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	02/09/2026

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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(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 - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide ordered respiratory care consistent with professional standards of practice. This deficient practice was identified for 3 of 4 residents (Residents #13, #102, and #103) reviewed for respiratory care, and was evidenced by the following: 1.On 1/28/26 at 10:20 AM, the surveyor interviewed Resident #102. The resident was lying in bed and the surveyor observed a nasal canula connected to a wall oxygen outlet, which was was in use. The surveyor examined the wall oxygen meter and observed it was set at 0.5 liters/minute of flow. The humidification bottle attached to the wall meter had no date indicating start of use. The resident stated he was not short of breath and demonstrated no signs or symptoms of distress or difficulty breathing. A review of the resident's admission record reflected he was admitted to the facility on [DATE] with diagnoses including but not limited: pneumonia and acute respiratory failure. A review of Resident #102's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/14/26 indicated a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which reflected that the resident's cognition was severely impaired. A review of the resident's physician's orders reflected an order dated 1/9/26 for the resident to receive oxygen via nasal canula at 3 liters per minute continuously as well as an order dated 1/9/26 to date the oxygen humidifier bottle if in use per protocol. On 01/29/2026 at 11:49 AM, the surveyor observed Resident #102 in his room seated in a wheelchair. The resident's nasal canula was in place and connected to the wall oxygen outlet and the flow rate read zero which indicated the oxygen was not turned on. The humidification bottle connected to the wall outlet was not dated. The resident did not exhibit signs of distress or shortness of breath. The resident denied shortness of breath or difficulty breathing. The surveyor requested Registered Nurse (RN) for the unit to enter the resident's room. The RN confirmed resident was ordered for 3 liter/minute of continuous oxygen via nasal canula. The RN confirmed that the resident's Nasal canula was in place and the tubing was connected to the wall outlet, but the valve was not turned on and no oxygen was flowing. The RN turned on the oxygen and set the flow to 3 liters/minute. The RN acknowledged that the resident should always be connected to oxygen at a flow rate of 3 liters/minute. The surveyor requested the RN examined the humification bottle and the RN confirmed the humidification bottle in use for this resident was not labeled with a start date. The RN immediately changed the humification bottle with a new one, dated at the time of application and acknowledged that humidification bottles should always be labeled with the date they were started. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/26 at 1:45 PM, the surveyor and the team met with Director of Nursing (DON) and Administrator and presented the concern over oxygen not set properly for Resident #107. The DON acknowledged that oxygen administration ordered by provider should always be set and delivered at the prescribed route and rate of flow. The DON acknowledged that humidification bottles should be labeled with the start date by the nurse putting the bottle in use. A review of the facility's Oxygen Therapy policy, with a revised date of April 2025, included the following procedures: Adjust liter flow per MD order. Observe the resident upon set up and periodically thereafter to be sure oxygen is being tolerated. 2. On 1/28/26 at 11:35 AM, the surveyor observed Resident #103 sitting in a wheelchair at their bedside. The resident was alert and verbally responsive. The surveyor observed respiratory equipment at the bedside which included a Continuous Positive Airway Pressure (CPAP) machine (a treatment for obstructive sleep apnea and other respiratory issues that uses a machine to deliver steady, pressurized air through a mask to keep airways open during sleep and improve breathing). Resident #103 stated the CPAP machine was their own from home and they used it at night. On 1/29/26 at 8:58 AM, the surveyor reviewed the Electronic Medical Record (EMR) of Resident #103. The Face Sheet (a summary of important resident information) revealed Resident #103 had diagnoses that included but were not limited to, Chronic Obstructive Pulmonary Disease (COPD; a progressive, long-term lung disease that makes it hard to breathe due to damaged, inflamed, and narrowed airways), and obstructive sleep apnea. A Comprehensive Minimum Data Set assessment, a tool used to facilitate management of care, dated 12/17/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #103 scored 11 out of 15, which indicated the resident had moderate cognitive impairment. A review of the physician's orders for Resident #103 revealed there was no order for the CPAP machine. A review of the resident's care plan revealed no documentation regarding the use of a CPAP machine. A respiratory note dated 1/19/26 indicated the resident used a CPAP machine at bedtime. A nurse progress note dated 1/24/26 at 12:28 AM indicated the resident was using the CPAP machine and was in no respiratory distress. On 1/29/26 at 11:43 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated there should be physician's orders for CPAP machines. The surveyor informed the LPN/UM of the concern Resident #103 had a CPAP machine at their bedside that was being used and there was no physician order. The LPN/UM reviewed with the surveyor Resident #103's physician's orders and confirmed there was no physician order for the CPAP machine. The LPN/UM stated she would review to provide any additional information. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/2026 at 1:14 PM, the LPN/UM informed the surveyor the physician was called, an order was received for the CPAP machine, and the resident would be referred to a pulmonologist (a medical doctor specialized in respiratory care and treatment). The LPN/UM could not speak to why there was no physician's order for the resident's CPAP machine. On 2/4/26 at 1:30 PM, Surveyor #2 informed the Administrator and the DON of the concern there was no physician's order for Resident #103's CPAP machine. On 2/5/26 at 10:34 AM, the LNHA, the DON, the regional DON and the IP met with the survey team. The DON acknowledged after surveyor inquiry a physician's order was entered for Resident #103's CPAP machine. There was no additional information provided by the facility. A review of the facility provided policy titled CPAP. revealed under Procedure: . Verify the physician's order for BIPAP/CPAP. Apply the settings per physician's order. NJAC 8:39-27.1(a) 3. On 1/28/26 at 9:47 AM, the surveyor observed Resident #13 awake, lying on the bed, with a nasal cannula (NC, a plastic prong attached to a tube, inserted into the nostrils through which O2 (oxygen) flows) on both nostrils attached to a portable oxygen tank (a device that supplies O2). The surveyor observed that the portable O2 tank was empty. The surveyor got the attention of the Licensed Practical Nurse (LPN), who checked that the tank was empty, then replaced it with a new full portable O2 tank. On 2/4/26 at 1:21 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #13, which revealed the following: A review of the admission Record (an admission summary) (AR) reflected that Resident #13 was admitted with diagnoses that included but were not limited to osteomyelitis of the vertebra (an infection in a bone), sacral, and sacrococcygeal (part of the body located in the lower back and the tail bone). A review of the quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care) of 1/13/26 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated that the resident had severely impaired cognition. Further review of the Q/MDS revealed in Section J – Health Conditions revealed that Resident #13 had a shortness of breath. A review of the Order Summary Report (OSR) with the start date of 1/26/26, oxygen at 2 lpm (liters per minute) via nasal cannula continuously every shift for SOB (shortness of breath). A review of the January 2026 Treatment Administration Record (TAR) revealed that the nurses recorded oxygen use every shift. On 2/5/26 at 9:15 AM, the surveyor interviewed the Registered Nurse, who stated that when she starts her shift, she will check the oxygen, make sure the tank is full, labeled, and that there is a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	humidifier. On 2/5/26 at 9:27 AM, the surveyor interviewed the LPN/Unit Manager, who stated that the resident's oxygen should be checked by the nurses who are in charge of the resident, and that the oxygen was labeled in the correct flow. If it's a portable tank, it should be full. On 2/5/26 at 10:34 AM, the surveyor met with the Licensed Nursing Home Administrator, Director of Nursing (DON), Infection Preventionist, and the Regional Nurse. The DON stated that the portable O2 tank was immediately bought for the nurses' attention, and the resident's O2 saturation is normal during those times. On 2/5/26 at 11:15 AM, the surveyor reviewed the facility's policy titled Oxygen Therapy, revised on 4/19/25, but it does not talk about the portable oxygen tank procedures. NJ 8:39-25.2(c)3,6

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure accurate and appropriate administration of a medication (med) for 4 of 36 (Res. #14, #173, 205, 166 and 4) residents reviewed for medication regimen. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient practice is evidenced by the following: 1.On 1/28/26 at 10:50AM, the surveyor conducted an interview of Resident #205. The resident was alert and oriented to self but not to place and time and the resident could not accurately provide a history of his care at the facility. A review of Resident #205's admission Record reflected that the resident was admitted to the facility with Spinal Stenosis lumbar region (narrowing of the spinal canal in the lower back, compressing the nerves), cerebral infarction (stroke) and urinary tract infection. A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated 1/20/26 reflected the resident had a history of frequent moderate pain in the five days preceding the assessment. The MDS reflected that the resident had a brief interview for mental status (BIMS) score 11 out of 15, which indicated a moderate cognitive impairment. A review of the physician's orders for Resident #205 reflected the resident was ordered medication that included but was not limited to: Oxycodone HCL oral tablet 5 mg. Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain 4 -10 dated 1/18/26 Lidocaine external patch 5% Apply to left hip and low back topically in the morning for back pain 1/19/26. A review of Plan of Care reflected a focus dated 1/18/2025 of at risk for pain due to advanced age and interventions for that focus that included but were not limited to administer pain medication as (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered. A review of the resident's medication administration record (MAR) reflected the resident was administered the following medications: oxycodone 5mg on 1/19/26 at 3:41 PM for a pain level charted as 0. oxycodone 5mg on 1/20/26 at 3:14 PM for a pain level charted at 0. Both administrations of the medicine were signed for by the LPN. On 2/5/2026 at 11:16 AM, the surveyor interviewed the LPN. The surveyor asked the LPN about pain medication administration, and she verbalized that residents should have pain managed appropriately and that the lowest level of medication or intervention should be implemented to control pain. The LPN confirmed she was knowledgeable of pain scale utilizing 0-10 , and she stated 0 means No pain and 10 is the worst pain they ever had. The surveyor asked the LPN about as needed (PRN) pain medication administration procedures. The LPN stated I ask the residents if they have pain and ask them to give it a number 0-10. If the resident states, they have pain I give them the medicine ordered for that level of pain. The surveyor asked the LPN to review administrations of oxycodone for Resident #205 for 1/19/26 and 1/20/26. The LPN confirmed she signed for the administration of PRN oxycodone 5mg for 1/19/26 at 3:41 PM and that she charted it was for a pain level of 0. The LPN confirmed administration of PRN oxycodone 5mg on1/20/26 at 3:14 PM and that she charted charted it was for pain level of 0. The LPN confirmed the physician's order was Oxycodone HCL oral tablet 5 mg to give 1 tablet by mouth every 6 hours as needed for moderate to severe pain 4 -10. The LPN acknowledged that resident should not have received medication if resident reported pain scale of 0 of 10 on the pain scale. The surveyor asked the LPN to review Resident #205's physician order for lidocaine patches, she confirmed the order was for application of lidocaine patch 5% applied to low back and left hip daily in the morning. She confirmed she places 1 patch on the area of skin between the left hip and lower back and indicates left hip as the location of administration. She confirmed order did not include directions for time of removal or total time patch should remain on the resident. The LPN stated, we take them off in the evening when he gets his voltaren gel applied she confirmed we don't chart anywhere that we took it off. On 2/6/26 at 1:43 PM, the surveyor and the team met with the Director of Nursing (DON) and the Administrator and discussed concerns regarding the Oxycodone administration for pain charted as 0 and outside of the administration parameter as well as the lidocaine patch application and lack of removal order. The surveyor reviewed with the DON the concerns with the MAR entries for the lidocaine topical patch administration for January and February. The DON acknowledged that of the 25 days reviewed, nurses had charted 10 days the patch was applied to the left hip, on 14 days the nurses charted the patch was applied to the lower back and on 1 day the nurse charted it was applied to other. The DON confirmed the physician's order was that lidocaine patch should be applied to both the left hip and lower back. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/9/26 at 10:35 AM, the surveyor and the team met with the DON and the DON provided the lidocaine patch manufacturer's guidelines that indicated the lidocaine patch could be applied for up to 12 hours and confirmed a removal instruction or removal order for time of removal should have been in place to assure proper use of the product. The DON acknowledged she reviewed the MAR for Resident #205 and confirmed the oxycodone doses on 1/19/26 and 1/20/26 were administered outside of order parameters as documented. 2. On 2/9/26 at 9:26 AM, the surveyor reviewed the electronic medical record of Resident #4. The admission Record (a summary of important information about a resident) revealed Resident #4 had diagnoses that included, but were not limited to, a compression fracture of the spine, a fracture of the humerus (a long bone in the upper arm), and supraventricular tachycardia (a heart rhythm disorder that causes a very fast heartbeat). A comprehensive Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, with an assessment reference date (ARD) of 12/29/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status test. Resident #4 scored 8 out of 15, which indicated the resident had moderate cognitive impairment. A physician's order dated 1/14/26 indicated oxycodone 5 milligram (mg) oral tablet, give 1 tablet by mouth in the morning every 6 hours as needed for pain- moderate 4-7. A physician's order dated 1/14/26 indicated metoprolol succinate extended release 100 mg oral capsule, give 1 capsule by mouth in the morning; Hold for systolic blood pressure (BP) less than 110 or heart rate (HR) less than 60. A review of the February 2026 Medication Administration Record (MAR) revealed the following: For the metoprolol succinate order entry with parameters, there was no documentation of the resident's BP and HR at the time of the medication's administration. For the PRN oxycodone entry, there were three entries with a documented pain level that was outside the ordered parameters (4-7 pain level) for administering the medication which were as follows: - On 2/2/26 at 7:24 PM, the nurse documented a pain level of 3. -On 2/3/26 at 8:27 PM, the nurse documented a pain level of 2. -On 2/4/26 at 6:51 PM, the nurse documented a pain level of 0. A review of progress notes revealed no documentation of the resident's BP and HR at the time of the metoprolol succinate's administration; and no documentation regarding the PRN oxycodone administration for the three identified entries. A review of the February 2026 Weights and Vitals section of the EMR revealed: There was no documentation to indicate the resident's BP and HR results at the time of the metoprolol succinate's administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no additional documentation for the resident's pain level at the time of the three identified PRN oxycodone administrations. On 2/9/26 at 11:00 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated the nurses checked a resident's BP and HR prior to administering a medication with corresponding parameters and held the medication according to the physician's orders. The LPN/UM explained that the BP and HR results were documented in the supplementary section of the MAR entry at the time of the medication's administration. The LPN/UM added the results could also be documented by the nurses in a progress note in the EMR. The surveyor asked the LPN/UM about PRN pain medications. The LPN/UM stated the expectation was for nurses to follow the indicated pain level when administering pain meds and the resident's reported pain level would be documented in the supplementary section of the MAR entry at the time of the medication's administration. The surveyor with the LPN/UM reviewed the February 2026 MAR entries for metoprolol succinate and PRN oxycodone. The surveyor discussed the above identified concerns for the entries. The LPN/UM stated the BP and HR entries under vitals indicated the nurses checked it. The LPN/UM confirmed the nurses had an hour before and one hour after a routine medication's scheduled time to administer the medication. A review of the BP and HR results in the MAR revealed there was no documentation to indicate the results were taken at the time of the metoprolol succinate's administration. The LPN/UM provided no verbal response regarding the identified PRN entries. The LPN/UM stated she would review to provide any additional information. On 2/9/26 at 2:23 PM, the surveyor informed the LNHA, the DON, and the Regional DON regarding the identified concerns with Resident #4's metoprolol succinate and PRN oxycodone. The DON stated Resident #4's vital signs were documented in the MAR. The surveyor discussed concern that the vital signs entry did not indicate time obtained and there was no documentation of the resident's BP and HR at the time of the metoprolol succinate's administration in the EMR. There was no verbal response regarding the concerns for the PRN oxycodone pain level. There was no additional information provided by the facility. The surveyor reviewed the facility provided policy titled, Pain Management, with a last revised date of 12/22/25 which revealed: . 5. The practitioner is notified of unresolved, new or worsening pain, lack of response to interventions or other concerns requiring medical review. 7. Pain Assessments, interventions, resident response, and relevant communications are documented in the medical record. The surveyor reviewed the facility provided policy titled, Medication Administration, with a last revised date of 1/6/26 which revealed under Policy Statement, Medications shall be administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation revealed: . 2. Orders are reviewed and clarified as needed prior to administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Medications are administered as ordered unless clinically contraindicated or refused. 6. Medication administration is documented in the medical record in a timely and accurate manner. 3. On 2/4/26 at 11:51 AM, Resident #173 came to the conference to talk to the team of surveyors. The team of surveyors interviewed Resident #173, who stated that they did not get the clonazepam (medication that helps reduce anxiety) 0.5 mg (milligram) tab. (tablet) medication on 2/1/26 at 9:00 PM and on 2/2/26 at 9:00 AM. The resident said that they asked the nurse to get it from the backup medications. The nurse told the resident that there is no backup medication for clonazepam. Resident #173 stated that they get anxious and cannot sleep if they have not received the clonazepam. The resident decided to call their family and told the daughter that they would miss their medication. The family came to the facility and gave them the clonazepam, and the family gave the resident an extra pill for the next day, as per the resident. Resident #173 added that the nurse was there and verbalized that the family saved the day. The nurse confirmed the bottled medication was prescribed to the resident and the medication inside was confirmed to be the correct medication. On 2/4/26 1:11 PM, the surveyor interviewed the LPN # 2, who is the nurse in charge of the resident on 2/2/26 in the evening and night shift, over the phone. The LPN # 2 stated that they did not have clonazepam that day on 2/2/26 at 9:00 PM for Resident #173. She made the resident aware that clonazepam is not available, and they do not have backup medication. The LPN added that the resident got upset and called the family, and it was around 9:30 pm. The daughter came after 9:30 pm, and she brought the supply of clonazepam from home. The family gave the clonazepam to Resident #173. The LPN did not confirm how many milligrams of clonazepam were given by the daughter. The LPN informed the supervisor, and the supervisor told her to call the doctor since the Nurse Practitioner (NP) was on vacation. On 2/5/26 at 12:23 PM, the surveyor interviewed the NP, who stated that she sent the prescriptions on 1/26/26 because they are not automatically refilled. The script went to the [Name redacted] pharmacy, and on 1/27/26, she faxed the script again to the pharmacy. On 1/29/26, she emailed the script again. The NP stated she does not know what happened after that. On 2/4/26 at 9:39 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #173, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #173 was admitted with diagnoses that included, but were not limited to, general anxiety (excessive feeling of worry, fear and stress) disorder. A review of the annual Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care), dated 1/14/26, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident had intact cognition. A review of the comprehensive Care Plan (CP) report with an initiated date of 1/9/23, with the focus on Resident #173, who uses anti-anxiety medication related to anxiety. A review of the Order Summary Report (OSR) with the start date of 2/28/25, clonazepam 0.5 mg by mouth every 12 hours for anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the February electronic Medical Administration Record (eMAR) revealed that there is no documentation of the clonazepam 0.5 mg on 2/2/26 at 9:00 PM. A review of the Medication Admin Audit Report with a schedule date of 1/31/26 to 2/2/26 revealed that on 2/1/26 at the scheduled time of 9:00 PM, the clonazepam 0.5 mg was documented on 2/5/26 at 10:10 AM after the surveyor's inquiry. A review of the Packing Slip form dated 2/2/26, with an unknown time received by the nurse for Resident #173, revealed that the clonazepam 0.5 mg had 14 tablets and was received by the facility. A review of the Individual Patient's Controlled Drug Record (IPCDR) with a received date on 2/2/26 and amount received was 14 tablets for Resident #173 revealed that the clonazepam tab 0.5 mg was administered with a handwritten note on 2/2/26 at 9:00 PM and initialed by the letter AH. A review of the IPCDR for Resident #166 for clonazepam tab 0.5 mg revealed that the clonazepam 0.5 mg tab was given on 2/1/26 at 9:00 AM, and was administered with a handwritten note on 2/1/26, no time provided, and initialed by the letter AH and co-initialed by the letter JP. On 2/5/26 at 1:47 PM, the surveyor interviewed the Director of Nursing, who stated that the clonazepam 0.5 mg tabs for Resident #173 were received on 2/2/26 and could not confirm the exact time they were delivered. On 2/6/26, O2 at 10:08 AM, the team of surveyors met with the Regional Nurse, LNHA, and the Director of Nursing (DON). The DON stated the clonazepam 0.5 mg tab for Resident #173 was given on the following: 2/1/26 at 9:00 AM, was borrowed from Resident #166, which was discontinued. 2/1/26 at 9:00 PM, the dose came from the family. 2/2/26 at 9:00 AM, the dose was provided by the family again. The medication was in a prescription bottle with the resident's name on it from home. 2/2/26 at 9:00 PM, the dose was signed on the declining inventory, but the eMAR was not signed by accident, and it was signed on 2/5/26. On the same day at 10:15 AM, the surveyor interviewed the DON regarding narcotics borrowing and whether it was allowed in the facility. The DON stated, I don't know. On 2/9/26 1:18 PM, the surveyor interviewed the DON, who stated that they do not have any policy for borrowing narcotics from one resident to another. 4. On 1/28/226 at 9:55 AM, the surveyor observed Resident #14 in bed asleep. On 2/9/26 at 1:29 PM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #14, which revealed the following: A review of the AR reflected that Resident #14 was admitted with diagnoses that included, but were not limited to, chronic pain syndrome. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the recent quarterly MDS (Q/MDS) dated [DATE] indicated that the facility assessed the residents' cognitive status using a BIMS score of 15 out of 15, which indicated that the resident had intact cognition. A review of the comprehensive Care Plan (CP) report with an initiated date of 12/23/19, with the focus on Resident #14, who uses comfort related to non-healing right hip surgical wound, right foot abrasion, impaired mobility, and diabetic neuropathy. A review of the OSR with an order date of 11/17/25, Dilaudid 2 mg by mouth every 4 hours as needed for severe pain, and acetaminophen 325 mg 2 tabs by mouth every 6 hours as needed for pain with an order date of 3/3/23. No indication of pain level scale for both medications. A review of the January 2026 eMAR revealed that the nurse's documentation of acetaminophen 325 mg 2 tabs by mouth every 6 hours as needed was given on 1/28/26 at 3:09 PM for a pain level of 7 (seven). Furthermore, the Dilaudid 2 mg for the pain level is the following: On 1/15/26 - 0 (zero) pain given and signed at 9:47 AM On 1/24/26 - 0 pain given and signed at 9:35 AM On 1/24/26 - 0 pain given and signed at 11:30 PM On 2/9/26 at 1:40 PM, the surveyor interviewed Asst. DON/Unit Manager, who stated that they do have a scale for pain medications. The scale could vary for each resident. When the nurses were giving pain meds, the system automatically asked about the pain level. If the resident cannot verbalize their pain, there is a sequence of questions/assessments for pain. NJAC 8:39-11.2 (b); 29.2(d)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 1 (one) of the 32 residents (Resident #3) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: The surveyor observed Resident #3 on 1/28/26 at 10:02 AM in bed with eyes closed. The resident's call device was clipped to the sheet behind the head of the bed. The device cord hung down behind the bed out of the reach of the resident. The surveyor observed the resident on 2/4/26 at 9 AM in bed with eyes closed. The call device was in the same position as the previous observation, hanging down behind the head of the bed. The surveyor observed the wound treatment nurse perform a treatment to Resident #3 on 2/4/26 beginning at 11:38 AM. The call device was observed on the floor under the resident's bed throughout the 40 minute treatment observation. At the conclusion of the treatment, the nurse picked up the call device from the floor and placed it on the resident's chest area. The surveyor interviewed the nurse on 2/4/26 at 12:25 PM. He stated call bells should always be accessible to the resident. A review of the resident's 11/19/25 significant change in status Minimum Data Set (MDS) assessment tool indicated the resident had moderate cognitive impairment (brief interview for mental status score of 8). The MDS also indicated the resident had no upper body limitations and was at risk for falls. The surveyor discussed the concern with Administrator and the Director of Nursing on 2/4/26 at 1:15 PM. They confirmed the call device should be in reach of the resident at all times. The facility Call Bell policy and procedure, revised 9/15/25, indicated the call bell will be placed within the resident's reach. NJAC 8:39-31.8 (c)9

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, it was determined that the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the appropriate timeframe and in accordance with federal guidelines for 2 of 35 residents (Residents #19, and #103), reviewed for resident assessments. This deficient practice was evidenced by the following:Reference: Centers For Medicare and Medicaid Services (CMS), RAI manual, Version 3.0, last revised in October 2025 indicated in Chapter 2, pages 2-8: .admission refers to the date a person enters the facility and is admitted as a resident.this date is considered the 1st day of admission .Under Chapter 2, Section 2.6-Required OBRA [Omnibus Budget Reconciliation Act] Assessments for the MDS revealed: .MDS Completion Date (Item Z0500B) No Later Than. 14th calendar day of the resident's admission (admission date + 13 calendar days) .Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the admission comprehensive assessment at any time prior to the end of day 14 .On 1/29/26 at 12:34 PM, the surveyor reviewed the MDS assessments of the following residents which revealed: 1. A review of Resident #19's admission (comprehensive) MDS assessment with an Assessment Reference Date (ARD) of 1/17/26 revealed that the MDS was dated and signed complete on 1/30/26. The resident's admission entry was 1/11/26. The MDS assessment was completed more than 14 days after the admission date.2. A review of Resident #103's admission MDS assessment with an ARD of 12/17/25 revealed that the MDS was dated and signed complete on 12/26/25. The resident's admission entry was 12/11/25. The MDS assessment was completed more than 14 days after the admission date. On 1/29/26 at 1:03 PM, the surveyor interviewed the Registered Nurse MDS coordinator (RN/MDSC) who stated an admission (comprehensive) MDS assessment should be completed within 14 days of a resident's admission entry. The surveyor informed the RN/MDSC about concern for the late completion of Residents #19's and #103's MDS assessments.On 1/29/26 at 1:29 PM, the RN/MDSC acknowledged the identified MDS assessments were completed late. The RN/MDSC stated the facility followed the RAI manual guidelines for MDS assessments. On 2/5/26 at 1:33 PM, Surveyor #2 informed the Licensed Nursing Home Administrator, the Director of Nursing (DON), and the Regional DON regarding the concern of late MDS assessment completion for Residents #19 and #103. There was no additional information provided by the facility.NJAC 8:39-11.1, 11.2(e)

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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. REPEAT DEFICIENCY Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS, an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 2 of 36 residents (Resident #13 and #18) during the review of resident assessment. This deficient practice was evidenced by the following: The MDS is a comprehensive tool, a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 1/29/26 at 10:03 AM, the surveyor provided the MDS Coordinator/Registered Nurse (MDSC/RN) with the list of 2 residents who had completed an MDS assessment for Residents #13 and #18. The surveyor also requested a copy of the resident's final validation report (generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On the same date at 1:03 PM, the surveyor interviewed the MDSC/RN, who provided the surveyor with the final validation of the late MDS submission. The MDSC/RN stated that it was submitted late because they needed to check if the assessment was completed by another department, which is also busy. If the other department is late for the assessment, the submission will be late too. The MDSC/RN stated that the MDS should be completed within 14 days and submitted at least 21 days. The MDS assessments that were not submitted within fourteen days after the assessment reference date (ARD, the last day of the observation period) are as follows: 1. Resident #13 admission MDS (A/MDS) assessment had an ARD of 10/19/25. It was signed as completed but not transmitted until 11/3/25. 2. Resident #18 A/MDS assessment had an ARD of 9/12/25. It was signed as completed on 10/9/25 and not transmitted until 10/13/25. On 2/5/25 at 1:33 PM, the surveyor met with the Licensed Nursing Home Administrator, Director of Nursing, and Regional Nurse regarding the concern above, but did not provide further information. NJAC 8:39-11.1

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** REPEAT DEFICIENCY Based on interviews and record review, it was determined that the facility failed to accurately code the Minimum Data Set (MDS, an assessment tool used to facilitate the management of care), in accordance with federal guidelines, for 1 of 36 residents (Resident #15), who were reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: On 1/29/26 at 8:57 AM, the surveyor observed Resident #15, who is seated in a motorized wheelchair, and stated that they would go down to smoke. The surveyor interviewed the Registered Nurse (RN), who stated that the resident is alert and oriented x3, and they can go by themselves to the smoking area. On 2/4/26 at 9:39 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #15, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #15 was admitted with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD, a lung disease that makes it difficult to breathe). A review of the annual Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care), dated 9/19/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had intact cognition. Further review of the A/MDS in Section J - Current Tobacco Use 0. No. A review of the Smoking/Vaping (handheld electronic device) Contract form dated 6/18/25 revealed that Resident #15 signed the form regarding the facility's smoking policy. A review of the Smoking Safety Screen assessment dated [DATE] revealed that the resident is a smoker. A review of the comprehensive Care Plan (CP) report with an initiated date of 11/6/25, with the focus on Resident #15, who is a smoker. On 2/5/26 at 10:42 AM, the surveyor interviewed the MDS/Licensed Practical Nurse (MDS/LPN), who stated that she is aware that Resident #15 is smoking either vape or tobacco, and she added that she must have missed coding the smoking status in the MDS assessment. On 2/5/25 at 1:33 PM, the surveyor met with the Licensed Nursing Home Administrator, Director of Nursing, and Regional Nurse regarding the concern above, but did not provide further information. NJAC 8:39-33.2 (d)

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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 facility polices, it was determined that the facility failed to document the non-compliance of the resident's fluid restriction. This deficient practice was identified for 1 (one) of 1 resident (Resident #11) reviewed for dialysis.The deficient practices were evidenced by the following: On 2/5/26 at 9:07 AM, the surveyor observed that the resident was not in the room. The staff stated that Resident #11 was on dialysis. The surveyor observed that the residents had 8 unopened cups of cranberry juice and 4 empty cups, for a total of 12 cups, on top of the overbed table. There are also 5 unopened bottles of bottled water (500 ml (milliliter) each) on top of the windowsill, 2 half-empty bottles of bottled water, and one 120 ml full bottle of water on top of the bedside table. On 2/5/26 at 11:51 AM, the surveyor reviewed the hybrid (paper and electronic) medical record for Resident #11, which revealed the following: A review of the Resident #11's admission Record (AR, an admission summary) documented that the resident was admitted to the facility with diagnoses that included but were not limited to end-stage renal disease (ESRD, the kidney cannot function adequately) and dependence on dialysis (treatment that helps the kidney function). A review of the annual Minimum Data Set (A/MDS) (an assessment tool used to facilitate the management of care) of 11/21/25 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had intact cognition. Further review of the A/MDS under section O shows that Resident #11 was receiving dialysis. A review of the Order Summary Report (OSR) with the start date of 11/10/25, fluid restriction 1000 ml/day, Nursing (7-3 Nursing 120 ml, 3-11 Nursing 120 ml, 11-7 Nursing 40 ml) = 280 ml. Dietary (Breakfast 240 ml, Lunch 240 ml, Dinner 240 ml) excludes liquid supplements, meds, and sauces/gravy every shift. A review of the January 2026 electronic Medication Administration Record (eMAR) shows that from January 1 to 31, the total amount of fluids is more than 280 ml, as documented by Nursing. A review of the comprehensive Care Plan (CP) report with an initiated date of 11/18/24, under focus that Resident #11 requires 1000 ml of fluid restriction daily related to ESRD. Interventions included, but were not limited to, monitoring for compliance with fluid restriction daily. Ensure to document all episodes of non-compliance. A review of the nursing progress notes revealed that there is no documentation that reflects that the resident is getting more than 1000 ml daily, and there is no compliance with fluid restrictions. On 2/5/26 at 9:17 AM, the surveyor interviewed the Registered Nurse (RN), who stated that the resident likes to drink juices, milk, and coffee. The family brings food to the residents. The RN added that the resident is getting 300 ml of water during her shift and will document it to the eMAR, but did not state that she was documenting the non-compliance in the medical record. On 2/5/26 at 10:00 AM, the surveyor interviewed the Registered Dietitian (RD), who stated that if there is a fluid restriction, each department, like Nursing, will get a certain amount of fluids. The dietary department has an allotted number of fluids. The coffee, milk, tea, juices, and soup are counted for fluid restrictions. The RD added that she knew the residents, and in her CP, she stated that the nurses should document if the resident is non-compliant with fluid restriction. On 2/6/26 at 10:08 AM, the team met with the Licensed Nursing Home Administrator, Regional Nurse, and the Director of Nursing (DON). The DON stated that Resident #11 wants the fluids on the bedside. The DON added that, with the fluid restrictions of 1000 ml in January, there was an incorrect documentation error in place for those shifts. The DON did not provide further information on why the non-compliance was not documented in the electronic medical records. A review of the facility's policy titled Fluid Restriction, revised on 12/30/25 under Policy Interpretation and Implementation, 11. Licensed staff should document in the electronic medical record as appropriate fluids taken from medication administration, meal consumption, and any additional fluid intake as observed or reported. NJAC 8:39-19.4 (a) (1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record review, it was determined that the facility failed to ensure the resident's designated smoking area was free from accident hazards, specifically by failing to clear snow and ice from the smoking area after the snow, to prevent slips and falls for 1 (one) of 2 residents (Resident #15), who were reviewed for smoking. This deficient practice was evidenced by the following: On 1/29/26 at 8:57 AM, the surveyor observed Resident #15, seated in a motorized wheelchair, who stated that they would go down to smoke to the 1st floor of the facility at the back patio. The surveyor interviewed the Registered Nurse (RN), who stated that the resident is alert and oriented x3, and they can go by themselves to the smoking area. The surveyor observed that the RN gave the vaping (handheld electronic device) device to Resident #15. On 1/29/26 at 9:03 AM, the surveyor went with Resident #15 to the first floor, to the back patio, to observe the resident vaping. The surveyor observed the No Smoking sign right in front of the automatic door. The surveyor observed there were cigarette butts right in front of the doorway in the no-smoking designated area. On 1/29/26 at 9:05 AM, the surveyor interviewed Resident #15, who stated that they made the administration aware that it is not safe to go there in the smoking designated area, which is why they stayed near the doorway. Resident #15 revealed that they cannot bring their motorized wheelchair to maneuver to the smoking area since there is a layer of snow and ice that makes it slippery. On 1/29/26 at 9:10 AM, the surveyor, together with the team coordinator (TC), came to the area and observed that the smoking designated area is full of snow and ice around the walkway, on top of the table, and on two benches. It was also observed that the fire extinguisher behind the bench was covered with snow. On 1/29/26 at 9:20 AM, the Licensed Nursing Home Administrator (LNHA) went to the designated smoking area together with the TC. The LNHA stated that the ice in the surrounding site is dangerous and is a big issue, but did not provide further information. On 2/4/26 at 9:39 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #15, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #15 was admitted with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD, a lung disease that makes it difficult to breathe). A review of the annual Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care), dated 9/19/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had intact cognition. A review of the comprehensive Care Plan (CP) report with an initiated date of 11/6/25, with the focus on Resident #15, who is a smoker. On 1/29/26 at 1:43 PM, the surveyor met with the LNHA and the Director of Nursing, but did not provide further information. The surveyor reviewed the facility titled Smoking Safety, revised on 1/4/26, which revealed under Policy interpretation and implementation 2. Smoking and /or vaping is permitted only in the designated resident smoking area, and no smoking is permitted in any other area of the facility under any circumstances, including residents' rooms. NJAC 8:39-33.1(d)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident with an indwelling catheter (inserted into the urethra (tube) and draining urine to the bag) had a privacy bag for dignity. This deficient practice was identified in 1 (one) of 3 residents (Resident #18) who were reviewed for urinary catheter use. This deficient practice was evidenced by the following: On 1/28/26 at 9:50 AM, the surveyor observed Resident #18 in bed, asleep. It was observed that the resident's indwelling catheter, draining yellowish urine, was lying on the floor outside the privacy bag. The surveyor observed that there was a family member of the roommate inside the room. On the same day at 10:00 AM, the surveyor observed that the Licensed Practical Nurse (LPN) went inside the resident's room to give the resident's medication. The LPN left after he gave the medications to the resident. On the same day at 10:05 AM, the surveyor went back to Resident #18's room to observe the indwelling catheter. The surveyor observed the indwelling catheter bag with yellowish urine draining outside of the privacy bag, still lying on the floor. On 2/4/26 at 10:02 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #18, which revealed the following: A review of the admission Record (an admission summary) (AR) reflected that Resident #18 was admitted with diagnoses that included but were not limited to obstructive and reflux uropathy (the flow of urine is blocked in the bladder, causing the urine to flow backward), unspecified. A review of the recent quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care), which was dated 12/13/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated that the residents had severe impairment of cognition. Further review of Q/MDS revealed in Section H - Bladder and Bowel that Resident #18 has an indwelling catheter. A review of the Order Summary Report (OSR) revealed an active order for indwelling catheter care every shift as of 10/3/25. A review of the comprehensive Care Plan (CP) report initiated on 11/6/25 focused on the resident's indwelling catheter due to the diagnosis of obstructive uropathy. On 2/5/26 at 9:16 AM, the surveyor interviewed the Registered Nurse, who stated that the indwelling catheter should not be touching the floor and it should be inside the privacy bag. On 2/5/26 at 9:27 AM, the surveyor interviewed the LPN/Unit Manager, who stated that the indwelling catheter should be checked by the nurse in charge of the resident. The catheter is not on the floor; there should be a privacy bag for dignity reasons because there is a family member visiting the roommate. On 2/6/26 at 10:08 AM, the team of surveyors met with the Regional Nurse, Licensed Nursing Home Administrator, and the Director of Nursing, but did not provide further information. The facility policy title Indwelling Urinary Catheter and Suprapubic Catheter Care has the revised date of 4/19/25 under Procedure: 14. Keep the bag covered for privacy and dignity. NJAC 8:39-33.2(c)5

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined that the facility failed to provide services in a manner to prevent or limit the spread of infection during a wound treatment observation. The deficient practice was observed for 1 resident (Resident #3) of 3 reviewed for pressure ulcers and other skin conditions and was evidenced by the following: The surveyor observed Resident #3 in bed with eyes closed on 1/28/26 at 10:02 AM and on 2/4/26 at 11:38 AM. A review of the resident's medical record revealed the following information. The 11/19/25 significant change in status Minimum Data Set (MDS) assessment tool indicated the resident had moderate cognitive impairment (brief interview for mental status score of 8). The MDS also indicated the resident had one pressure ulcer. The resident had a 1/22/26 physician's order for a sacral pressure ulcer as follows. Apply Santyl External Ointment 250 units/gram to sacrum topically every day shift for wound after cleansing with normal saline, pack with calcium alginate, and cover with dry dressing. The surveyor reviewed the facility Handwashing Technique Competency Validation, undated, which indicated after applying soap to hands, employees should lather all surfaces of hands, wrists, and fingers producing friction for at least 20 seconds, then rinse hands under running water. A review of the facility Hand Washing/Hand Hygiene Policy and Procedure, revised 4/2012, indicated employees must wash their hands for at least 20 seconds using soap and water. The surveyor observed the Licensed Practical Nurse (LPN) perform the full thickness sacral pressure ulcer treatment on 2/4/26 beginning at 11:38 AM. During the course of the 40 minute treatment, the following breaks in infection control technique were observed. The LPN washed their hands 8 times during the treatment pass. Of the 8 handwashing observations the LPN lathered outside of running water before rinsing for 15 seconds on 2 occasions, once for 13 seconds, once for 11 seconds, twice for 10 seconds, once for 7 seconds, and once placed hands under running water immediately after applying soap. Additionally, during the treatment pass, the LPN removed a pen from their uniform pocket, dated a bottle of normal saline and dated the cover dressing. The LPN then placed the pen onto the clean drape on the over bed table where the clean treatment supplies were gathered. After the treatment was completed, the drape and used supplies were bundled and discarded, however the used pen, scissors, and open bottle of normal saline were placed directly on the resident's over bed table. The pen, scissors, and normal saline bottle were then placed on the top of the treatment cart. The unsanitized pen was returned to the LPN's uniform pocket, the unsanitized bottle of normal saline was returned to the inside of the treatment cart. The scissors were sanitized and returned to the treatment cart. The LPN returned to the resident's bedside. They did not sanitize the resident's over bed table where lunch was to be served to the resident. Additionally, the LPN observed that the resident's call device was on the floor. The LPN picked the device up off the floor and placed it on the resident's chest without sanitizing it. The surveyor interviewed the LPN. They stated hands should be lathered outside of running water for at least 20 seconds. The surveyor discussed the breaks in infection control techniques with the Administrator and the Director of Nursing on 2/4/26 at 1:15 PM. NJAC 8:39-19.4(a)1; 19.4(m); 27.1(a)