

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Salem County		STREET ADDRESS, CITY, STATE, ZIP CODE 438 Salem-Woodstown Road Salem, NJ 08079	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to ensure the kitchen was clean and staff performed handwashing between glove use and task changes. These failures had the potential to affect 103 residents who consumed food prepared by the facility's kitchen. Findings include: During observation of the kitchen on 08/04/25 at 10:02 AM, dust was noticed on the potholder above the steam table where meals were served and on the ceiling around the vent areas above the sink and shelving. During observation on 08/06/25 at 11:56 AM, lunch was served from the steam table that sat directly beneath the potholder that had dust on it. And staff were observed to use tongs that had been hanging on the potholder. Also, the trays and plates were set up under the vent area where dust was hanging from the ceiling. During the meal service on 08/06/25, the following was observed: At 11:6 AM, Cook1 was observed to take off gloves and went over to the stove and touched the knob on the front of the stove. Cook1 went to the sink and started grabbing utensils that hung above the sink and moving them over to the steamtable for serving. At 11:58 AM, Cook1 was observed to put gloves on and took dirty dishes to the dish area and returned to the main kitchen wearing the same gloves and went to the sink and began wiping it down. At 12:01 PM, Cook1 was observed to take off gloves and wash hands. There were no paper towels in the dispenser, and she left the kitchen area and went to the storeroom with wet hands and grabbed some napkins. She returned with the napkins and placed them at the sink area. At 12:03 PM, Cook1 was observed to pick up a paper towel off the floor and put it in the trash. Cook1 went over to the stove and adjusted knobs and then reached into a box of gloves and pulled out a pair. During an interview on 08/06/25 at 12:51 PM, Cook1 was asked about the different observations made during the meal service. Cook1 agreed with the observations and admitted her hands should have been washed after taking off gloves and before putting on new gloves. Cook1 stated she should have washed hands after picking up the paper towel and placing it in the trash. Cook1 also confirmed the dust on the ceiling and potholder above the food service area. Cook1 was asked who should be cleaning the ceiling. Cook1 stated she did not know. During an interview on 08/06/25 at 12:55 PM, the Dietary Manager (DM) was shown the ceiling. The DM confirmed the dust and grease was over the food service area. The DM was asked who should clean it and she stated it was maintenance that should clean the ceilings. The DM was also asked about the hand washing observations for Cook1. The DM stated hands should be washed when gloves are removed and before putting on another pair. The DM also stated hand washing should have occurred after picking up the paper towel off the floor. During an interview on 08/07/25 at 12:22 PM, the Maintenance Director (MD) was asked who should clean the ceilings in the kitchen and he stated it was maintenances responsibility. Review of the facility policy titled, Routine Cleaning and Disinfection dated August 2025 revealed, Policy Statement: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Policy Explanation and Compliance Guidelines. 4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to. o. Ceiling vents, tiles and ceiling surfaces should be inspected and cleaned when visibly soiled or as part of (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 315058

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	scheduled deep- cleaning protocols to minimize dust and microbial buildup. 13. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. Ceiling tiles and air vents should be dusted and cleaned as needed or as part of scheduled preventive maintenance. Review of the facility policy titled, Hand Hygiene dated April 2023 revealed, Policy Statement: All staff perform proper hand hygiene procedures to prevent the spread of infection to the other personnel residents, and visitors. This applies to all staff working in allocations within the facility. Policy Explanation of Compliance Guidelines. immediately before putting on gloves and after glove removal. NJAC 8:39-17.2(g)		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and policy review, the facility failed to ensure the dumpsters' lids were closed, the plugs were in place, and used gloves and debris was picked up off the ground. This failed practice had the potential to allow trash and animals to enter and leave the dumpster and cause sanitary issues. Findings include: Observation of the dumpster on 08/04/25 at 10:10 AM, revealed two dumpsters for refuse. Both dumpsters' lids were open and when the dietary Director (DM) shut the lids a liquid substance splashed on the DM. There were gloves and other debris lying on the ground around the dumpsters. Neither dumpster had plugs in the holes at the bottom of the container. During an interview on 08/04/25 at 10:10 AM, The DM was asked whose responsibility it was to clean up the area and maintain the dumpsters. The DM stated the maintenance department. During an interview on 08/07/25 at 12:22 PM, the Maintenance Director (MD) stated it was maintenance responsibility. Review of the facility policy titled, Preventive Maintenance Program dated 12/28/22 revealed, Policy: A preventive Maintenance Program shall be developed and implemented to ensure the provision of safe, functional, sanitary, and comfortable environment for residents, staff, and the public. NJAC 8:39-19.7		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to assess one resident (Resident (R) 7) of 33 sampled residents to self-administer medications prior to leaving medications at the bedside. This had the potential for the resident not to receive their ordered medications. Findings include: During an observation on 08/04/25 at 11:26 AM, an inhaler and a bottle of nose spray were sitting on the bedside table. The resident was asked why they were there. R7 stated, I need to use them. Review of R7's undated admission Record found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD) and shortness of breath. Review of R7's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/11/25 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of the R7's EMR under the Orders tab revealed physician orders on 03/04/24 for Breo Elipta 200-25 micrograms (MCG)/inhalation aerosol powder, breath activated one puff inhale orally one time a day for COPD. And on 07/03/24 Fluticasone Propionate Nasal Suspension 50 mcg, two sprays in both nostrils one time a day for rhinitis and congestion. Review of R7's comprehensive Care Plan located in the EMR under the Care Plan tab was reviewed and indicated no Care Plan related to the resident administering his own medication. During an interview on 08/07/25 at 1:24 PM, Licensed Practical Nurse (LPN)7 was shown the medication at the bedside. LPN7 stated, These medications should not be there. During an interview on 08/07/24 at 2:34 PM, the Unit Manager (UM)2 was asked if the resident should have medications at the bedside. The UM2 stated residents should be assessed and verified that R7 had not been assessed. During an interview on 08/07/25 2:56 PM, the Director of Nursing (DON) was asked about residents having medication at the bedside. The DON stated, Not without an assessment. Review of the undated facility policy titled, Self-Administration of Medications revealed, Policy Statement: Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. Policy Interpretation and Implementation: As part of their overall evaluation, the staff and practitioner (Interdisciplinary team) will assess resident's mental and physical abilities, to determine whether a resident is capable of self-administering medication. NJAC 8:39-29.2(c)6		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of policy, the facility failed to ensure a resident's dignity was maintained when he laid in bed with his backside exposed to anyone walking in the hallway outside of his room for one resident (Resident (R) 102) out of a total sample of 33 residents. This failure had the potential to cause distress to the resident and other residents and visitors who might witness the exposure. Findings include: Review of R102's admission Record located in the electronic medical record (EMR) under the Profile tab revealed he was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy. Review of Evaluations tab of the EMR revealed R102 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) dated 07/25/25, which indicated moderate cognitive impairment. During an observation on 08/05/25 at 8:30 AM, R102's room door was fully open with R102 lying in the far bed on his side facing away from the door. R102 wore a gown, tied at the neck and open in the back with his back and upper buttocks exposed. He wore an incontinent brief which was also observed and covered the lower half of his buttocks but not the upper buttocks. The top of his blanket covered a strip of his mid-back and the lower part of the blanket covered his legs. No privacy curtain was pulled around the bed. During constant observation of R102's hallway on 08/05/25 from 8:30 AM to 9:30 AM, four staff were observed walking past the door and three residents passed the doorway. None appeared to look into the room. During an interview and observation on 08/05/25 at 9:30 AM, Licensed Practical Nurse (LPN) 2 was asked by this surveyor to look at R102. LPN2 stated his privacy curtain needed to be pulled to provide dignity, as R102 was currently exposed to anyone who might look into his room. LPN2 pulled the privacy curtain around the bed, stated she would get a certified nursing assistant (CNA), and asked the resident if he wanted to get up. R102 responded with a groan-like noise but did not verbally talk. During an interview and observation on 08/07/25 at 3:10 PM, R102 laid in bed facing away from the door. The door was partially closed, which made it difficult to see R102 from the hallway. The resident was observed from the doorway; the privacy curtain was not pulled around his bed. R102 was dressed in a shirt and pants with his pants pulled down exposing most of his buttocks from the doorway. When asked if he wanted others to see his bottom, R102 shook his head no but did not answer further questions. During an interview on 08/06/25 at 4:11 PM, the Director of Nursing stated she expected staff to maintain residents' dignity and to close doors or pull privacy curtains as needed. Review of the facility's Dignity and Respect policy, updated January 2025, revealed that, Residents shall be treated with dignity and respect at all times. Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. NJAC 8:39-4.1(a)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure residents were free from resident-to-resident abuse for two residents of three residents (Resident (R8 and R55) reviewed for abuse out of a sample of 33 residents. Findings include: 1. Review of R8's "admission Record," located in the "Profile" tab of the EMR, revealed R8 admitted to the facility on [DATE] with diagnoses including major depressive disorder, bipolar disorder, post-traumatic stress disorder, and other schizophrenia. Review of R8's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/21/25 revealed he scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. 2. Review of R55's "admission Record," located in the "Profile" tab of the EMR, revealed R55 admitted to the facility on [DATE] with diagnoses including major depressive disorder and anxiety disorder. Review of R55's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/02/25 revealed he scored three out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of a "Nurse's Notes" located in the EMR under the "Notes" tab written by Licensed Practical Nurse (LPN) 4, dated 05/31/25, revealed nurse reported R8 scratched R55 in face and an incident report was needed. Upon investigation, residents were in dining room in activities and when R8 got in reach of R55, R8 scratched R55's face. When asked why R8 stated I don't know. Residents separated immediately. Review of the Self-Report Form provided by the facility, dated 06/01/25 at 8:04 AM revealed the incident occurred on 05/31/25 at 11:40 AM. Further review revealed the incident did occur and R8 did intentionally scratch R55 in the face. During an interview on 08/06/2025 at 11:29 AM with Unit Manager (UM)1 revealed she spoke with R8 after the incident occurred and he stated that he scratched R55 in the face because he did not like the way he (R55) spoke to a female, and he thought R55 was being disrespectful. During an interview on 08/06/25 at 12:07 PM, LPN4 said on 05/31/25 staff came and told her there was an issue. She saw R55's face, and it was scratched. She said she got statements from the staff and spoke with R8 who stated he did not know why he did it. During an interview on 08/07/25 at 12:43 PM, the Activities Aide (AA)1 said on 05/31/25 R8 and R55 were sitting together in the dining room, while she was reading the daily chronicle to the residents. R8 went to get a lollipop and on his way back he reached across and scratched R55 in the face. AA1 stated she immediately took R55 to the nursing supervisor and then went back and took R8 to his room. During an interview on 08/07/25 at 5:09 PM, the Administrator stated the investigation concluded that the incident did occur. He said they were able to see the incident occur on the security cameras. He said R8 scratched R55 because he felt R55 said something suggestive to a female staff member, and he believed he was defending her. NJAC 8:39-4.1(a)NJAC 8:39-9.4(f)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and policy review, the facility failed to monitor target behaviors for the use of Risperdal (an antipsychotic medication) for one of five residents (Resident (R)5) reviewed for unnecessary medications out of a total sample of 33. This had the potential for R5 to receive medication without being assessed if behaviors had improved or declined. Findings include: Review of R5's undated Resident Face Sheet, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including dementia. Review of R5's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/30/25 and located in the EMR indicated a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated R5 was severely cognitively impaired. The assessment indicated the resident was not exhibiting any behavioral symptoms during the assessment period but was taking an antipsychotic medication. Review of R5's Physician Order Report, dated 08/14/24 and found in the EMR under the Orders Tab, indicated R5 was to receive Risperdal 1 milligrams (mg), one tablet by mouth twice daily for psychotic disorder. Review of R5's Medication Administration Record (MAR), dated June, July and August 2025 and found in the EMR under the Orders tab, revealed no documented evidence to show which specific behaviors were associated with the administration of the resident's antipsychotic medications and required routine monitoring. Review of R5's "Nurse's Notes" located in the EMR under the "Notes" tab for June, July and August 2025 revealed no documented behaviors related to the diagnosis of psychotic disorder. During an interview on 08/06/25 at 11:29 AM, Unit Manager (UM)1 was asked if specific target behaviors were listed on the resident's monthly psych evaluation. She said if the resident were having any behavior during a shift it would be documented under progress notes, which she counts all behaviors each month and those behaviors are discussed during their weekly meetings. She stated the side effects were listed on the medication administration review to track but not specific behaviors. She was unable to state how any nurse would know what specific behaviors were tracked for a resident if they were only listed on the monthly psych evaluations. During an interview on 08/07/25 at 3:07 PM, the Director of Nursing (DON) stated she expected staff to be monitoring specific target behaviors for residents with psychotropic medications. NJAC 8:39-4.1(a)NJAC 27.1(a)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to report an allegation of resident-to-resident abuse for two of three residents (Resident (R) 8 and R55) reviewed for abuse out of 33 sampled residents. This failure had the potential to allow for continued abuse. Findings include: 1. Review of R8's "admission Record," located in the "Profile" tab of the EMR, revealed R8 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, bipolar disorder, post-traumatic stress disorder and other schizophrenia. Review of R8's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/21/25 revealed he scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. 2. Review of R55's "admission Record," located in the "Profile" tab of the EMR, revealed R55 admitted to the facility on [DATE] with diagnoses including major depressive disorder and anxiety disorder. Review of R55's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/02/25 revealed he scored three out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of a "Nurse's Notes" located in the EMR under the "Notes" tab written by Licensed Practical Nurse (LPN) 4 dated 05/31/25 revealed nurse reported R8 scratched R55 in face and an incident report was needed. Upon investigation, residents were in dining room in activities and when R8 got in reach of R55, R8 scratched R55's face. When asked why R8 stated I don't know. Residents separated immediately. Review of the Self-Report Form provided by the facility, dated 06/01/25 at 8:04 AM revealed the incident occurred on 05/31/25 at 11:40 AM. During an interview on 08/06/25 at 12:07 PM, LPN4 said immediately after the incident occurred on 05/31/25 she reported it to the corporate nurse and the Administrator. During an interview on 08/07/25 at 5:09 PM, the Administrator stated they did not report the incident within two hours of becoming aware of it because the facility had to complete their investigation first. Review of the facility's policy titled Abuse, Neglect and Exploitation undated revealed, the facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. NJAC 8:39-9.4(f)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure written notice of the transfer to the hospital and the bed hold policy were provided to the resident and the resident's representative upon transfer for three (Resident (R)25, R88, and R4) of four residents reviewed for hospitalization out of a sample of 33 residents. This failure had the potential to cause confusion or distress upon transfer and a lack of understanding of appeal rights or bed hold should the resident not be permitted to return or disagree with the reason for transfer. Findings include: 1. Review of R25's admission Record located in the electronic medical record (EMR) under the Profile tab revealed he was admitted to the facility on [DATE] with diagnoses including stroke and prostate cancer. Family Member (F) 1 was listed as his only emergency contact. Review of R25's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/06/25 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated severely impaired cognition. Review of General Nurses Notes dated 06/28/25 and 06/29/25 and located in the EMR under the Progress Notes tab revealed R25 was sent to the emergency department (ED) on 06/28/25 due to a non-responsive episode. F1 was informed by nursing of the transfer to the ED. He was admitted to the hospital on [DATE]. Review of a copy of R25's Notice of Emergency Transfer to a Hospital and/or Therapeutic Leave dated 06/28/25 and provided by the facility revealed it was directed to R25. The transfer form was addressed: To: _____ with Residents Name under the line where R25's name was handwritten. The transfer form documented the location of the transfer, reason for the transfer, appeal rights, and contact information for appeals and the facility Ombudsman. There was no evidence that this written notice was provided to F1. Review of a copy of R25's Notice A Bed Hold Form dated 06/28/25 and provided by the facility revealed it included the facility's policy on holding a bed and the cost. The form documented: Sent to the hospital with the residents transfer documentation on 6/25/25 by [nursing]. There was no evidence that the form was provided to F1. During an interview on 08/05/2025 at 11:17 AM, F1 reported the facility called him when R25 was sent to the hospital. No verbal information was given regarding the bed hold policy, and no written notice of transfer or bed hold policy were provided to him. 2. Review of R88's admission Record in the EMR under the Profile tab revealed R88 was admitted to the facility on [DATE] with diagnoses including stroke and diabetes. Review of General Nurses Notes dated 11/27/24 and located in the EMR under the Progress Notes tab revealed R88 was taken from an appointment to the hospital where she was admitted for pneumonia. Review of R88's quarterly MDS with an ARD of 07/20/25 and located under the MDS tab of the EMR revealed a BIMS score of 15 out of 15 which indicated intact cognition. The facility was unable to locate a Notice A Bed Hold Form or Notice of Emergency Transfer to a Hospital and/or Therapeutic Leave for R88's 11/27/24 discharge to the hospital. During an interview on 08/04/25 at 11:30 AM, R88 reported she had been hospitalized for pneumonia. She did not recall receiving any written notice of transfer or the bed hold policy. During an interview on 08/06/25 at 12:37 PM, Licensed Practical Nurse (LPN) 1 reported that the facility had a packet of items which went to the hospital with the resident when they were sent to the ED. The packet included the Notice A Bed Hold Form and the Notice of Emergency Transfer to a Hospital and/or Therapeutic Leave both of which were triplicate forms. The white copy went with the resident, and the pink and yellow copies were kept by the facility. During an interview on 08/06/25 at 12:50 PM, the Social Services Director (SSD) reported she received the pink copies of the Notice of Emergency Transfer to a Hospital and/or Therapeutic Leave and Notice A Bed Hold Form and kept them to use for notifying the Ombudsman of the discharges. During an interview on 08/06/25 at 12:53 PM, the Admissions Coordinator stated it was the facility's policy to let the family know of the transfers to the hospital with a phone call. The Admissions Coordinator was not aware of any paper trail regarding (continued on next page)		

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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.			
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the transfer or bed hold policy. During an interview on 08/06/25 at 2:20 PM, LPN3 reported nursing called residents' responsible parties to let them know when a resident was sent to the hospital. She let the responsible party know where the resident went and why. The facility had a packet of items which went to the hospital with the resident. LPN3 said the original of the Notice of Emergency Transfer to a Hospital and/or Therapeutic Leave and Notice A Bed Hold Form was sent with the resident, and she thought the two copies went to the Director of Nursing (DON) and to the Admissions Coordinator, who notified the family. During an interview on 08/06/25 at 4:02 PM, the SSD provided the pink copies of the two forms for R25 but reported she was unable to locate them for R88. To the knowledge of the SSD, no one in the facility followed up with the responsible party and provided the written forms to them. R25's responsible party was F1. R25 was unable to make decisions on his own. There were no forms for R88 because she went directly from an appointment to the hospital, so the facility did not send them with her. During an interview on 08/07/25 at 2:50 PM, the DON stated that nurses filled out the triplicate sheets for the emergency transfer to the hospital and for the bed hold policy. They sent one to the hospital with the resident, gave one to her, and one went to the SSD to notify family. 3. Review of R4's undated admission Record found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy and multiple sclerosis. Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/30/25 located in the EMR under the MDS tab revealed the facility assessed R4 to have a Brief Interview for Mental Status (BIMS) score of one out of 15 indicating severe cognitive abilities. Review of R4's Progress Notes dated 03/31/25 in the EMR under the Progress Notes tab revealed R4 was transferred to the hospital due to increased oral secretions with respiratory distress. R4 was transferred to the hospital. During an interview on 08/07/25 at 1:43 PM, Licensed Practical Nurse (LPN)7 was asked about the Bed Hold. LPN7 stated, The Bed Hold is in triplicate one copy goes to the hospital with the resident. Second goes to the Social Worker (SW) and the third goes to the Director of the Nurses (DON). All we do is call the family member and notify of the hospital. During an interview on 08/07/25 at 2:19 PM, Unit Manager (UM)2 stated the packet is put together and a copy of the Bed Hold is sent with resident, the SW and the DON. UM2 stated the SW will mail the Bed Hold to the family. During an interview on 08/07/25 at 2:44 PM, the SW stated she was not aware of the family receiving the Bed Hold or transfer. Review of the facility's undated Bed Hold Prior to Transfer policy revealed: The facility will have policies that address holding the resident's bed during periods of absence, such as during hospitalization or therapeutic leave. The facility will provide written information about these policies to residents and/or resident representatives prior to and upon transfer for such absences. The facility will provide this written information to all facility residents, regardless of their payment source. Review of the facility's undated Transfer or Discharge, Emergency policy revealed: Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: . Prepare a transfer form to send with the resident; Notify the representative or other family member . The policy failed to contain information regarding the notification to the representative or other family member needed to be in writing. NJAC 8:39-4.1(a)NJAC 8:39-5.1(a)NJAC 8:39-5.3(b)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that an accurate Preadmission Screening and Resident Review (PASARR) Level I assessment was completed after admission for one resident (Resident (R)8) out of 33 sampled residents. This failure increased the risk for the resident not receiving specialized services as determined by a Level II prompted by a Level I that indicated mental illness. Findings include: Review of R8's "admission Record," located in the "Profile" tab of the EMR, revealed R8 admitted to the facility on [DATE] with diagnoses including major depressive disorder, bipolar disorder, post-traumatic stress disorder and other schizophrenia. Review of R8's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/21/25 revealed a score of 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Review of the Facility Reportable Investigation dated 06/01/25 revealed he was physically aggressive towards another resident and was sent out for a psych crisis evaluation. Review of R8's PASARR I, located under the Resident Documents tab in the EMR dated 06/25/25 revealed it did not indicate the resident's diagnosis of bipolar disorder, post-traumatic stress disorder or schizophrenia. Further review revealed it did not indicate R8 was sent out for psychiatric crisis evaluation on 06/01/25. During an interview on 08/07/25 at 11:52 AM, the Social Services Director (SSD) revealed R8's PASARR level I was not completed correctly and based on his diagnosis and crisis intervention R8 should have been referred for a level II PASARR. NJAC 8:39-5.1(a)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure the medical staff documented the correct indication for the use of an antipsychotic medication and instead documented a diagnosis of Schizophrenia in the medical record for one resident (Resident (R) 6) out of five residents reviewed for unnecessary medications out of a total sample of 33 residents. This failure had the potential to cause psychological distress and impact treatment. Findings include: Review of R6's admission Record located in the electronic medical record (EMR) under the Profile tab revealed he was admitted to the facility on [DATE] with diagnoses including Post-Traumatic Stress Disorder (PTSD). Review of the Care Plan tab revealed a focus area, [R6] uses psychotropic medications r/t [related to] mood disorder dated 04/02/25. The Care Plan did not reflect a diagnosis of schizophrenia. Review of a General Nurses Note dated 04/07/25 and located in the EMR under the Progress Notes tab revealed R6 was sent to a hospital for a procedure. Review of an admission Note dated 05/02/25 and located in the EMR under the Progress Notes tab revealed R6 returned to the facility but medications were unable to be verified because he returned without a medication list. The facility was waiting for a fax. Review of a hospital Discharge summary dated [DATE], faxed to the facility on [DATE], and located under the Misc tab of the EMR revealed: continue quetiapine [Seroquel] under the heading of PTSD/mood. The hospital records did not document a diagnosis of schizophrenia. Review of an Order Audit Report for Seroquel (an antipsychotic medication) ordered 05/03/25, located under the Orders tab, revealed the medication order was entered by Licensed Practical Nurse (LPN) 4 and was indicated for schizophrenia. The order was signed by a nurse practitioner on 05/07/25. Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/31/25 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. The MDS indicated R6 had schizophrenia. Review of the Med Diag [Medical Diagnoses] tab of the EMR revealed a diagnosis of schizophrenia was created on 06/06/25 with an effective date of 05/02/25. During an interview on 08/04/25 at 3:43 PM, R6 reported he had PTSD but denied having schizophrenia. During an interview on 08/05/25 at 3:18 PM, the MDS Coordinator (MDSC) stated she entered the diagnosis of schizophrenia into the EMR while she completed the 05/31/25 quarterly MDS assessment. She clicked the Verify button as directed after completing the MDS to review coding inconsistencies for quality measures. An alert showed up: QM [quality measures] Alert: Resident is receiving antipsychotic [medication] without a diagnosis of schizophrenia, Tourette's Syndrome or Huntington's disease. This QM is included in the Five Star calculation. The MDSC stated she saw that R6 had an order for Seroquel for schizophrenia and so used that diagnosis for the MDS and entered the diagnosis in the EMR under the Med Diag tab. During an interview on 08/05/25 at 3:50 PM, the Director of Nursing (DON) reported the nurse practitioner who signed the Seroquel order was on emergency medical leave and unavailable for interview. During an interview on 08/06/25 at 9:25 AM, the Regional Nurse stated the schizophrenia diagnosis was an error on admission. During an interview on 08/06/25 at 4:16 PM, the DON stated she looked over R6's documentation and verified he should not have had a schizophrenia diagnosis. During an interview on 08/07/25 at 3:15 PM, LPN4 reported she knew that Seroquel was tricky to receive from pharmacy without a correct diagnosis. When asked if she saw a schizophrenia diagnosis in his hospital documentation, LPN4 stated she was unable to say she saw it, but she had glanced through R6's records and saw that he had behavioral episodes. LPN4 said she went with her clinical judgment to be able to get the Seroquel from the pharmacy. Review of the facility's Medication and Treatment Orders policy, dated July 2024, revealed: Orders for medications must include: . clinical condition or symptoms for which the medication is prescribed . NJAC 8:39-27.1(a)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide wound treatments as ordered by the physician for one (Resident (R) 80) of 33 sampled residents. Findings include: Review of R80's admission Record located in the electronic medical record (EMR) under the Admission tab revealed R80 was admitted to the facility on [DATE] with diagnoses including cellulitis of other sites and type 2 diabetes mellitus with other circulatory complications. During an observation and interview on 08/04/25 at 11:15 AM, revealed R80 had an ace bandage on his lower right leg. R80 stated the bandage had not been changed since 08/01/25 and it was supposed to be changed daily. During an observation and interview on 08/04/25 at 11:23 AM, Licensed Practical Nurse (LPN1) revealed R80 had a white bandage under an ace bandage dated 08/01 with LPN1's initials. LPN1 also stated she did wound care on R80's lower right leg on 08/01/25. She further stated R80's wound care was supposed to be done daily. Review of the physician order dated 07/28/25 and located in the EMR Orders tab revealed : Cleanse right lower extremity with normal sterile saline apply absorbent dressing followed by cling wrap with ace bandage every day shift for weeping. Record review of the Treatment Administration Record (TAR) located in R80's EMR under the Orders tab revealed the following: Cleanse right lower extremity with normal sterile saline apply absorbent dressing followed by cling wrap with ace bandage everyday shift for weeping. Order date 07/28/25, discharge date [DATE]. During an interview on 08/07/25 at 2:03 PM, the Administrator stated if the resident's bandage was ordered to be changed every day, his expectation was the bandage to be changed every day. During an interview on 08/07/25 at 2:19 PM, the Director of Nurses (DON) stated the resident's bandage should have been changed every day until the order was discharged according to the physician's order. Review of the facility's policy and procedure titled Wound Care, undated, revealed the following: It is the policy of this facility center to provide wound care as directed by physician order to promote healing. NJAC 8:39-3.2(a)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and policy review, the facility failed to ensure a resident utilizing supplemental oxygen (Resident (R) 65) had orders and a plan of care for its use and a resident (R31) had clean oxygen concentrator filters out of two residents reviewed for oxygen use out of a total sample of 33 residents. This failure had the potential to cause impaired respiratory function. Findings include: 1. Review of R65's admission Record located in the electronic medical record (EMR) under the Profile tab revealed she was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia (low oxygen levels), acute pulmonary edema (fluid in the lungs), pleural effusion (fluid between the lung and chest wall), and heart failure. Review of the hospital Discharge summary dated [DATE] and located under the Misc tab of the EMR revealed: Patient received incentive spirometry, . and we weaned O2 [oxygen] as tolerated. Patient has been weaned from 4L [liters] to 1L, baseline is room air. Will discharge with oxygen. It also stated to wean O2 as tolerated. If O2 requirements increase, can consider transfer for pulm [pulmonary] eval [evaluation]. Review of R65's Baseline Care Plan dated 07/21/25 and located under the Evaluations tab of the EMR revealed the box for oxygen therapy was not checked. It included no information regarding supplemental oxygen use. Review of R65's Brief Interview for Mental Status (BIMS) dated 07/22/25 and located under the Evaluations tab of the EMR revealed she scored a seven out of 15, which indicated severely impaired cognition. Review of Medical Visits dated 07/22/25 and 07/23/25 and located under the Evaluations tab of the EMR revealed R65 was: Seen at bedside today. continues with supplemental O2 at 1L via NC [nasal cannula]. Review of the Order Recap Report dated 07/21/25 to 08/04/25 and located under the Orders tab of the EMR revealed an order dated 07/23/25 to consult pulmonology for acute hypoxemia requiring supplemental O2. There were no orders regarding supplemental oxygen use to include the amount of oxygen required or the checking of oxygen saturation levels. Review of a Medical Visit dated 07/24/25 and located under the Evaluations tab of the EMR revealed directions to: Wean FiO2 [supplemental oxygen] to keep O2 sat [greater than] 90%. If pulse OX [oxygen saturation levels] remains above 90 percent, patient may not need long term O2. Review of the unfinished Care Plan on 08/04/25 revealed no documentation of R65's use of supplemental oxygen. Review of the O2 Sats [saturation] Summary dated 08/05/25 revealed five documented oxygen saturation levels from 07/21/25 to 08/01/25 and none after 08/01/25. Review of the Progress Notes tab of the EMR revealed no documentation regarding R65's use of oxygen. During an observation on 08/04/25 at 12:23 PM, R65 had a nasal cannula in her nostrils, connected to oxygen tubing, with the end of the tubing lying on the floor and not connected to any oxygen concentrator or tank. The oxygen concentrator in her room was turned on and set at 1L. R65 did not appear in respiratory distress. During an observation on 08/04/25 at 1:08 PM, R65 held the oxygen tubing in her hand with it not connected to her oxygen concentrator or tank. During an interview on 08/04/25 at 2:14 PM, Licensed Practical Nurse (LPN) 1 stated she recalled R65 needed oxygen when she was first admitted to the facility. She felt R65 had orders on admission to wean off the oxygen and to consult pulmonology if she continued to need oxygen. LPN1 reviewed the EMR Orders tab and located the pulmonology order but no orders indicating the use of oxygen. She then went into R65's room and noted her oxygen tubing was connected to the oxygen tank on the back of her wheelchair, which was set at 1L. LPN1 said sometimes when R65 was in bed she did not use oxygen, and her saturation levels were fine. LPN1 felt R65 used the oxygen more with therapy. During an interview on 08/06/25 at 3:44 PM, the Director of Rehab (DOR) reported R65 needed oxygen during therapy. The therapists checked her saturation levels before and during therapy to determine her needs. R65's oxygen saturations sometimes dropped below 90% during activity while utilizing oxygen. During an interview on 08/06/25 at 4:06 PM, the Director of Nursing (DON) voiced the expectation that if a resident used oxygen there were orders for it in the EMR to include the rate and to check a pulse (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ox (oxygen saturation level) every shift. If there was no order, the nurses were expected to call the provider to obtain one. The nurses were to document oxygen use in the Baseline Care Plan evaluation. Review of the facility's undated Oxygen Administration policy revealed: Oxygen is administered under orders of a physician, except in the case of an emergency. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders. . 2. Review of R31's admission Record, located under the Resident tab of the electronic medical record (EMR), revealed R31 was admitted on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia and acute respiratory failure with hypoxia. Review of R31's quarterly Minimum Data Set (MDS), located in the EMR under the RAI (Resident Assessment Instrument) tab with an Assessment Reference Date (ARD) of 07/13/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating R31 had severe cognitive impairment. Review of R31's Physician Order Sheet, located in the EMR under the Resident tab, revealed the following order dated 07/10/25: Oxygen Inhalation (via nasal cannula @ 2 lpm) every shift check every shift. During observations on 08/04/25 at 10:59 AM, R31's oxygen concentrator had two dust filled filters located on each side of the concentrator. During an interview on 08/05/25 at 3:48 PM, Registered Nurse Supervisor (RN SUP) stated an RN or Licensed Practical Nurse (LPN) were responsible for cleaning oxygen concentrator filters. During an interview and observation on 08/05/25 at 3:50 PM, LPN1 went into R31's room and brought out the filters and showed them to this surveyor on the 100 hall. LPN1 stated both filters were dusty and dirty. LPN1 further stated maintenance were responsible for cleaning oxygen filters. During an interview on 08/05/25 at 3:57 PM, the Maintenance Director (MD) stated the Certified Nurse Aides (CNA) were responsible for cleaning oxygen concentrator filters. During an interview on 08/05/25 at 3:57 PM, the Director of Nurses (DON) stated the nurses were responsible for cleaning the oxygen concentrator filters. She further stated the filters should be cleaned weekly. During an interview on 08/07/25 at 2:03 PM, the Administrator stated his expectation was for the filters to be cleaned weekly. Review of the facility's policy and procedure titled Departmental (Respiratory Therapy Equipment) - (Prevention of Infection), undated, revealed the following: 9. Wash filters from oxygen concentrators as needed with soap and water. Rinse and squeeze dry. NJAC 8:39-27.1(a)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure documentation of assessment prior to, and upon return from, dialysis and failed to ensure communication forms were used between the facility and the dialysis center for one of one resident reviewed for dialysis (Resident (R) 2) out of 33 sampled residents. This had the potential to affect the health of residents receiving dialysis. Findings include: Review of R2's admission Record located in the electronic medical record (EMR) under the Profile tab revealed she was admitted to the facility on [DATE] with diagnoses including end stage renal disease and dependence on renal dialysis. Review of the Care Plan tab revealed a focus area, [R2] needs hemodialysis renal failure dated 03/04/24 with interventions including to check the thrill and bruit (dialysis access site) per protocol, observe/document/report any peripheral edema, any signs of infection to the access site, and any bleeding. Review of the Order Summary Report revealed orders to check vital signs every day shift order date 07/04/24, monitor fistula on left upper extremity every shift dated 05/03/24, remove pressure dressing from dialysis fistula every dialysis day dated 06/03/24, and Dialysis: Dialysis center phone number is: xxx-xxx-xxxx Dialysis days: Monday, Wednesday, Friday. Time for pick up: 4:45 AM, return time 10:30 AM. Transport to: [dialysis center] via wheelchair. with order date 05/03/24. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/10/25 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. The MDS indicated R2 received dialysis. Review of R2's Evaluations tab of the EMR revealed no pre- and post- dialysis evaluations. Review of R2's Medication Administration Record (MAR) dated 07/01/25 - 07/31/25 and located under the Orders tab of the EMR revealed vital signs were recorded daily by day shift but not by night shift when she went out to dialysis. Review of R2's Weights/Vitals and Progress Notes tabs of the EMR revealed inconsistent documentation of pre- and post- dialysis assessments, to include vital signs. Review of R2's Misc tab of the EMR revealed no scanned communication forms between dialysis and the facility. Review of R2's paper chart, located at the nursing desk, revealed Nursing Home Communication Sheets from dialysis to the facility with recorded pre- and post- dialysis weight, blood pressure, and heart rate by dialysis. There were forms for dates: 03/17/25, 03/10/25, 03/21/25, 03/24/25, 03/26/25, 03/28/25, 04/02/25, 05/02/25, and 05/09/25. In addition, the facility was able to provide communication sheets from 07/25/25, 08/01/25, and 08/06/25. There were no communication forms between 04/02/25 to 05/02/25 and between 05/09/25 to 07/25/25. During an interview on 08/05/25 at 8:46 AM, R2 reported she went to dialysis via transport from the facility around 4:00 AM on Mondays, Wednesdays, and Fridays. R2 was unable to recall if the facility staff checked her vital signs, to include her blood pressure, before and after dialysis. She knew they were checked at the dialysis center. R2's dressing over her dialysis access site on her left arm remained intact from her dialysis the day prior. R2 removed the dressing during the conversation and stated, Sometimes when I take it off, I bleed so I put it back. During an interview on 08/06/25 at 2:20 PM, Licensed Practical Nurse (LPN) 3 reported R2 left for dialysis on night shift. When R2 returned on day shift, LPN3 got a paper sent from dialysis with her blood pressure and pre- and post- weights recorded on it. LPN3 stated she put a note in the EMR about what was recorded on the paper from dialysis, and the paper went into R2's paper chart. There were no orders for an assessment upon R2's return from dialysis. During an interview on 08/06/25 at 4:02 PM, the Unit Manager (UM) 1 reported that nursing checked residents' vital signs before they left for dialysis. If there was anything abnormal or anything changed with the residents, nursing called the dialysis center. Dialysis sent a paper communication form back with R2. They were in the paper chart at the desk. In addition, UM1 located three more communication forms from dialysis at the desk that were not in the chart. During an interview on 08/06/25 at 4:05 PM, the Director of Nursing (DON) reported she was used to facilities using communication sheets that went out with (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to dialysis with pertinent information from the facility about the resident's status prior to dialysis as well as the communication from the dialysis center, but she did not think the facility did that. A review of R2's paper chart was completed with the addition of the three dialysis papers provided by UM1, and the DON acknowledged many days were not accounted for. Review of the facility's undated Dialysis policy located in the facility's Survey Binder revealed the facility will send a Dialysis Communication book with communication sheets to be completed and returned. Review of the facility's End Stage Renal Disease, Care of a Resident with policy, updated June 2024, revealed: Staff caring for residents with ESRD [End Stage Renal Disease], including residents receiving dialysis care outside of the facility shall be trained in the care and special needs of these residents. Initiate communication sheets which will be sent and received from the dialysis unit to have routine communication. The communication sheet will be kept on unit and/or in resident medical record. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis. NJAC 8:39-27.1(a)		

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails and that assessments were completed for the risk of entrapment for one of four residents (Resident (R)59) reviewed for side rails out of 33 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment. Findings include: Review of R59's admission Record located in the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder and cognitive communication deficit. Review of R59's annual Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 07/09/25, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating no cognitive impairment. Review of R59's Care Plan, located under the Care Plan tab of the EMR and dated 06/25/24, revealed no intervention related to side rail use. Review of R59's Physician Orders, located under the Orders tab in the EMR and dated 06/27/24, revealed, .may have two half side rails while in bed for repositioning. Review of R59's Resident Evaluation/Bedrail Assist Device, located under the Observations tab in the EMR and dated 06/25/25, revealed no evidence of alternatives explored and no assessment for risk for entrapment. During an interview on 08/06/25 at 11:29 AM, Unit Manager (UM)1 revealed that on admission staff determine if residents need side rails for repositioning, and if so, they get a consent form signed. She said side rails were considered a restraint unless they were used for repositioning and bed mobility. They got a physician order and care planned it and residents were reevaluated quarterly. She said they offer residents alternatives on admission but most of the time they do not want the alternatives, so they are offered the bedrails. UM1 said they do not explore alternates prior to bed rails being used for residents. She said risk for entrapment was done with the consent form, but she did not want to say there was a process to assess for risk of entrapment. She said nursing and nursing assistant staff do a visual observation of the bed and bedrail. During an interview on 08/07/25 at 11:24 AM, the Maintenance Director stated there was not a process to assess for risk of entrapment for bedrail use. During an interview on 08/07/25 at 3:07 PM, the Director of Nursing (DON) said sometimes the family would request bedrails and/or therapy would say if there was a need for bedrails. She said it would be on the care plan, and they got informed consent. She said she was unsure if they are accessing for risk of entrapment or exploring alternatives prior to use. Review of the facility policy titled Siderails undated revealed, each resident has the right to be free from restraints imposed for purposes of convenience or discipline. Siderails will be applied and monitored within the context of individualized care planning after alternative methods for treating the resident's medical symptoms have been found to be ineffective. On admission all residents will be evaluated for side rail use. Maintenance will do side rail entrapment assessment of the bed and equipment. NJAC 8:39-27.1(a)		