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South Jersey Extended Care	99 Manheim Avenue Bridgeton, NJ 08302

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31654 Based on observation, interview and document review it was determined that the facility failed to ensure a resident room and the resident environment was free of insects, and that staff addressed a resident in a dignified manner. This deficient practice occurred for 1 of 20 residents reviewed (Resident #55) and was evidenced by the following: On 06/13/24 at 10:28 AM, Surveyor #1 observed Resident #55 in bed and there was a noticeable urine odor in the room and the resident's urinary catheter was lying on the bed. Resident #55 stated, he/she was waiting for coffee at that time and acknowledged there was an odor. Black flies were noted scattered throughout the room and when asked the resident about the flies, the resident confirmed he/she was aware of the flies. Resident #55 then stated the smell isn't from me. On 06/13/24 at 2:01 PM, Surveyor #1 and #2 observed the resident in bed on top of a pink bedspread, with the urine catheter also on the bed and the bed remote next to it. The surveyors observed two black flies on the bedspread, one on the remote and observed flying in the room. The surveyors requested the Licensed Practical Nurse Unit Manager (LPNUM) to accompany the surveyors to the room. The LPNUM stated Resident #55 was alert and oriented and was non-compliant with care. When asked the LPNUM about the flies and if having flies on the bed and in the room was okay, she stated, it is not okay, it is not clean. The LPNUM stated then stated she never saw the flies before. On 06/14/24 at 9:07 AM, Surveyor #2 observed black flies inside of Resident #55's room while resident was eating a meal. A black fly was on top of the burgundy meal tray lid that was on the bed next to the resident. Surveyor #2 requested the nurse (LPN #2) to come to the resident's room. The surveyor showed the nurse the flies and LPN #2 stated Resident #55 was very hard of hearing and he/she is a very noncompliant [gender redacted] and walked away from the surveyor and exited the room. Surveyor #2 interviewed LPN #2 at the nursing station about Resident #55 and the flies. LPN #2 stated, Resident #55 was a dirty old [gender redacted]. Surveyor #2 asked LPN #2 if that is what she called her residents and she stated he/she was set in his/her ways. On 06/14/24 at 10:08 AM, the Director of Nursing (DON) provided a Promoting/Maintaining Resident Dignity Policy, implemented 01/09/24 which revealed: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 10. Speak respectfully to residents; avoid discussions about residents that may be overheard. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/14/24 at 11:01 AM, Surveyor #2 in the presence of another surveyor interviewed the DON regarding the observations of flies and how LPN #2 spoke about Resident #55 at the nursing station as others walked by. Surveyor #2 then asked if what LPN #2 referred to the resident as was okay. The DON stated, no, that was not okay and stated that she heard about what happened and that the LPN #2 was trying to be cute and it was a dignity issue. On 06/17/24 at 10:35 AM, Surveyor #1 observed Resident #55 in bed, and the urinary catheter bag was observed on the floor and black flies were observed in the room. On 06/19/24 at 11:34 PM, the survey team held an exit conference with the DON, Infection Preventionist, and Licensensed Nursing Home Administrator to reviewed the above concerns. NJAC 8:39-4.1(11)(12)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 27193 Based on observation, interviews and record review, the facility failed to ensure Resident #12 preferences had been accommodated. This deficient practice occurred for 1 of 20 residents reviewed (Resident #12) for accommodation of needs and was evidenced by the following: During the initial tour on 6/14/24 at 10:31 AM, interview with Resident #12 revealed that would like to get out of the bed at a certain time and their wishes had not been honored. On 6/17/24 at 10:14 AM surveyor #2 followed up with Resident #12 regarding their concerns. The observation of Resident #12 revealed that Resident #12 was in bed dressed in a hospital gown. Resident #12 was upset and was crying to the surveyor and stated that he/she had not been able to contact their family. Resident #12 further stated that their belongings were still at the other facility and could not get in touch with the Social Worker (SW). When inquired if the resident enlisted the assistance of the SW at the current facility, Resident #12 stated, yes but nothing had been done. On 6/17/24 at 12:30 PM, the surveyor reviewed Resident #12 admission record. The admission face sheet reflected that Resident #12 had diagnoses which included but were not limited to; metabolic encephalopathy, difficulty in walking, weakness and morbid obesity. Review of the 2/16/24 Quarterly Minimum Data Set Assessment in the Electronic Medical Recort (EMR) for Resident #12 revealed that Resident #12 had no difficulties with communication, vision, hearing, or cognitive function. Resident #12 received a score of 15/15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. Resident #12 reported to the surveyor that it was very important for him/her to: Choose what to wear, take care of their personal belongings, and have family involved in their care. Review of Resident's #12 comprehensive care plan addressed, ADLs Self Care Performance Deficit with the goal to maintain a sense of dignity by being clean, dry odor free and well groomed. Bed mobility, but did not specify their choice for their time to get out of bed. Review of the progress notes from social services dated 4/19/24 revealed that she attempted to call the Social Worker (SW) at the prior facility regarding Resident #12's belongings, but was unsuccessful. No other attempts were documented in the EMR. On 6/17/24 at 9:30 AM, the surveyor met with the Director of Social Services, to inquire regarding Resident #12's personal belongings. The SW informed the surveyor that she called the prior facility several times and could not reach the SW. While in her office she called the facility, and she was prompted to leave a message or to call later. The surveyor then asked the SW what other methods could have been used to communicate with the facility, the SW stated that she could have sent a letter to the facility but had not done so. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/18/24 the surveyor met again with the SW and inquired regarding if she was able to contact the prior facility, she stated no. The surveyor then inquired if she discussed the concerns with the facility's Administrator for further guidance she replied, No. On 06/18/24 at 10:30 AM, the surveyor observed the resident sitting at the nursing station, dressed in a hospital gown and was seated in a recliner chair. The resident stated, [he/she] would feel much better, wearing their own personal clothing. On 6/19/24 at 12:30 the survey team presented the above concerns to the facility and requested any documentation regarding how Resident #12's concerns were addressed by the facility. On 6/19/24 at 2:30 PM the Administrator provided a letter dated 6/19/24 that will be forwarded to the facility on behalf of Resident #12. Resident #12 had been at the facility since February. The surveyor contacted the facility on 6/19/24 and left a message with the receptionist for the Director of Nursing and the SW. The facility's SW returned the call and informed the surveyor that she never received any correspondence from the SW. The SW further stated that she was informed only on 6/18/24 that Resident #12 was trying to locate their personal belongings. The SW went on to state that Resident #12's family could not be contacted. A review of the Resident's rights policy dated, last revised. NJAC 8:39-27.1(a)

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 31654 Based on interview and document review it was determined that the facility failed to ensure a Surety Bond was in place to provide coverage to protect resident personal needs account funds held by the facility. The deficient practice effected all residents who had personal needs funds held by the facility and was evidence by the following: On 06/13/24 at 2:00 PM. and again on 06/14/24 at 9:00 AM, the surveyor requested a facility Surety Bond from the Liscensed Nursing Home Administrator (LNHA). On 06/14/24 at 9:30 AM, the LNHA provided a Funds Balance Report for 06/03/24 which listed 48 active residents with a combined balance of $20,829.05. The surveyor again requested a Surety Bond from the LNHA. On 06/14/24 at 12:20 PM, the LNHA provided a Commercial Crime Policy effective: July 24, 2023- July 24, 2024, for a Bond Limit: $90,000. The policy did not specify any coverage to secure resident funds. On 06/14/24 at 11:37 AM, during an interview with the LNHA, in the presence of four surveyors, the LNHA provided a copy of a surety bond, effective June 14, 2024 for $100,000. The surveyor inquired to the LNHA why the surety bond was effective the same day and the LNHA stated he told the new business office that he needed the surety bond as soon as possible and he was provided the copy on June 14, 2024 and the surety bond was effective the same day. The surveyor requested the prior surety bond. On 06/17/24 at 9:12 AM, the LNHA provided a copy of a Certificate of Property Insurance, dated 06/14/24. The document revealed the Type of Policy: Crime, Limits: $90,000. The LNHA then stated that was the surety bond policy. On 06/17/24 at 11:01 AM, the Director of Nursing provided the Surety Bond Requirements, Policy dated 11/01/23. The Policy Explanation and Compliance Guidelines: revealed 1. The facility must be able to show proof that it has a surety bond, or another alternative to a surety bond, a crime policy etc. 3. Reasonable alternatives to a surety bond must: a. Designate the oblige (depending on State law, the resident individually or in aggregate, or the Stte on behalf of each resident) who can collect in case of a loss; B. Specify that the oblige may collect due to any failure by the facility, when by omission, bankruptcy, or omission, to hold, safeguard,, manage, and account for the residents' funds; and ac. Be managed by a third party unrelated in any way to the facility or its management. 4. Self insurance is not an acceptable alternative to a surety bond. On 06/19/24 at 1:39 PM, during the exit conference, the surveyor asked the LNHA why the surety bond was effective after surveyor inquiry. The LNHA stated, he cannot speak to the old owners, and did not respond as to why the bond was not in place prior to surveyor inquiry. The facility had no additional information to provide. NJAC 8:39-9.5(d)1

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 31654 Based on observation and interview it was determined that the facility failed to maintain all resident rooms and common areas in a clean and sanitary manner. The deficient practice occurred on 1 of 3 units and in the Sub-Acute smoking courtyard and was evidenced by the following: On 6/13/24 at 10:41 AM, two surveyors toured the Sub-Acute smoking courtyard and observed cigarette butts were located throughout the lawn area surrounding the gazebo, on top of a garbage can and partially filling the inside of an open bucket that rested on the ground which included empty cigarette packages. There were signs posted to utilize cigarette disposal not the ground. On 06/17/24 at 9:39 AM, the surveyor observed Resident #47 in bed and observed the privacy curtain was stained in several areas, there was soiled areas on several walls and a broken window blind with flies in the room. The surveyor asked about the flies and the resident confirmed there were flies in the room. On 06/19/24 at 11:13 AM, the surveyor, in the presence of the survey team informed the LNHA, Director of Nursing and Interum Infection Preventionist nurse of the above findings. NJSA 8:39-4.1(11)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38680 Based on observation, interview, and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASARR) level II assessment after a resident was newly diagnosed with a mental illness. This deficient practice was identified in 1 of 2 residents reviewed for Preadmission Screening and Resident Review PASARR (Resident #44) and was evidenced by the following: Resident #44 was a resident of the facility. On 06/13/2024 at 11:43 AM the surveyor reviewed the Level I PASARR (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) for Resident #44 dated 12/21/17 which was negative, meaning the resident did not have any mental illness diagnoses that could lead to a chronic disability. The surveyor reviewed the quarterly Minimum Data Set (MDS), an assessment tool dated 10/4/2023. The MDS reflected that Resident #44 was cognitively intact and had a diagnosis of depression. On 06/13/24 at 1:49 PM the surveyor reviewed the Annual MDS dated [DATE], which reflected that Resident #44 was not currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability or a related condition. It reflected that Resident #44 had diagnoses which include but are not limited to depression and psychotic disorder (a psychiatric illness). On 06/17/2024 at 9:36 AM the surveyor reviewed the psychiatry consult for Resident #44 dated 12/28/23. The consult included a new diagnosis of psychosis. During an interview with the surveyor on 06/17/2024 at 9:52 AM, the Director of Social Services (SW) who began working at the facility in February of 2024 and stated that when a resident was diagnosed with a new psychiatric disorder, it would prompt an interdisciplinary conference for the resident. She would request that a Level II PASARR be completed. The SW stated she does not have a PASARR Level II for Resident #44 since the new psychiatric diagnosis on 12/28/23. During an interview with the surveyor on 06/17/24 at 10:22 AM, the [NAME] President of Clinical Services Interrum Infection Preventionist stated that a new psychiatric diagnosis should have triggered a PASARR level II. The surveyor reviewed the facility policy titled, Resident Assessment-Coordination with PASARR Program, with a date implemented on 1/10/24. The policy reflected that any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level ii resident review. Examples include A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). NJAC 8:39-27.1 (a)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 00167157 Based on interview and rerecords review, it was determined that the facility failed to address Resident #194's (Activities of Daily Living) ADLs care needs by ensuring that the resident was independent with care prior to discharge. The facility did not have a care plan that addressed discharge. The facility discharged Resident #194 without addressing and acknowledging family members voiced concerns of the resident being unable to independently care for himself/herself. This deficient practice was identified for 1 of 2 residents reviewed for discharge and was evidenced by the following: On 6/17/24 at 10:30 AM, the surveyor reviewed Resident #194's closed medical record. Resident #194 was admitted to the facility on [DATE] and discharged on [DATE]. Resident #194's diagnoses included but were not limited to; Hypertension, pulmonary emboli, deep vein thrombosis, pneumomediastenum, multiple hemorrhagic strokes and intravenous drug use. A review of the Discharge Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #194 had intact cognition. Resident #194 scored 14 out of 15 on the Brief Interview For Mental Status (BIMS). Resident #194 required assistance with bed mobility and transfer. Resident #194 needed one-person physical assist with toileting. A review of the comprehensive care plan dated 04/17/2023 did not include a care plan for discharge planning. Review of a progress notes dated 6/29/23, revealed Resident #194 was out on pass. The progress note further indicated that Resident #194 was to return to the facility on [DATE] for discharge and the note continued and indicated that Resident #194 was previously notified via care conference (no date). On 6/18/24 at 9:30 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) regarding the facility's discharge protocol. The LPN/UM stated that the discharge planning must be initiated on admission. The resident's goals for discharge must be discussed and reviewed by all involved with the resident's care. Prior to discharge, the Interdisciplinary team will convene to review the plan and formulate the discharge summary. The surveyor showed a copy of the discharge paperwork to the UM who confirmed that the discharge was incomplete and there was no physician order for the discharge. On 6/18/24 at 10:30 AM, the surveyor reviewed the Physical Therapy (PT) Evaluation completed on 4/11/23 which indicated that Resident #194 demonstrated good rehab potential as evidenced by ability to follow 2-steps directions, high prior level of functioning and strong family support. The Occupational (OT) Therapy Evaluation also completed and signed on 4/15/23 revealed that Resident #194 demonstrates excellent rehabilitation potential as evidenced by ability to follow 1-step directions and ability to initiate targets with a target date of 5/21/23. There were no further entries from PT/OT included in the medical record indicated resident #194 met the goals. The Therapy screen completed upon admission did not include the goal for discharge and the level of care that would be required upon discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/23 at 11:00 AM, the surveyor attempted to contact via telephone, and then left a message for the Resident Representative (RR). The RR returned the call on 6/24/24 and requested to be called later. On 6/24/24 at 7:14 PM, during a telephone interview with the surveyor, the RR revealed that the resident was discharged home despite not being ready for discharge. The facility informed the resident that he/she was being discharged because the Health Insurance would expire and would not pay for their stay. The RR further stated that she had informed the facility that Resident #194 still needed assistance with care and should not be discharged . An interview on June 19, 2024 at 12:30 PM, with the nurse who initiated the discharge summary, revealed that she was not familiar with the resident's care. She was employed by an agency at that time and was not familiar with paperwork to be completed prior to discharge. The nurse revealed she had completed the discharge paperwork on June 30, 2024, for Resident #194. The surveyor showed the incomplete discharge paperwork to the nurse, who then stated she was instructed to complete the paperwork. The nurse further stated that day was the only day she had worked with this resident, and she really didn't know much about the resident. An interview with the Director of Nursing (DON) on June 18, 2024, at 11:30 AM, who was then the Assistant Director of Nursing, revealed that the discharge summary was incomplete and there was not much she could do about it as she was not the physician. On June 19, at 1:30 PM, an interview with the Regional Nurse (Interum Infection Preventionist) who was at the facility to assist with the survey, revealed that moving forward, the facility would develop a discharge planning and all the disciplines will be involved with the discharge planning. A review of the facility's policy titled, Discharge Planning last reviewed, 2/16/24 included the following: Objective: To evaluate each resident relative to their potential for discharge to a least restrictive environment and to make recommendations to facilitate that goal. Goal: The discharge plan utilizes the interdisciplinary approach to plan for care in an attempt to bring all disciplines together to formulate individual goals and a personalized plan of care for each resident. All disciplines interact to establish objectives in order to provide this continuity of care. Within 7 days of admission, each discipline must enter on the Discharge planning form their discharge plan. The attending physician of each resident must estimate how long the resident will stay and record the resident's potential for discharge. Each discipline, including the resident and/ or their family, shall have input into their own formulation of the most appropriate treatment and discharge goal. Discharging Procedure: (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents are usually discharge only upon the written order of the attending physician. Or the sponsor may sign a form for discharge against medical advice. The facility failed to follow their own policy. The discharge summary revealed that the discharge form must be completed within 30 days of discharge. The discharge Form provided by the facility on 06/13/24 was not completed and not signed by the physician. NJAC 8:39-5.4 (b)(c)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 27193 Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to provide appropriate incontinence care, and personal hygiene care for 1 of 2 residents. (Resident #12) reviewed for activities of daily living. The deficient practice was evidenced by the following: On 06/17/24 at 9:24 AM, the surveyor observed Resident #12 in bed. Resident #12 was alert and stated that incontinence care was not provided in a timely manner. When asked to elaborate, Resident #12 stated he/she was assisted with incontinence care at 11:00 PM and again this morning at 3:00 AM. Upon inquiry, the resident stated that he/she had not received care yet. The resident further stated that he/she was soiled and would like to be changed. The surveyor left the room and informed the Licensed Practical Nurse/Unit Manager. The Unit Manager provided the surveyor with the assignment sheet and identified the Certified Nursing Aide (CNA) assigned to the resident. On 06/17/24 at 9:44 AM, the surveyor interviewed the CNA who had Resident #12 on her assignment. The CNA revealed that she had 10 residents on her assignment of which seven of them required total assistance with care. The CNA confirmed that she had not yet provided incontinence care to Resident #12. The CNA stated that by 11:00 AM she would complete her first round and provide incontinence care to all. On 06/17/24 at 10:00 AM the surveyor asked the CNA if she can check Resident #12. Resident #12 agreed to be changed. The surveyor and the CNA observed that Resident #12 wore 2 incontinent briefs which were saturated with urine. The pad underneath the resident was also soiled. The CNA indicated that was not the first time she observed the residents with double briefs. The surveyor then left the room and accompanied the LPN/UM to the room. At the surveyor's request, the resident's incontinent brief was checked by staff, and we all observed Resident #12 with two incontinent briefs which were saturated with urine. When asked about her expectations, the UM replied, the resident should not have double briefs on. The UM further stated that the concerns with double briefs were addressed sometimes this year and the staff was in-serviced. On 06/17/24 at 11:55 AM, the surveyor again with the UM regarding incontinence care. The UM stated that the facility's protocol was to provide incontinence care every 2 hours and as needed. The UM further stated that the concerns with double briefs was discussed at morning meeting and in-service education was provided this year. On 06/18/24 at 10:45 AM, the surveyor reviewed Resident #12's electronic medical record. Resident #12's Admission Record (AR) revealed, Resident #12 was admitted to the facility with diagnoses which included but were not limited to; difficulty in walking, weakness, chronic respiratory failure, and morbid obesity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set (MDS) assessment tool used by the facility to prioritize care, dated 02/29/24, revealed that Resident #12 scored 15/15 on the Brief Interview for Mental Status (BIMS) and indicated the resident was cognitively intact. Section GG of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #12 was totally on staff for toileting and hygienic care. Review of the Care Plan for Resident #12 initiated on 05/20/24, included a Focus for ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner related to: functional limitations in range of motion or decrease mobility., Behaviors., pain. The goal was for Resident #12 will maintain a sense of dignity by being clean dry, odor free, and well groomed through the next review date. Resident #12 had a focus for Incontinence/ bowel and bladder related to Disease Process, Impaired mobility, physical limitations. The interventions were to check frequently for wetness and soiling, change as needed. Initiated 05/20/24. Resident #12 wears extended wear/night time briefs at night to assist in preventing interrupted sleep for incontinent care. The care plan did not specify the frequency for staff to provide incontinence care to the resident. Resident #12 was provided with incontinence care at 3:00 AM and then seven hours later at the surveyor's request 10:30 AM. On 06/18/24 at 7:16 AM, the surveyor interviewed the 11:00 AM- 7:00 AM LPN regarding incontinence care. The LPN stated that incontinence care was to be provided every 2 hours depending on the level of resident incontinence. The LPN further stated that all residents were to be changed x 2 during the shift. When inquired regarding residents wearing double briefs and stated, that was not the practice. On 06/19/24 at 11:30 AM, the facility was made aware of the above concerns and requested the facility policy for incontinence care and Activity of daily living. On 06/19/24 at 3:00 PM, during the exit conference that was held with the survey team, the Director of Nursing (DON), Licensed Nursing Home Administrator and the Interim Infection Preventionist (IP), the IP stated, that staff should not use double briefs on the residents. A review of the facility's policy titled, Activities of Daily Living (ADLs) implemented 3/5/24 revealed the following: Policy The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: Bathing dressing, grooming and oral care. Policy Explanation and compliance Guidelines Guideline #3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a form titled, Resident Care- Certified Nursing Assistant Responsibilities provided by the facility on 6/17/24, indicated the following: All residents must be properly dressed, clothes neat and clean, females must have bra and proper unclothes. Residents must be assisted with toileting as needed. Any resident on bowel and bladder training must be toileted every 2 hours and as needed. All residents must be treated with dignity and respect. NJAC 8:39-27.1 (a)2(h)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. 49712 Based on interview, record review, and pertinent facility documentation it was determined that the facility failed to identify conflicting physician's orders for emergency treatment on the medical record for 1 of 1 resident reviewed for cardio-pulmonary resuscitation (a medical procedure involving repeated compressions of a person's chest, performed in an attempt to restore blood flow to and breathing of a person whose heart stopped), resident #49. This deficient practice was evidenced by: A review of Resident #49's Order Summary Report in the Electronic Medical Record (EMR) revealed that, resident #49 had a full code order with a start date of 05/02/2024, and a DNR/DNI (do not resuscitate/do not intubate (to insert a tube into a person's throat, to help with breathing) order with a start date of 01/29/2024. A review of Resident #49's New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) dated 10/03/2022, contained the following order: Do not attempt resuscitation, allow natural death, and do not intubate. On 06/17/2024 at 12:33 PM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) Unit Manager (LPN/UM), stated that Resident #49 was a DNR/DNI. The surveyor reviewed the DNR/DNI, and the (POLST) with the LPN/UM, the LPN/UM confirmed it was a conflicted order, she stated that the order should not say, Full code as well. On 06/19/2024 at 11:34 AM, during an interview with the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), and the Interim Infection Control Preventionist (IP) the surveyor asked if Resident #49 should have both full code and DNR/DNI status. The IP stated, no. Review of the facility's POLST/Advanced Directive policy dated 11/13/23, the policy revealed under #5 the following: Upon, a quarterly basis or significant change, code status will be reviewed with the resident or health care representative. NJAC 8:39-9.6 (b)

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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** 31654 Based on interview and document review it was determined that the facility failed to ensure that a system was in place and followed to review and notify physicians of laboratory values. This deficient practice occurred for 1 of 20 residents reviewed (Resident #47) and was evidenced by the following: On 06/17/24 at 9:39 AM, observed resident in bed and respond pretty good I guess when asked how was doing. A review of the electronic medical record revealed resident was discharged to the hospital and admitted for six days, and a discharge summary from the hospital, revealed the discharge diagnoses that included acute kidney injury, altered mental status, dehydration, hypernatremia (elevated blood sodium levels), Diabetes Type 2 and Urinary Tract Infection. A Nutrition Note dated: 06/12/24, timed 17:15 [5:15 PM] that was completed by the Registered Dietitian, revealed: Assessment and Plans: Resident is on a NCS [no concentrated sweets] puree diet. Intake varies. Is supplemented with 237 ml Glucerna daily [nutritional drink for protein and calories]. Weight June 122#, May 118#, [DATE]#. Was sick past 6 months. BS [blood glucose] still uncontrolled A1C [HbA1C a laboratory value that measures the average blood glucose level for the past three months] 11.8. Monitor intake, weight and labs [laboratory values]. Reviewed Lab Result which was located in a tab in the Electronic Medical Record which revealed HbA1C; Collection Date: 6/4/2024; 03:15 Received Date: 6/4/2024 15:05 Reported Date: 6/4/2024 16:35 HbA1C 11.8 % (highlighted in orange) <=5.6 H [high] FinalReport contains abnormal results (results highlighted with orange text). The surveyor reviewed the Electronic Medical Record from 06/04/24 through current and did not locate any documentation where the HbA1C was referred to the physician or the physician reviewed the laboratory value that was identified by the Registered Dietitian as the resident had uncontrolled blood glucose. On 06/17/24 at 11:43 AM, the surveyor interviewed the Director of Nursing (DON) regarding physician coverage and the DON stated the nurse practitioner came to the facility twice weekly, and completed progress notes. 06/17/24 at 11:53 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPNUM) for Resident #47. The surveyor asked about the process when receiving labs and the LPNUM stated the labs would pop up under each resident in a tab, and the nurse or LPNUM would check it and notify the physician or nurse practitioner. The surveyor asked about the 06/04/24 HbA1C level and the LPNUM reviewed the lab in the computer in the presence of the surveyor. The surveyor asked if the physician was notified of the abnormal result as the surveyor could not locate any documentation. The LPNUM reviewed the progress notes and stated, I don't see anything either. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/24 at 12:12 PM, the surveyor conducted a telephone interview with the Medical Director/Resident #47's physician, regarding when he should be notified of abnormal laboratory values and he stated the same day. NJAC 8:39-27.1(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 38680 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to obtain a Physician's Order (PO) for an orthotic device for 1 of 1 resident (Resident#14) reviewed for positioning and mobility. On 06/13/2024 at 10:04 AM, the surveyor observed Resident #14 in the bed. An orthotic device was observed near Resident #14's right elbow. According to the Admission Record, Resident #14 was admitted to the facility with a diagnosis including but not limited to; multiple sclerosis (a chronic disease of the central nervous system), cerebral infarction (a stroke) and hemiplegia (paralysis). Review of the Annual Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated 03/30/2024, reflected that the resident was cognitively intact and had impaired use of the upper extremity on one side of the body. Review of the Order Summary Report with active orders as of 06/18/2024 did not reveal an order for Resident #14's orthotic device for the right elbow. Review of Resident #14's current Care Plan reflected that Resident #14 required assistance with activities of daily living. The interventions included to encourage use of the elbow splint. Review of Resident #14's occupational therapy discharge summary from 01/16/2024 reflected recommendations for a right elbow extension orthotic as tolerated. During an interview with the surveyor on 06/18/2024 at 7:47 AM, the [NAME] President of Clinical Services (VPCS) stated that there should be an order for Resident #14's right elbow orthotic. The surveyor and the VPCS reviewed the physician orders for Resident #14 together. The VPCS acknowledged that there was no physician order for the right elbow orthotic. During an interview with the surveyor on 06/18/2024 at 10:19 AM, the Licensed Practical Nurse #1 stated that there should be a physician order for an orthotic. Review of the facility policy titled Range of Motion, Splinting, Bracing implemented 1/10/24 reflected that a physician's order must be obtained for use of equipment such as splints, braces, handrolls. NJAC 8:39-27.1 (a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49712 Based on observation, interview and document review it was determined that the facility failed to ensure the smoking policy was followed to ensure the safety for residents who smoked and held their own cigarettes and lighters. This deficient practice occurred for 2 of 2 residents who held their own lighters (Resident #22 and #25) and was evidenced by the following: a. During the initial tour on 6/13/2024 at 09:49 AM, the surveyor observed Resident #22 in their room. Upon inquiry, Resident #22 informed the surveyor that he/she was a smoker. On 06/17/2024 at 10:38 AM, the surveyor observed Resident #22 in the designated smoking area and was smoking. On 06/18/2024 at 09:00 AM, the surveyor observed Resident #22 in their room. Resident #22 informed the surveyor that they held their own cigarettes and lighter. The resident showed to the surveyor their cigarettes and lighter and stated that the facility was aware. On 6/18/24 at 10:30 AM, the surveyor reviewed Resident #22's medical record. The Admission Summary reflected that Resident #22 was admitted to the facility with diagnoses which included but were not limited to; Respiratory failure (a condition that makes it difficult to breathe on your own), gastro-esophageal reflux disease (a digestive disease in which stomach acid irritates the food pipe lining), and Alcohol Abuse, uncomplicated. A review of the Annual Minimum Data Set (MDS) dated [DATE], an assessment tool used to facilitate resident care, revealed that Resident b#22 had intact cognition. Resident #22 scored 15/15 on the Brief Interview for Mental Status (BIMS). A review of a Care Plan with an initiated date of 06/13/24, revealed a focus area for Smoking. The goal was for Resident #22 will abide by the facility's smoking policy and remain safe during smoking times through the next review. The interventions included to remind residents and their family that all cigarettes, lighters, matches, and smoking paraphernalia must be kept at the nurses station. On 6/18/24 at 9:14 AM, the surveyor interviewed the Smoking Aide who informed the surveyor that alert residents could hold their own cigarettes and lighters. On 06/18/2024 at 11:33 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated, We don't allow residents to have their own lighters for safety reasons. On 06/18/24 at 12:37 PM, the surveyor interviewed the Social worker (SW) who stated, if residents were care planed as an independent smoker, they could hold their own cigarettes and lighter. The surveyor reviewed with the SW Resident #22's care plan. The SW stated then, No, they should not have their lighter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/18/2024 at 12:41 PM, during an interview with the surveyor, on the Licensed Practical Nurse (LPN) Unit Manager confirmed that residents should not hold their lighters because it was a smoking hazard. A review of an undated smoking policy provided by the facility policy titled Smoking Policy revealed under subsection procedure that 8. The smoking monitor will be assigned to observe the courtyard to monitor all smokers. All residents will have their products lit by the smoking monitor or designated staff. 31654 b. On 06/14/24 at 11:50 AM, five surveyors were in the conference room and observed Resident #25 walk past the back of the building by the Sub Acute area bordering the woods, was on a path and was observed smoking a cigarette. At that time, the surveyor reviewed the electronic Medical Record (EMR) for Resident #25 which revealed the following Care Plan: Focus Smoking: Resident is a smoker and is at risk for injury. Resident is an independent smoker and does not require direct supervision to smoke. Date Initiated: 05/27/2024 Revision on: 05/27/2024 Goal: -Resident will abide by facility's smoking policy and remain safe during smoking times through the next review. Date Initiated: 05/27/2024 Revision on: 06/13/2024 Target Date: 10/15/2024 - Resident will smoke in designated areas without occurrence of injury through the next review. Date Initiated: 05/27/2024 Revision on: 06/13/2024 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Target Date: 10/15/2024 Interventions - Perform smoking assessment according to facility policy. Date Initiated: 05/27/2024 - Educate resident on smoking policy. Date Initiated: 05/27/2024 - INDEPENDENT SMOKER: Resident is an independent smoker and does not require the use of a smoking apron or direct staff supervision during smoking breaks. Date Initiated: 05/27/2024. (The Care Plan did not indicate the resident was able to hold own smoking material and lighter and walk around the building smoking.) Resident #25's most recent smoking assessment, dated 02/12/24 revealed #3 Is resident physically capable of holding a cigarette, matches/lighter, and lighting and extinguishing own cigarette without assistance; yes; 9. Has resident been instructed in facility policy regarding safety of himself/herself or others; yes; 10. Has resident signed the [Facility Name] smoking agreement and smoker release of responsibility form, yes. On 06/14/24 at 11:58 AM, a surveyor observed Resident #25 entering the building from the main entrance. The surveyor inquired as to what the resident did outside and the Resident stated was outside walking the parameter of the building and was smoking. Resident #25 stated he/she smoked a pack of cigarettes a day and stated kept a personal lighter to light his/her own cigarettes. The Smoking Policy, provided on 06/13/24 at 12:00 by the LNHA revealed Safe smoking assessment and smoking rules. Purpose to determine a resident's level of ability to smoke safely. Procedure: 1. Upon admission, the social worker or admitting nurse will determine if the resident is a smoker. 6. Residents are only permitted to smoke in the designated smoking area. 8. The smoking monitor will be assigned to observe the courtyard to monitor all smokers. All residents will have their products lit by the smoking monitor or designated staff member. On 06/18/24 at 11:30 AM, the surveyor conducted an interview with the LNHA, in the presence of the survey team, regarding the smoking policy. The LNHA confirmed the policy was the current policy and asked per the policy could a resident hold their own lighter and light there own cigarettes. The LNHA stated, we don't allow them to have lighters and asked why not and the LNHA stated, safety. NJAC 8:39-31.6 (e)

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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. 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to follow the physician orders related to the use of continuous oxygen (O2) for 1 of 1 resident (Resident #42) reviewed for the use of oxygen. This deficient practice was evidenced by the following: On 06/13/2024 at 9:44 AM, the surveyor observed a staff member assisting Resident #42 via a recliner chair, into the common area of the facility. The surveyor observed Resident #42 was wearing a nasal cannula attached to a portable O2 tank and the amount was set at 2 liters per minute (lpm) of oxygen. On 06/14/2024 at 8:43 AM, the surveyor observed the resident's privacy curtain drawn around the bed and could hear a staff member assisting the resident. At that time, the surveyor observed the resident's recliner chair in the hallway. The portable O2 tank was on the back of the chair and there was tubing with the nasal cannula wrapped around the tank. The nasal cannula was not in a protective covering and was exposed to the environment. On 06/14/2024 at 8:59 AM, the surveyor returned and observed Resident #42 in bed with his/her eyes closed. There was no oxygen being administered and the nasal cannula was tucked under the mechanical lift pad that was under the resident. A review of Resident #42's hybrid (both paper and electronic) medical records revealed an Admission Record with diagnoses which included but were not limited to; diffuse traumatic brain injury, unspecified psychosis, seizures, dysphagia (difficulty swallowing), dementia, and respiratory failure. A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool used to prioritize care, dated 05/17/2024, included but was not limited to; Section B the resident was coded a 3 rarely/never understood when considering ability to express ideas; Section C the Brief Interview for Mental Status (BIMS) was coded 0 for no the interview should not be conducted as the resident was rarely/never understood; Section GG indicated the resident was dependent on staff for Activities of Daily Living (ADL); and Section O indicated the resident required oxygen therapy. A review of the Order Summary Report included but was not limited to; O2 at 2 lpm via n/c (nasal cannula) every shift dated 04/02/2024. A review of the resident-centered, on-going Care Plan included but was not limited to; a focus area of Communication related to weak or absent voice with interventions including to anticipate and meet needs; and Respiratory Status impaired and is at risk for shortness of breath, respiratory distress, increased anxiety, and hypoxia (lack of oxygen) with interventions including to administer medications [oxygen] and to monitor the resident's respiratory status. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/14/2024 at 9:02 AM, the Director of Nursing (DON) was in the hallway by the resident's room. The surveyor asked the DON to come to the resident's room. The DON acknowledged the resident was not wearing his/her O2 and stated he/she should be wearing the O2 so the resident can breathe. The DON also acknowledged that the nasal cannula on both the room oxygen concentrator and the recliner chair portable oxygen tank were both uncovered and exposed to the environment. The DON asked the Licensed Practical Nurse Unit Manager (LPN UM) to come to the room. The LPN UM acknowledged the resident was not being administered his/her continuous oxygen as ordered and assessed Resident #42's O2 level. The DON obtained new O2 tubing and nasal cannula to administer the physician ordered continuous O2 to the resident. A review of the facility provided, Oxygen Administration policy revised 10/2010, included but was not limited to; Purpose: . to provide guidelines for safe oxygen administration. Preparation: . verify that there is a physician's order. Steps in the Procedure: . 9. Place the appropriate oxygen device (i.e. nasal cannula) on the resident. 10. Adjust the oxygen delivery device . proper flow of oxygen is being administered. 13. Observe the resident . and periodically to be sure oxygen is being tolerated. On 06/19/2024 at 11:13 AM, the above concern was addressed with the Licensed Nursing Home Administrator, the DON, and a Corporate nurse who was the facility interim Infection Preventionist. The facility stated the Oxygen policy provided was the only one the facility had and also provided in-servicing and education that was started with the staff regarding the use of oxygen. NJAC 8:39-11.2(b); 27.1(a)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43936 Based on interview and review of Nursing Staffing Report sheets, Payroll Based Journal (PBJ) Reports and facility provided documents, it was determined that the facility failed to ensure the Director of Nursing served as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents for 7 of 16 days reviewed The deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for 05/07/2023 through 05/13/2023 revealed the facility had one RN for the day shift on 05/12/2023. On 05/12/2023, the census was 100 residents. A review of the Nurse Staffing Reports completed by the facility for 05/26/2024 through 06/01/2024 revealed the facility had one RN for the day shift on 05/26/2024 and 05/27/2024. On 05/26/2024, the census was 92 residents. On 05/27/2024, the census was was 91 residents. A review of the Nurse Staffing Reports completed by the facility for 06/02/2024 through 06/08/2024, revealed the facility had one RN for the day shift on 06/08/2024. On 06/08/2024. the census was 90 residents. On 06/17/2024 at 1:24 PM, during an interview with the surveyor, the Human Resource Director told the surveyor that the Director of Nursing (DON) worked the specified days above as the Registered Nurse. At that time, the surveyor requested time sheets that show when the DON arrived to the facility. At that time, the Human Resource Director stated that the DON is a salaried employee and does not record the time of arrival to the facility. On the same date at 2:05 PM, the surveyor received an email from the Human Resource Director titled, RN Coverage Schedule. The email contained an attached document with the heading, The following RN rotation coverage for May 2024-June 2024 is completed by Salaried RN's. The email showed the that the dates mentioned above were covered by the DON. On 06/18/2024 at 9:59, AM during an interview with the DON, the surveyor asked, How were you acting as the RN when you are DON and had census over sixty residents. The DON replied, we had a weekend supervisor and she quit. We had to implement something for the time being. A review of the Payroll Based Journal (PBJ) Report for fiscal year quarter 2, 2024 (January - March) revealed that the facility triggered for no RN (Registered Nurse) hours. The infraction dates, as reported by the facility were: 01/27/2024 01/28/2024 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Jersey Extended Care	99 Manheim Avenue Bridgeton, NJ 08302

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	02/24/2024 02/25/2024 03/10/2024 03/23/2024 03/23/2024 Upon request of the census and employees who worked those days, it was determined that the facility's previous Director of Nursing, as identified by the [NAME] President of Clinical Services (VPCS), worked as the only RN on the following days: 02/24/2024 02/25/2024 03/10/2024 The resident census was provided to the surveyor through email from the VPCS. The resident census on 02/24/2024 was 96. The resident census on 02/25/2024 was 95, and the resident census on 03/10/2024 was 92. On 06/19/2024 at 11:13 AM during an interview with the surveyor, The VPCS replied, I'm not quite sure. I'd have to look back at that. when the surveyor asked what was the reason the DON worked as the facility's only Registered Nurse on days when the daily census was over 60. On 06/19/2024 at 1:39 PM during an interview with the surveyor, the DON told the surveyor she became the DON in April, 2024. A review of the facility-provided policy titled, Nursing Services-Registered Nurse (RN) with an implemented date of 11/14/23 revealed but was not limited to, 1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. NJAC 8:39-25.2(h)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 43936 Based on interview and review of facility documents, it was determined that the facility failed to provide Certified Nurse Aides (CNA) regular in-service education based on the outcome of employee job performance appraisals. The deficient practice was identified for 3 of 10 CNAs reviewed. The deficient practice was evidenced by the following: A review of the facility provided documents titled, Employee Job Performance Appraisals revealed eleven measurable attributes such as but not limited to, Job Expectations, Adaptability, Leadership, and Dependability. Each attribute also has a comments section and a goal section. Each attribute can be scored with a numeral revealing the following: 0 - Fails to Meet Expectations 1 - Needs Immediate Improvement 2 - Meets Expectations 3 - Above Average 4 - Excellent A review of CNA # 1's Employee Job Performance Appraisal revealed a score of 1 under Adaptability. Number 1 indicated, Needs Immediate Improvement. The comments and goal section were left blank. On the reverse side of the document under Leadership, the score was 1. The comments and goal section was left blank. Further, under Dependability, the score was 1 and a hand written note revealed that CNA # 1, Requires to improve attendance call outs. The document was signed by the employee on 9/11/2023. A review of CNA # 2's Employee Job Performance Appraisal document revealed a score of 1 under Leadership. A handwritten note revealed, Area requires improvement. The document was signed by the employee but no date was indicated. A review of CNA # 3's Employee Job Performance Appraisal document revealed a score of 1 under Adaptability. A handwritten note revealed, Improve Attendance. The document was signed by the employee on 6/19/2023. On 06/18/2024 at 9:59 AM, during an interview with the Director of Nursing (DON), the surveyor asked how an area that needs immediate improvement can be left blank. The DON stated, not that it's supposed to happen but we go case by case. The DON then stated, No when the surveyor asked if she was ever trained on completing employee appraisals. The DON said that at the time of the appraisal, the employee signed the document and the concerns were verbally discussed with them. Lastly, the DON confirmed the document was blank stating, I provided what I had. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/19/2024 at 9:21 AM, the DON informed the surveyor that the facility does not have a policy on Employee Job Performance Appraisal and that it was at DON discretion. On 06/19/2024 at 11:13 AM, during an interview with the surveyor, the [NAME] President of Clinical Services (VPCS) interim infection preventionist replied, No, when the surveyor asked if the comments and goal section should be left blank. The VPCS replied I'd have to look at specific case. when the surveyor asked if employees who scored a one or zero receive education based on the outcome of the review. The surveyor asked how should the in-service be documented. The VPCS replied, We do education with them and they would have to sign the education. The surveyor then asked if someone scored poorly, what would be the procedure from that point. The VPCS replied, They would receive an education and they would have to sign it. On the same date at 1:39 PM, the VPCS confirmed the facility did not have a policy on Performance Evaluations. A review of the Facility Assessment titled, revealed under section, J. but not limited to, Training/education and competencies/skill checks are generally provided upon hire, during monthly in-servicing/training, annual in-servicing/training, whenever an area of concern is identified, new areas or new situations/developments evolved are identified based on resident diagnoses and/or clinical condition. The document further revealed, Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff. A review of the facility-provided document titled, Director of Nursing-Job Description revealed under, Major Duties and Responsibilities that the DON, Interprets and communicates policies and procedures to nursing staff, and monitors staff practices and implementation. The document also revealed that the DON, Evaluates work performance of all nursing personnel and implements discipline according to operational policies. Lastly, the documented revealed, Individual performance will be evaluated using the following scale: 1. Unsatisfactory: Achieves results which are far less than the standards identified for performance factors rated. 2. Needs Improvement: Achieves results which are less than the standards identified for the performance factors rates. Exhibits the potential to become a competent performer. May be new to job or need skill development. N.J.A.C. 8:39-43.17

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48422 Based on observation, interviews, and other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by: On 06/13/24 between 09:24 AM until 10:01 AM, the surveyor observed the following in the kitchen in the presence of the Dietary Manager (DM): 1. On 06/13/24 at 9:25 AM, the surveyor observed a Dietary Aid (DA) preparing food during the initial tour of the kitchen and was noted not wearing a beard guard. The DM stated that all staff have been trained according to the policy and procedure of the kitchen to wear proper attire while working in the kitchen. He confirmed that all staff must wear a hairnet and beard guard to prevent food contamination. The DA left the workstation and walked towards the entrance to put on his beard guard. 2. On 06/13/24 at 9:27 AM, the surveyor observed an opened package of hot dog buns containing 3 buns left in the package that was not dated with an opened date and use by date. The DM stated that items need to be dated when they are opened and dated with a use by date according to the facility policy. 3. On 06/13/24 at 9:35 AM, the surveyor observed 6 lbs (pound) can of diced potatoes in the dry storage area with a 2 inch dent located on the seam of the can. The DM confirmed that the canned diced potatoes should not be used and was removed. 4. On 06/13/24 at 9:40 AM, the surveyor observed dried spiced goods in the food preparation line that did not contain a date when the spices were opened, nor did it contain a use by date. These items consisted of grated cheese, adobo seasoning, paprika, black pepper, onion power and cinnamon. 5. On 06/13/24 at 9:43 AM, the surveyor observed 10 prepared salami sandwiches in the walk-in refrigerator. Only 1 out of 10 salami sandwiches had the prepared date labeled, and 10 out of 10 did not have a use by date. The DM stated once the sandwiches were prepared, they were good for 3 days. The DM confirmed that all food items should have a date of preparation and use by date labeled. 6. On 06/13/24 at 9:46 AM, the surveyor observed 15 dessert cups of diced pineapple on a tray in the walk-in refrigerator. Only 1 out of 15 pineapple cups had a prepared date labeled, and 15 out of 15 did not have a use by date. 7. On 06/13/24 at 9:48 AM, the surveyor observed 3 pitchers that contained dark liquid in the walk-in refrigerator, that the DM verified was iced tea. The 3 pitchers of iced tea were not labeled with a preparation date and use by date. 8. On 06/13/24 at 9:50 AM, the surveyor observed a plate of leftover cheese ravioli with tomato sauce covered with a clear food service film in the walk-in refrigerator. The cheese ravioli was not labeled with a preparation date and use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. On 06/13/24 at 9:57 AM, the surveyor observed left over sauteed spinach in a stainless-steel pan covered with a clear food service film in the walk-in refrigerator. The sauteed spinach was not labeled with a preparation date and use by date. The surveyor reviewed the facility provided policy titled Food Safety and Sanitation. The policy revealed the following: 2. Employees All staff will be in good health, will have clean personal habits and will use safe food handling practices. Hair restraints are required and should cover all hair on the head. Beard nets are required when facial hair is visible. 3. Food Purchasing Bulging or leaking cans, cans with severe dents on the seams, or broken containers of food will not be used. 4. Food Storage All time and temperature control for safety foods (including leftovers) should be labeled, covered, and dated when stored. When a food package is opened, the food item should be marked to indicate the open date. This is used to determine when to discard the food. Leftovers are used within 72 hours (or discarded) NJAC 8:39-17.2 (g)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on observation, interview and document review it was determined that the Licensed Nursing Home Administrator failed to ensure that facility policies and procedures were developed and consistently implemented. This failure to ensure a system was in place for residents who smoked independently and held their own smoking material and lighter, had the potential to effect all residents on 3 of 3 resident units and was evidenced by the following: On 06/13/24 at 2:03 PM, three surveyors observed a person walking behind the building on a path by the woods. The surveyors approached the person, who was by him/herself, to interview them, while the person was headed toward the road and then turned toward the parking lot. The person identified him/herself as Resident #25 and stated that he/she lived at the facility. The surveyors accompanied Resident #25 for the duration of the walk throughout the parking lot and into the main entrance and then asked the Receptionst about the resident walking around the building. The Receptionist stated, Resident #25 signed the paper that if anything happened to him/her that we are not responsible and handed the surveyor a List of residents signed release of responsibility papers that contained nine names. On 06/14/24 at 10:00 AM, the surveyor interviewed the Director of Nursing (DON) regarding the list of residents that signed the paper and asked about the paper related to Resident #25. The DON stated residents can walk around the building, and yes it is a paper, we created a paper. The DON stated that she and the old administrator made up the paper. The DON was the assistant director of nursing at that time. The surveyor requested the paper. The DON provided a copy of the paper which revealed: I, [Signed by Resident #25] am alert and capable of making my own decisions. It is my wish to be allowed to come and go in and out of this facility freely and at my own will and risk. I understand hat this is against the advice and policy of [facility name redacted] and it's staff and doctors. By signing this document I hereby release [facility name redacted] and all its employees, mangers and management companies of any responsibilities of injuries I might sustain while out of the building. This shall include leaving the building and moving about in the parking lot or the entire area outside of the building. Signed by Resident #25, dated 07/25/23. The document also revealed: We hereby attest to the fact that [Resident #25] is alert and oriented and capable of making their own decisions. Signed by the current DON, dated 07/25/23 and [Doctor], 07/28/23. On 06/14/24 at 11:50 AM, five surveyors were in the conference room and observed Resident #25 walk past the back of the building by the Sub Acute area bordering the woods, was on a path and was also observed smoking a cigarette. At that time, the surveyor reviewed the electronic Medical Record (EMR) for Resident #25 which revealed the following: The Admission Record revealed diagnoses including Ecephalopathy, Unspecified (broad term for brain disease), Major Depressive Disorder, recurrent severe without psychotic features and hemilplegia and hemiparesis unspecified cerebrovscular disease affecting unspecified side. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Quarterly Mimimum data set dated [DATE] revealed the resident scored a 15/15 on the Brief Interview for Mental Status which indicated the resident was cognitively intact. Section GG, section K revealed the resident required supervision or touching assistance to walk 150 feet in a corridor or similar space. Section J1300 Tobacco use was left blank, neither yes or know was checked. The Current nine page Care Plan included the following Focus areas: Anticoagulant, Falls, Psychotropic Medicaiton, Pain, Altered Sleep Pattern, Smoking, ADL, Nursing non-compliance with daily clothing changes, showers and skin checks. and Activities. The Focus for Smoking revealed: Resident is a smoker and is at risk for injury. Resident is an independent smoker and does not require direct supervision to smoke. Date Initiated: 05/27/2024 Revision on: 05/27/2024 Goal: -Resident will abide by facility's smoking policy and remain safe during smoking times through the next review. Date Initiated: 05/27/2024 Revision on: 06/13/2024 Target Date: 10/15/2024 - Resident will smoke in designated areas without occurrence of injury through the next review. Date Initiated: 05/27/2024 Revision on: 06/13/2024 Target Date: 10/15/2024 Interventions - Perform smoking assessment according to facility policy. Date Initiated: 05/27/2024 - Educate resident on smoking policy. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Date Initiated: 05/27/2024 - INDEPENDENT SMOKER: Resident is an independent smoker and does not require the use of a smoking apron or direct staff supervision during smoking breaks. Date Initiated: 05/27/2024. The Care Plan did not indicate the resident was able to hold own smoking material and lighters and walk around the building smoking. The Falls Care Plan Date Initiated: 05/08/24 The resident will be free from falls and subsequent injuries through the review date. Date Initiated: 05/18/2024 Revision on: 06/13/2024 Target Date: 10/15/2024 Resident's call light is within reach Date Initiated: 05/08/2024. There was no Care Plan related to the document that the resident signed, the ability to hold a lighter and cigarettes and smoke at will around the building perimeter. Resident #25's most recent smoking assessment, dated 02/12/24 revealed #3 Is resident physically capable of holding a cigarette, matches/lighter, and lighting and extinguishing own cigarette without assistance; yes; 9. Has resident been instructed in facility policy regarding safety of himself/herself or others; yes; 10. Has resident signed the [Facility Name] smoking agreement and smoker release of responsibility form, yes. On 06/14/24 at 11:58 AM, a surveyor observed Resident #25 entering the building from the main entrance. The surveyor inquired as to what the resident did outside and the Resident stated was outside walking the perimeter of the building and was smoking. Resident #25 stated he/she smoked a pack of cigarettes a day and stated kept a personal lighter to light his/her own cigarettes. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/18/24 at 11:33 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team regarding what was his responsibilities. The LNHA stated he was responsible for the oversight and care of all residents and all regulations in accordance with state and federal law since he had been hired on 12/3/23. The surveyor asked if he ensured policies were followed and he stated, yes, and the surveyor asked if that included the smoking policy and he stated yes. The surveyor asked how he would ensure that, the LNHA stated through meeting, daily rounds, and walked through all three units, including the kitchen, maintenance shop and laundry. The surveyor asked the LNHA if the smoking policy would allow residents held their own lighters to light there own cigarettes. The LNHA stated,we don't allow them to have lighters. The surveyor asked why not, and the LNHA responded, forsafety. The surveyor asked if a resident chose to not follow the policy what would happen, and the LNHA stated, we educate them. The LNHA stated they are supposed to be smoking in the smoking area. The surveyor asked if residents were allowed to keep there own lighters and walk around the building smoking. The LNHA then stated there were a handful of residents that were able to do that and they signed a waiver. The LNHA stated they sign themselves to go out on the property and they are more independent of ADLs [activities of daily living]. The LNHA, then stated some light there own cigarettes outside and they know they need to smoke 25 feet away from the building. The surveyor asked how he would know that and he stated, it's a building policy. The surveyor showed the LNHA the document signed by Resident #25 and asked where the document came from and was it a legal document. The LNHA stated he was not sure who made it up, and I did not say it was legal. The surveyor asked what the policy was for use of the document and the LNHA stated, I would have to check. The surveyor asked if the resident could hold onto their own lighters and keep them with them. The LNHA stated, my original answer was for those residents that were in the designated smoking area and he was not sure if there was a policy and stated independent residents had their own lighters. The surveyor showed the LNHA the document again and also showed him the list of residents that signed responsibility papers and asked what the documents were for since the documents did not have smoking listed. The LNHA stated it was a release of responsibility of their own risk and the residents can be independent outside of the building and facility would not be responsible. The surveyor asked about a policy for residents who hold their own lighters inside the facility, come and go as they wish to smoke around the facility. The LNHA stated he doesn't know, I have to check and not sure if there was a policy and would go check. On 06/18/24 at 11:55 PM, the LNHA returned and stated, there was no specific policy for residents who smoked outside and there was no policy for the use of the waiver. The LNHA stated the smoking policy only was for the residents that smoked in the designated areas. The surveyor asked how do you protect other residents from gaining access to the lighter, and asked how many residents hold their own lighters, and the LNHA did not respond. The surveyor informed the LNHA about the observations of Resident #25 smoking around the facility. The LNHA confirmed he was aware. The surveyor asked if there was a policy to prevent other residents from gaining access to the lighters and the LNHA stated, I do not have an answer for that. On 06/18/24 at 12:26 PM, the surveyor interviewed the facility Social Worker (SW) regarding the document Resident #25 signed. The SW stated the paper was for the residents who leave independently and so the resident can go to the store. The SW stated it was for the resident were pending Medicaid, but they they met criteria for residency in a long term care facility. The SW stated the paper allowed for people to go through the front door without somebody having to sign them out. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Administrator signed job description, dated 12/23/23 revealed Position Purpose: Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to the residents. Major Duties and Responsibilities; Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations. NJAC 8:39-9.2(a)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 43936 Based on interview and review of pertinent facility documents it was determined that the facility failed to submit accurate No RN [Registered Nurse] Hours Payroll Based Journal (PBJ) Report to the Centers of Medicare and Medicaid Services (CMS). The deficient practice was identified for 4 of 7 infraction dates on the PBJ Report for Fiscal Year Quarter 2 January 1 - March 31. A review of the PBJ Report for Fiscal Year Quarter 2 2024 January 1 - March 31 revealed the following days as ,Infraction Date under the No RN Hours Metric: 01/27 01/28 02/24 02/25 03/10 03/23 03/24 A review of the facility provided document titled, The Following RN rotation coverage revealed that on 01/27/2024 and 01/28/2024, the facility's current Director of Nursing worked as an RN. At that time, the DON was not promoted to the DON role. A review of the same document revealed that on 03/23/2024 and 03/24/2024 the [NAME] President of Clinical Services worked as the RN. On 06/19/2024 at 1:57 PM during an interview with the surveyor, the current DON revealed she became the DON sometime in April of 2024. A review of the facility policy titled, Nursing Services-Registered Nurse (RN) implemented on 11/14/23, revealed under Policy Explanation and Compliance Guidelines that, 3. The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system. NJAC 8:39-41.1

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to a.) appropriately don (put on) Personal Protective Equipment (PPE), and b.) store respiratory equipment to prevent contamination and exposure to the environment. This deficient practice was evidenced by the following: On 06/13/2024 at 9:44 AM, the surveyor observed a staff member assisting Resident #42 via a recliner chair, into the common area of the facility. The surveyor observed Resident #42 was wearing a nasal cannula attached to a portable O2 tank and the amount was set at 2 liters per minute (lpm). On 06/14/2024 at 8:43 AM, the surveyor observed Resident #42's portable O2 tank was on the back of the recliner chair in the hallway. The surveyor observed that there was tubing with the nasal cannula wrapped around the tank. The nasal cannula was not in a protective covering and was exposed to the environment. On 06/14/2024 at 8:59 AM, the surveyor returned and observed Resident #42 in bed with his/her eyes closed and the oxygen tubing with the nasal cannula was not in a protective covering and was in direct contact with the mechanical lift pad that was under the resident. On 06/14/2024 at 9:02 AM, the Director of Nursing (DON) was in the hall by the resident's room. The surveyor asked the DON to come to the resident's room. The DON acknowledged the resident was not wearing his/her O2 and stated he/she should be wearing the O2 so the resident can breathe. The DON also acknowledged that the nasal cannula on both the room oxygen and recliner chair portable oxygen tank were both uncovered and exposed to the environment. At that time, the DON asked the Licensed Practical Nurse Unit Manager (LPN UM) to come to the room. The LPN UM acknowledged the resident was not being administered his/her continuous oxygen as ordered. The LPN UM donned a PPE gown but failed to secure the tie around her waist. The LPN UM donned gloves and entered Resident #42's room to apply a monitor to his/her hand and check the resident's oxygen levels, and to apply a blood pressure cuff to the resident's arm to obtain a blood pressure reading. The LPN UM also connected new oxygen tubing to the oxygen concentrator and applied a new nasal cannula to the residents nostrils. During that time, the PPE gown ties were dragging on the floor and when the LPN UM leaned over the resident, the PPE gown was falling down. On 06/14/24 at 9:15 AM, two Certified Nursing Assistants (CNA) arrived at the resident's room to assist him/her via a mechanical lift into the recliner chair. CNA #1 donned the PPE gown but failed to secure the ties around her waist. CNA #1 assisted with securing the resident to be lifted and moved and made the resident's bed. While assisting the resident and making the bed, the PPE gown was falling down and dragging on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #42's hybrid (both paper and electronic) medical records revealed an Admission Record with diagnoses which included but were not limited to; diffuse traumatic brain injury, unspecified psychosis, seizures, dysphagia (difficulty swallowing), dementia, and respiratory failure. A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool used to prioritize care, dated 05/17/2024, included but was not limited to; Section B the resident was coded a 3 rarely/never understood when considering ability to express ideas; Section C the Brief Interview for Mental Status (BIMS) was coded 0 for no the interview should not be conducted as the resident was rarely/never understood; Section GG indicated the resident was dependent on staff for Activities of Daily Living (ADL); and Section O indicated the resident required oxygen therapy. A review of the Order Summary Report included but was not limited to; O2 at 2 lpm via n/c (nasal cannula) every shift dated 04/02/2024; and an order dated 04/19/2024, for Enhanced Barrier Precautions (EBP) every shift. A review of the resident-centered, on-going Care Plan included but was not limited to; a focus area that the resident requires EBP with interventions which included to wear gowns and gloves during high-contact resident care activities. On 06/14/2024 at 9:17 AM, the LPN UM stated that the process was to put the PPE gown on over the head via the opening, put arms through the sleeves and tie the back of the PPE gown around the waist area. The LPN UM stated that the PPE gown was to ensure she was completely covered and stated, sorry it [the PPE gown] should be tied in back to prevent contamination. On 06/14/2024 at 9:21 AM, CNA #1 stated that the PPE gown should be put on over the head and the arms through the sleeves. She stated, I forgot to tie it. CNA #1 further stated that it was important to be fully covered by the PPE gown so there is no cross contamination. On 06/14/2024 at 9:26 AM, the DON stated that the process was to put the PPE gown on over the head and to tie it around the back. She stated the purpose was, to prevent the spread of infection. A review of the facility provided, Inservice Attendance Sheet dated 01/30/2024, revealed the subject of the in-service included PPE and that the LPN UM and CNA #1 had attended the education which was provided by the previous DON. A review of the facility provided, Oxygen Administration policy revised 10/2010, included but was not limited to; Purpose: . to provide guidelines for safe oxygen administration. The policy failed to include how to store the oxygen delivery equipment. A review of the facility provided, Personal Protective Equipment policy revised 04/10/2024, included but was not limited to; Policy: . to prevent the transmission of pathogens to residents, visitors, and other staff. 1. All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. 4. Indications/considerations for PPE use: . b. Gowns: i. wear to protect arms, exposed body areas, and clothing from contamination . ii. Gowns should fully cover torso from neck to knees, . wrap around the back. Fasten in back at neck and waist. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/19/2024 at 11:13 AM, the above concern was addressed with the Licensed Nursing Home Administrator, the DON, and a Corporate nurse who was the facility interim Infection Preventionist. The facility provided in-servicing and education that was started with the staff regarding the use of oxygen and appropriate PPE donning. The facility stated there were no other Oxygen policies to address the storage of respiratory equipment. NJAC 8:39-19.4(a)(c)(k); 27.1(a)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 00167157 Based on interviews, record review and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure that the resident call system was maintained in operable condition as evidenced by the following: 1. On [DATE] at 11:30 AM, the surveyor entered a random resident's room and asked the resident to activate the call light in the room. The surveyor went into the hallway and observed that the light was flashing and an audible sound could be heard. During an interview with the residents, they indicated that the call light was working but staff would take time to answer the call light. One of the resident revealed that 30 minutes could elapsed before staff would answer the call light. The surveyor reviewed the Maintenance logs and observed on 2 of the 4 units the following entries: Unit CD: [DATE] outside call light broken, repaired [DATE] (room [ROOM NUMBER]) [DATE] light not working repaired [DATE]. (room [ROOM NUMBER]) [DATE] call light knob broke,checked [DATE].(room [ROOM NUMBER]) [DATE] call light does not worked on the outside, repaired [DATE].(room [ROOM NUMBER]) [DATE] call light does not work, repaired [DATE].(room [ROOM NUMBER]) [DATE] light not working, repaired [DATE].(room [ROOM NUMBER]) [DATE] call light not working, repaired [DATE]. (room [ROOM NUMBER] A) [DATE], call light not working, repaired [DATE].(room [ROOM NUMBER] A) Unit AB: [DATE] call bell not working, repaired [DATE].(room [ROOM NUMBER] A) [DATE] call light broken, repaired [DATE]. room [ROOM NUMBER]) [DATE] call bell not working on the outside, repaired [DATE].(room [ROOM NUMBER] A) [DATE] call light not working at all., repaired [DATE]. (room [ROOM NUMBER]) [DATE] red box at nurse's station system blinking missing monitor company called., repaired [DATE]. Nurse's station. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident who filed the complaint resided on another unit and the facility did not provide the maintenance log for that particular unit. The Maintenance Director indicated that he could not locate the log for 2023. On [DATE] at 09:51 AM, the surveyor interviewed the Maintenance Director (MD) in the presence of another surveyor. The surveyor reviewed the log with the (MD). He stated that any issue with the resident call light system should be addressed immediately. However there would be a delay if the issue arose during the weekend as there was no maintenance service on the weekend. The surveyor showed the order for the call light repair on Unit AB dated [DATE] that was repaired 7 days later. The MD informed the surveyors that the call system was defective and could not be repaired immediately. The MD could not comment on what was done during the 7 days, whether or not the facility informed the Department of Health (DOH) of the concerns or if the residents were provided with other means to alert the staff of their needs. On [DATE] at 11:30 AM, the surveyor asked the Director of Nursing (DON) for any Call Bell Audits that were completed at the facility since the last survey. The DON informed the surveyor there was no need to complete any call bell audits and none were provided. On [DATE] at 1:30 PM, the surveyor discussed the concerns with the call light system with the Administrator, and inquired regarding the protocol if the call light system was defective on all the units. The Administrator stated, The State had to be notified, the residents were to be provided with a tap bell, staff were to monitor all the residents more often. The Administrator added that he could not comment further on the issue with the call light of [DATE] to [DATE] as he was not employed by the facility. The surveyor asked for any invoice/ work order that was completed for that period, none was provided. On [DATE] at 09:26 AM, the facility provided a policy titled, Maintenance Inspection. The following were noted: It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe functional sanitary, and comfortable environment for residents, staff, and the public. Policy Explanation 1. The Director of Maintenance Services will perform routine inspection of the physical plant. 2. The Administrator or designee, will perform random inspections of the physical plant. z 3. Maintenance issues will be communicated through the maintenance log on each unit. 4. All opportunities will be corrected immediately by maintenance personnel. 5. The facility shall establish quality/ compliance thresholds as a benchmark for QA purposes. 6. Data recorded on the Maintenance log will be compared to establish thresholds, and actions plans will be generated as needed. 7. Maintenance Director will report to QA team Quarterly. Date implemented [DATE] with no revision date. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Call lights: Accessibility and Timely Response revealed the following: Call lights : Accessibility and Timely Response Policy The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. 8. Staff will report problems with a call light or call call system immediately to the supervisor and/ or maintenance director and will provide immediate or alternative solutions until the problem can be remedied include: (Examples include: replace call lights, provide a bell or whistle, increase frequency of rounding, etc.) On [DATE] at 1:20 PM the DON provided one page of an invoice dated [DATE] that contained the following: Description: Room AB no light at doors of annunciator panel. [DATE] Front Door. [DATE] Lobby Door Wanderguard monitor. The facility was unable to provide any documentation regarding how the documented concern with the call light system had been addressed. NJAC 8:,d+[DATE].2(e), 31.8(c)9

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38680 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain a resident bathroom toilet (Resident room [ROOM NUMBER]) in a sanitary working condition for four days and was evidenced by the following: On 06/13/2024 at 9:58 AM, during initial tour of the facility, the surveyor observed the toilet in Resident room [ROOM NUMBER]. The toilet bowl was observed with brown debris and paper products in the bowl. There was no water observed in the toilet. The resident stated that the toilet does not work, and the facility was aware the toilet had been broken for a few days. On 06/13/2024 at 12:59 PM, the surveyor reviewed the unit maintenance log sheets. The toilet in Resident room [ROOM NUMBER] was not on the log sheets to be repaired since 5/24/24. There was a work order dated 6/12/2024 for the paper towel dispenser in Resident room [ROOM NUMBER] needing batteries which was completed the same day. On 06/13/2024 at 1:12 PM, the surveyor observed the toilet in Resident room [ROOM NUMBER]. The toilet bowl was observed with brown debris and paper products in the bowl. There was no water observed in the toilet. On 06/17/2024 at 8:08 AM, the surveyor observed the toilet in Resident room [ROOM NUMBER]. The toilet bowl was observed with brown debris and paper products in the bowl. There was no water observed in the toilet. At 8:44 AM, the resident stated that the toilet had not been repaired. During an interview with the surveyor on 06/17/2024 at 8:44 AM, the Certified Nursing Assistant #1 (CNA) stated that when items needed to be repaired, she informed the Unit nurse then completed a work order in the maintenance log located on the unit. The CNA stated that Resident room [ROOM NUMBER]'s toilet was often out of order as the resident flushed paper towels in the toilet bowl. The CNA further stated that she believes the toilet was plunged on 06/10/2024. During an interview with the surveyor on 06/17/2024 at 8:48 AM, the Licensed Practical Nurse #2 (LPN#2) stated that Resident room [ROOM NUMBER] toilet was always messed up because the resident likes to place towels in the toilet. She stated it is usually unclogged every other day. When asked if she reported the clogged toilet recently, she replied, No. She stated that she had not been at the facility since 06/14/2024. On 06/18/2024 at 8:55 AM, the surveyor interviewed the Unit Manager on the CD Unit. The UM confirmed that all equipments needed repair must generate a work order. The order would be placed in the book and the maintenance director would be verbally informed. The UM revealed that the concern with Resident #72's toilet was an ongoing issue. The surveyor then inquired if the toilet should be in disrepair, the UM stated, No. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/18/2024 at 9:50 AM, the surveyor interviewed the Maintenance Director (MD) who revealed that all work orders were entered in the maintenance log located on each unit and at times would verbally communicate the concern. The MD stated the toilet in Resident room [ROOM NUMBER] should not be clogged for 4 days. He stated that a toilet being clogged for 4 days was an inconvenience to the resident and unhealthy. A review of the facility policy titled Maintenance Inspection with an implemented date of 11/15/23 reflected that it is the policy of this facility to utilize a maintenance inspection checklist to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. NJAC 8:39-31.4(a)