449 2. On 10/2/24 at 9:25 AM, the surveyor observed Resident #134 asleep, covered with a blanket, and did not rouse to the voice of the surveyor. On 10/2/24 at 9:33 AM, the surveyor observed Registered Nurse/Unit Manager verbally requested permission from Resident #134 to assess their arteriovenous (AV) fistula (a surgically created connection between the artery and the vein to provide access for dialysis). At that time the RN/UM and the surveyor observed the AV fistula shunt was intact. The surveyor reviewed the medical record for Resident #134. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Admission Record, Resident #134 was admitted with diagnoses that included, end stage renal disease and congestive heart failure. Review of the Admission Minimum Data Set (MDS), an assessment tool used to manage care dated 8/27/24, revealed Resident #134 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact and while a resident received dialysis services. Review of Resident #134's medical record revealed that the resident was scheduled for hemodialysis (HD) on Monday, Wednesday, and Friday at 1:00 PM. During an interview with the surveyor on 10/2/24 at 9:36 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that the process for communication with dialysis was that the nurses would fill out a pre-dialysis communication log prior to the HD appointment which would be kept in the dialysis communication book. The log contained information such medications sent with the resident, meals sent, labs drawn, weight and vitals. The HD communication book would go with the resident to the HD center. After dialysis the HD center would fill out the post dialysis communication log that contained information such as completion of treatment as ordered, pre dialysis weight and post dialysis weight, treatment complications, when a physician was notified, the AV shunt report and the Registered Nurse completing the report. The HD communication book traveled back with the resident to the facility. The LPN/UM stated that when the resident returned to the facility, the receiving nurse would assess the resident's AV fistula's thrill (vibration or buzzing when fingers are place on the fistula) and bruit (a swooshing sound heard near fistula when using a stethoscope), obtain vital signs and write the result of the assessment on the bottom of the HD communication log. A review of the September 2023 HD communication log reflected the following: - 9-2-24 the post dialysis communication to be filled out by the HD center was blank, and did not include pre-weight post dialysis weight, treatment complication. The AV fistula assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility. - 9-20-24 the post dialysis communication to be filled out by the HD center was blank, and did not include pre-weight post dialysis weight, treatment complication. The AV fistula assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility. - 9-25-24 the pre-dialysis communication log did not contain information such medications sent with the resident, meals sent, labs drawn, weight and vitals. the post dialysis communication to be filled out by the HD center was blank, and did not include pre-weight post dialysis weight, treatment complication. The AV fistula assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility. - 9-27-24 The AV fistula assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Park Renaissance	521 Pine Brook Road Lincoln Park, NJ 07035

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9-30-23 The AV fistula assessment completed by the facility staff was documented as positive however no vitals were documented after returning to the facility. On 10/4/24 at 1:26 PM, in the presence of the survey team, the Director of Nursing (DON), the Licensed Practical Nurse/Infection Preventionist (LPN/IP) and the Regional Nurse, the surveyor discussed the concerns regarding the failure to consistently and completely assess Resident #134's vitals upon return from the HD center as reflected on the HD communication log. On 10/7/24 at 10:44 AM, in the presence of the survey team, the DON acknowledged that the communication log was not always done and would be addressed, A review of the facility provided policy End-Stage Renal Disease, Care of a Resident dated/revised 1/28/24 reflected that Agreements between this facility and the contracted ESRD facility included all aspects of how the resident's care will be managed, including how information will be exchanged between the facilities. The general medical nurse should document in the resident's medical record every shift as follows: location of catheter, condition of dressing (interventions if needed), if dialysis was done during shift, any part of report from dialysis nurse post-dialysis being given and observation post dialysis. NJAC 8:39 - 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 19106 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the period of 9/15/24 to 9/28/24 (2 weeks prior to the standard survey of 10/10/24) and the period of 5/5/24 to 5/11/24 (the time period covering complaint investigations) revealed the following: For the 2 weeks of staffing prior to survey from 09/15/2024 to 09/28/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -09/15/24 had 18 CNAs for 170 residents on the day shift, required at least 21 CNAs. -09/16/24 had 20 CNAs for 170 residents on the day shift, required at least 21 CNAs. -09/17/24 had 16 CNAs for 170 residents on the day shift, required at least 21 CNAs. -09/19/24 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs. -09/20/24 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs. -09/21/24 had 18 CNAs for 174 residents on the day shift, required at least 22 CNAs. -09/22/24 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs. -09/23/24 had 21 CNAs for 174 residents on the day shift, required at least 22 CNAs. -09/24/24 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs. -09/25/24 had 21 CNAs for 178 residents on the day shift, required at least 22 CNAs. -09/26/24 had 20 CNAs for 177 residents on the day shift, required at least 22 CNAs. -09/27/24 had 21 CNAs for 177 residents on the day shift, required at least 22 CNAs. -09/28/24 had 19 CNAs for 177 residents on the day shift, required at least 22 CNAs. For the week of Complaint staffing from 05/05/2024 to 5/11/24, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -05/05/24 had 21 CNAs for 181 residents on the day shift, required at least 23 CNAs. -05/06/24 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs. -05/07/24 had 21 CNAs for 179 residents on the day shift, required at least 22 CNAs. -05/08/24 had 20 CNAs for 179 residents on the day shift, required at least 22 CNAs. -05/11/24 had 20 CNAs for 176 residents on the day shift, required at least 22 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 10/8/24 at 12:15 p.m., the surveyor informed the Director of Nursing and Licensed Nursing Home Administrator (LNHA) of the staffing ratio and resident care concerns. 36419 On 10/1/24 at 11:34 AM, the surveyor observed Resident #59 in bed on a specialty mattress, with his/her eyes open. Resident #59 did not respond to the surveyor's greeting. The surveyor observed a strong unpleasant odor in the resident's room. On 10/1/24 at 11:40 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who had been assigned to Resident #59's care for the 7AM-3:00 PM shift. During the interview, the CNA stated that she had 10 residents on her assignment and that this was the first opportunity she had to provide care to Resident #59. The surveyor asked the CNA how often she provided incontinence care to the residents on her assignment. The CNA replied she would usually provide incontinence care 3 times a shift, but today it would be only twice since it was already so late. On 10/1/24 at 11:45 AM, the CNA exposed Resident #59's incontinence brief. The surveyor and CNA observed that the Resident's incontinence brief had a bladder absorbency pad inserted within the adult brief. The adult brief, pad and pad under the resident were all saturated with urine. On 10/7/24 at 10:35 AM, in the presence of the survey team, the DON stated that despite the number of residents the CNAs have on their assignments, incontinence care should be provided to the residents three times on the night shift and every 2 hours on the day shift. Refer to F677D NJAC 8:39-5.1(a); 27.1(a); 27.2(d); 27.2(h)