STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315066	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Manor Rehabilitation and Care Center	787 Northfield Ave West Orange, NJ 07052

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure a.) the bed hold-policy that was provided to the Resident or Resident's Representative (RR) included information about the reserve bed payment policy plan, the explanation of the right to appeal the transfer, and the Resident and/or RR's information for 2 of 2 residents (Residents #2 and #16) reviewed for hospital transfer and b.) the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution, including the discharge summary for 1 of 1 resident (Resident #15) reviewed for transfer.The deficient practice was evidenced by the following: 1.On 9/15/25 at 1:24 PM, Surveyor #1 (S#1) reviewed the electronic medical records (eMR) of Resident #2, and revealed: A review of the admission Record (AR; an admission summary) or face sheet, revealed Resident #2 had been admitted with diagnoses which included but were not limited to; heart failure unspecified, other sequelae following unspecified cerebrovascular disease (stroke), hemiplegia (a neurological condition characterized by paralysis of one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction affecting right dominant side, and chronic obstructive pulmonary disease (COPD; an ongoing lung condition caused by damage to the lungs) unspecified. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/22/25, reflected a brief interview for mental status (BIMS) score of 13 of 15, indicated that the resident was cognitively intact. A review of the two most recent discharge return anticipated MDS (DRAMDS), revealed that the resident had an unplanned transfer to acute hospital. On 9/16/25 at 10:28 AM, S#1 asked the Licensed Nursing Home Administrator (LNHA) for the facility's Bed Hold Notifications files. On 9/16/25 at 11:28 AM, S#1 reviewed the binder provided by the LNHA with regard to bed hold policy notifications and revealed that the resident had two bed hold notifications, dated 7/1/25 for lethargy and 9/5/25 for shortness of breath (SOB). In addition, the bed hold policy notifications (for dates 7/1/25 and 9/5/25) did not include information about the reserve bed payment policy plan, the explanation of the right to appeal the transfer, and the information to whom the bed hold policy was given. On 9/18/25 at 12:25 PM, S#1 interviewed the Director of Social Services (DSS) in the presence of (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	another Social Worker (SW) about facility's practice and policy with bed hold notification. The DSS informed S#1 the process was when the resident was being transferred to the hospital, it was the responsibility of the social services department to fill out the Notice of Emergency Transfer and Bed Hold Policy notice (paper form) and the same form would be provided to cognitively intact resident or to the RR if the resident was cognitively impaired. The DSS further stated that the filled out form then will be filed to the binder that was provided to the surveyor. On that same date and time, S#1 asked the DSS if there were documentation to whom the bed hold policy notice was given and if the reserve payment was provided to the resident or RR in the language that they were able to understand. The DSS responded that the social services mail the same filled out form or given to the resident and there was no evidence it was sent because it was sent as a regular mail and not as registered mail. The DSS further stated that there was no other documentation about reserve payment and other information except for the filled out. Furthermore, S#1 asked the DSS if she was aware of the regulation about notifying the resident or RR of the reserve payment for bed hold, and she responded that she was unaware. The DSS confirmed that the bed hold policy form in the Notice of Emergency Transfer had no reserve payment and no information whom the form was provided. On 9/19/25 at 12:18 PM, the survey team met with the LNHA, Director of Nursing (DON), Regional Nurse, Chief Nursing Officer (CNO), Director of Operations (DoO), and [NAME] President of Operations (VPoO), and S#1 notified them of the above concerns with Resident #2's bed hold policy notices for 7/1/25 and 9/5/25. On 9/22/25 at 10:33 AM, the survey team met with the LNHA, DON, Regional Nurse, CNO, and the DoO. The LNHA stated that the facility's policy with regard to bed hold was updated to include the rate for bed hold and the opportunity for the resident or RR the explanation of the right to appeal the transfer. A review of the facility's Bed Hold and Ombudsman Notification Policy that was provided by the LNHA, with a reviewed date of 8/2025, revealed, there were no information about reserve payment policy plan, the explanation of the right to appeal the transfer, and the RR's information. 2. On 9/16/25 at 1:31 PM, S#1 reviewed the eMR of Resident #15, and revealed: A review of the AR revealed Resident #15 had been admitted with diagnoses which included but were not limited to; cerebral infarction (stroke), encounter for palliative care, type 2 diabetes mellitus with mild non proliferative diabetic retinopathy without macular edema bilateral, aphasia (a language disorder that affects a person's ability to communicate) following cerebral infarction, major depressive disorder recurrent and specified, and unspecified psychosis not due to a subacute or known physiological condition. A review of the current personalized Care Plan (CP) with focus that the resident planned to remain for long term care, that was created and revised on 3/19/23. There was no documented evidence the resident had CP for transfer to another facility. A review of the Social Service quarterly progress notes (PN) with an effective date of 6/12/25, revealed that long term care remained appropriate. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the quarterly MDS (qMDS), with an ARD of 9/1/25, reflected C1000. Cognitive Skills for Daily Decision Making was coded #2, indicated that the resident cognition was moderately impaired. The qMDS also reflected that the resident participated in the assessment and goal setting and there was no plan for discharge (d/c). A review of the recent discharge return not anticipate Minimum Data Set (DRNAMDS), revealed that the resident had a planned transfer to hospice institutional facility. A review of the Miscellaneous tab of eMR revealed hospice meeting dates for 7/15/25 and 8/12/25 that were uploaded on 9/10/25, there was no documented evidence about plan to transfer to another hospice facility. A review of the monthly nursing comprehensive summary in the PN dated 9/1/25, reflected that resident observed to be much calmer and cooperative. The PN also include that the resident's sleep pattern was good and no change in ADL (activities of daily living) function. A review of the PN revealed that there was no documented evidence that the physician documented and was aware of the plan to transfer Resident #15 to another facility or hospice facility prior to transfer on 9/11/25. The last physician PN was from 9/1/25 with documentation that there was no new issues with the resident. A review of the Social Service PN created on 9/11/25 at 11:51 AM, reflected that the DSS documented that the resident was scheduled for transfer to another facility, notified the RR of transfer, transportation was arranged for pick up at 1:00 PM, and nursing was made aware of transfer. There was no documented evidence that the physician was notified of the transfer and the order was obtained. A review of the assessment, eINTERACT Transfer Form, revealed: Description: Discharge to Hospital. Date: 9/11/25 1:42 PM. Lock Date: 9/11/25 2:06 PM. Treatment/discharge details: to [name of hospital] date 8/16/22, reason for transfer: behavioral symptoms. Resident Representative: [name of RR and phone number]. A review of the Universal Transfer Form (UTF) revealed, date of transfer 9/11/25 at 3:00 PM, transfer to, code status, reason for transfer, attached documents, sending and receiving facility contacts, form filled and completed by information were blank. The contact person was not the RR identified in the Social Service PN dated 9/11/25 at 11:51 AM, and was not in the Resident's AR or face sheet. A review of the September 2025 Order Summary Report revealed that there was no documented evidence that the physician ordered a transfer for 9/11/25 d/c to another facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 9/15/25 at 10:51 AM, the Surveyor #2 (S#2) observed Resident #16's room with Enhanced Barrier Precaution (EBP-an infection prevention strategy) signage on the door and Personal Protective Equipment (PPE-use of gloves and gowns for direct contact) cart in the hallway. S#2 interviewed the Licensed Practical Nurse (LPN), who stated that the resident was in hospital due to the gallbladder drain that the resident had, and that was why there was an EBP signage on the doorway. On 9/16/25 at 3:02 PM, S#2 reviewed the medical records of Resident #16, and revealed: A review of the resident's AR revealed diagnoses which included but not limited to; acute cholecystitis (inflammation of the gallbladder, a small organ that stores bile from the liver), other mechanical complication of gastrointestinal prosthetic devices, and personal history of other diseases of digestive system. A review of the qMDS, with an ARD of 9/10/25, reflected a BIMS score of 15 out of 15 indicating intact cognition. Further review of the MDS, revealed that the resident was transferred on 6/13/25 to the acute care (hospital) for hypotension (blood pressure significantly lower than normal), on 7/3/25 due to right biliary drain and abdominal pain, and on 7/30/25 for cholecystostomy tube malfunction. On 9/18/25 at 2:30 PM, S#2 reviewed the Social Services and Nursing PN in the eMR regarding the discharge/transfer to the hospital on 6/13/25, 7/3/25, and 7/30/25 which included: On 6/13/25, the resident had a fall while going to the bathroom and was admitted in the hospital for hypotension. There was no documented evidence regarding Resident #16 and the RR were notified (informed) on bed reserve payment. On 7/3/25, the resident was transferred to the hospital due to right biliary drain leakage. There was no documented evidence regarding Resident #16 and the RR were notified on bed reserve payment. On 7/30/25, the resident was transferred to the emergency room due to the Nurse Practitioner (NP) order for cholecystostomy drainage system possible malfunction. There was no documented evidence regarding Resident #16 and the RR were notified on bed reserve payment. A review of the miscellaneous tab in eMR revealed a Notice of Emergency Transfer forms for the three dates above were completed but no information on reserve payment. The form did not contain a signature from the resident or RR that they were informed of the bed hold policy and did not specify who the form was given to. On 9/19/25 at 9:40 AM, S#2 interviewed the DSS in the presence of the assistant Social Worker, and reviewed the bed hold transfer notification transfer binder. S#2 asked the DSS if she was aware of the notification for bed hold reserve payments and that residents and families had to be notified, and she replied, No, I'm not aware. S#2 asked if she was aware of the regulations for reserved payment for bed hold and she replied No. S#2 asked if they had any other documentation, notifications or notes in eMR regarding bed hold transfer notifications for reserve payments, and she replied she did not have other documentation. On 9/19/25 at 12:18PM, the survey team met with the LNHA, DON, Regional Nurse, CNO, DoO, VPoO, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and S#2 notified them of the concern regarding bed hold policy that the resident and RR were not informed of reserve payments for the dates of emergency transfers on 6/13/25, 7/4/25, and 7/31/25. The DoO stated that they had on admission packet upon admission for the information needed. S#2 notified the DoO that the regulation specifically explained the reserve bed payment bed hold policy to be submitted upon admission and on every emergency transfer there had to be a reissuance. S#1 also stated that the facility form did not state or include information on who was informed on the bed hold transfer because the form did not specify and there were no resident or RR signatures on the forms. NJAC 8:39-5.1(a); 5.4(c)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to ensure licensed staff credentials were verified upon hire for 3 of 7 licensed staff of the total 10 newly hired staff reviewed, Staff Member (SM) #6, #7 and #8. The deficient practice was evidenced by the following:On 9/18/25 at 12:40 PM, the surveyor reviewed the facility provided employee files of 10 randomly selected newly hired employees of which 7 were licensed staff which included the following: 1. A review of Staff Member #6 (SM#6), a Certified Nursing Assistant (CNA), hired on 6/12/24, had a New Jersey Department of Health (NJDOH) online Public Registry license verification printout (used to verify the status of a CNA's license and to check the nurse aide registry) which was not dated. There was no documented evidence that SM#6's license was verified prior to the date of hire (doh).2. A review of Staff Member #7 (SM#7), a CNA, hired on 10/2/24, had a NJDOH online Public Registry license verification printout which was not dated. There was no documented evidence that SM#7's license was verified prior to the doh.3. A review of Staff Member #8 (SM#8), a CNA, hired on 5/1/25, had a NJDOH online Public Registry license verification printout which was not dated. There was no documented evidence that SM#8's license was verified prior to the doh.4. A review of Staff Member #9 (SM#9), a CNA, hired on 12/31/24, had a NJDOH online Public Registry license verification printout which was dated 12/29/24. There was documented evidence that SM#9's license was verified upon hire.On 9/18/25 at 1:16 PM, the surveyor interviewed the Human Resources Manager (HRM), in the presence of the Director of Operations (DoO) regarding the process for new hires and license verification. The HRM stated that she would make sure their license was active and in good standing on the New Jersey website prior to the hire date. The surveyor showed the HRM and DoO the 3 SM's license verification printout that did not have a date. The DoO stated that the printer did not always print the date on it. The surveyor then showed the HRM and DoO SM #9's license verification printout that had a date on it. The DoO confirmed that SM #6, #7 and #8's license verification printouts did not have a date on them. The DoO stated that the verification was done before the doh. On 9/19/25 at 12:18 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse, Chief Nursing Officer (CNO), DoO and [NAME] President of Operations (VPoO) the concern that three CNAs did not have documented evidence that their license verification was done prior to their doh.On 9/22/25 at 10:50 AM, in the presence of the DON, Regional Nurse, CNO and DoO, the LNHA stated that staff were educated on the new hire process and that moving forward to have all proper documentation upon hire.The LNHA did not provide any additional information.A review of the facility's New Hire Policy and Procedure with a reviewed date of 2/2025, included the following:1. Upon a successful completion of the facility's pre-screening process for a new hire (including but not limited to, background checks, interviews, reference checks, etc.) only than will the new hire be able to move forward with the onboarding process. A review of the facility's Resident Abuse/Neglect Misappropriation of Property Policy with a reviewed/revised date of 4/1/25, included the following:Hiring Practices/Screening of Potential Employees and VolunteersThe facility will not knowingly employ any individual who has a history of abusing other persons. Potential employees and volunteers shall be screened thoroughly through structured interviews, personal and employment reference checks, criminal background checks, and contact with State licensing boards and registries, when applicable.For any individual applying for employment as a certified nursing assistant, the New Jersey Nurse Aide Registry will be contacted to determine if any findings of abuse, neglect, mistreatment of individuals and/or theft of property have been entered in the applicant's file.For any licensed professional applying for a position that may involve direct contact with a resident, his/her respective licensing board will be contacted to determine if any sanctions have been assessed against the applicant's license. N.J.A.C. 8:39-43.15

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the admission Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 1 resident (Residents #4) reviewed for timing of assessments.This deficient practice was evidenced by the following:Reference: According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2024, page 2-17, the Comprehensive admission assessment must be completed no later than the admission date + 13 calendar days.On 9/22/25 at 9:09 AM, the surveyor reviewed the electronic medical record (eMR) of Resident #4, reflected that the resident was admitted to the facility on [DATE]. The Comprehensive (and modified) admission MDS with an assessment reference date (ARD) of 8/12/25, was completed on 8/21/25, and transmitted and accepted on 9/7/25. The MDS was completed more than 14 days of the required timeframe.On 9/22/25 at 9:33 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC), who stated that the MDS assessment on a new admission was due within 14 days of admission. She further stated that she was responsible for the MDS assessments of all residents in the facility while the Lead MDS who left two months ago was responsible for scheduling MDS. She also stated that she was not at the facility for three weeks in the July 2025. She acknowledged that the admission MDS for ARD 8/12/25 was completed late and should have been completed on 8/18/25.On 9/22/25 at 10:33 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse, Chief Nursing Officer (CNO), and the Director of Operations (DoO), and the surveyor notified them of the above concerns with late MDS of Resident #4.A review of facility's MDS Policy that was provided by the RN/MDSC, with a reviewed date of 12/2024, reflected:Policy: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS regulations and requirements.Purpose:1. To outline the procedure of identifying and addressing residents' strengths and needs through the RAI process.2. To provide information on the resident's condition3. To facilitate development of a comprehensive care plan (CP).4. To ensure care delivery that enhances the resident's quality of life.5. To help achieve the highest and practical level of self-sufficiency.Procedure:MDS Department1. Schedules MDS and CP Meeting in accordance to existing regulations governing RAI process.3. Assures the completeness and accuracy of the information in the MDS.5. Coordinates, signs and certifies the completion of the MDS.6. Submits MDS data in required format to CMS.8. Reviews and corrects errors with the MDS Coordinator.9. Files final validation submission report.On 9/22/25 at 12:18 PM, the survey team met with the LNHA, DON, Regional Nurse, CNO, and the DoO for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-11.1; 11.2(e)(h)

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	315066	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stratford Manor Rehabilitation and Care Center	787 Northfield Ave West Orange, NJ 07052

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on interview and record review, it was determined that the facility failed to ensure that the residents Attending Physician visited and documented monthly visits, every other month when the Advanced Nurse Practitioner (ANP) visited on the subsequent month for 1 of 28 residents reviewed (Resident #11). This deficient practice was evidenced by the following:On 9/17/25 9:31 AM, the surveyor reviewed Resident #11's hybrid (paper and electronic) medical record which revealed that the resident's attending physician had no documented visit from 5/1/24 through 12/31/24. The remaining documented visits in the resident's electronic medical record were done by the ANP for the same time frame.A review of Resident #11's admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; cerebral infarction (a stroke, where blood flow to part of the brain is blocked), atherosclerotic heart disease (a condition of progressive narrowing and hardening of coronary arteries), and essential hypertension (high blood pressure).Further review of the resident's medical record also reflected that they were receiving hospice care, which was a specialized form of healthcare designed to provide comfort, support, and dignity to individuals in the final stages of a terminal illness.On 9/17/25 at 10:40 AM, the surveyor interviewed the Unit Manager (UM), who stated that the Medical Doctor (MD) comes in once in a while or once in a blue moon, usually probably in the evenings. The UM also stated that the ANP and the Hospice Nurse visited the resident.On 9/18/25 at 9:56 AM, the surveyor interviewed the APN, who stated that they were a contracted vendor with the facility for two years and visited three days a week. The APN further stated that they supplement physician visits, and usually sees Resident #11 alone, without the MD. The surveyor asked the APN if they recall the last time that the resident was seen and evaluated by the MD, and the APN responded that they believed it was last year.On 9/22/25 at 9:26 AM, the surveyor interviewed the UM and asked if there was anywhere else that Resident #11's MD documented other than the paper chart. The UM stated no, other than a note that was entered into the electronic medical record (EMR) on 9/4/25. On 9/22/25 at 10:58 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), The Regional Nurse, the Chief Nursing Officer (CNO), and the Director of Operations. The surveyor showed the DON Resident #11's paper chart and asked if they could locate any MD notes for the period of 5/1/24 through 12/31/24. The DON stated that they could not locate any. The surveyor asked if Resident #11's MD documents anywhere else other than the paper chart. The DON stated that the MD documented in the paper chart and only recently in the EMR.At that same time, the DON stated that APN and Hospice Nurse both see the resident and document. The surveyor asked the DON if they were aware of the regulations for MD and non-physician practitioners that reflect that an APN could only alternate with the MD every other month. The DON agreed that that was the regulation. The surveyor showed the DON and LNHA the recently provided MD notes for January 2025 through September 2025, that reflected the MD had documented monthly, not alternating as was suggested. The surveyor asked the DON if any of the notes from January 2025 through September 2025 reflected as being comprehensive progress notes. The DON stated no that they do not look like comprehensive notes. The MD notes for January 2025 through September 2025 did not reflect the resident's name or any other identifier.On 9/22/25 at 11:54 AM, the survey team met with the LNHA and DON, and the LNHA provided documentation of a Quality Assurance Performance Improvement (QAPI) report dated 9/5/25, titled Physician Visit Documentation Compliance. The facility did not provide MD progress notes for the period of 5/1/25 through12/31/25 as requested.The LNHA did not provide any further pertinent information.A review of the facility's Physician Visits Policy, dated as reviewed 12/24, reflected under Policy: It is the policy and procedure of this facility that the Attending Physician must make visits in accordance with applicable state and federal regulations. Procedure: 1. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admissions, (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and then at least every sixty (60) days thereafter. 2.an alternate schedule of visits may be established, but not to exceed every sixty (60) days. A .nurse practitioner may make alternate visits. N.J.A.C. 8:39-23.2(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication per manufacturer specifications and standards of practice. This deficient practice was identified in 1 of 3 medication carts observed on 1 of 2 nursing units of the facility. This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 9/16/25 at 1:55 PM, the surveyor began to inspect selected medication (med) storage areas in the facility and observed the following:The surveyor in the presence of Licensed Practical Nurse (LPN) inspected the med cart identified as the East Cart. The surveyor observed a total of 19 unidentified tablets (tabs) and/or capsules (caps) located in the bottom of the 3rd drawer. The surveyor asked the LPN if they could identify the loose tabs or caps and if they should be stored that way. The LPN stated that they were in the process of cleaning out the cart and could not identify what the med was or who it was for and that it should not be stored that way since it was not clean.The surveyor showed the LPN/Unit Manager (LPN/UN) the loose medications (meds) and asked if the meds should be stored loose. The LPN/UM stated that the meds should not be in the cart that way and thought that the cart had been previously cleaned. The surveyor observed the LPN assigned to the med cart dispose of the unidentified meds in a self-contained drug disposal system. On 9/18/25 at 1:17 PM, the survey team met with the facility Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to discussed the above findings and concerns.On 9/22/25 at 10:33 AM, the survey team met with the LNHA, DON, Regional Nurse, Chief Nursing Officer (CNO), and Director of Operations (DoO), and the DON provided a copy of staff education for med storage and loose pills.A review of the facility's Medication Storage Policy dated reviewed June 2025, reflected under Policy: .facility to store meds in a safe and proper manner. Procedure: 1. Meds are stored in the containers in which they are received. 7.Meds are stored in an orderly manner in cabinets, drawers or carts.The LNHA did not provide any further pertinent information for med storage.NJAC 8:39-29.4(d)(g)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain a complete, accurately documented, readily accessible, and systematically organized medical records. This deficient practice was identified for 2 of the 28 residents reviewed (Residents #2 and #15). This deficient practice was evidenced by the following:1.On 9/15/25 at 1:24 PM, The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #2, and revealed:A review of the admission Record (AR; an admission summary) or face sheet, revealed Resident #2 had been admitted with diagnoses which included but were not limited to; heart failure unspecified, other sequelae following unspecified cerebrovascular disease (stroke), hemiplegia (a neurological condition characterized by paralysis of one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction affecting right dominant side, and chronic obstructive pulmonary disease (COPD; an ongoing lung condition caused by damage to the lungs) unspecified.A review of the comprehensive Minimum Data Set (MDS), with an assessment reference date (ARD) of 7/22/25, reflected a brief interview for mental status (BIMS) score of 13 of 15, indicated that the resident was cognitively intact.A review of the neurology (neuro) consult (paper consult) dated 4/25/25, revealed recommendations for CT (computed tomography scan is a non-invasive imaging procedure that uses X-rays to create detailed images of the brain and surrounding structures, helping diagnose various medical conditions) brain and neuro follow up in two months.A review of the cardiology consult (paper consult) dated 6/18/25, revealed recommendations for five day [NAME] (a portable device that continuously records the heart's electrical activity for 24 to 48 hours, helping to diagnose irregular heart rhythms) monitor given, follow up in a month, continue medications including metoprolol and apixaban. Further review of the above neuro and cardiology consults revealed that there were no documented evidence that Resident #2's physician was notified of the above recommendations for CT scan of brain and follow up with neuro in two months and the recommendations for five day [NAME] monitor and follow up in a month were followed, or as to why it was not followed.On 9/16/25 at 11:04 AM, the surveyor asked the Registered Nurse (RN) if the recommendations were followed and where were the results for 4/25/25 and 6/18/25 consults, and the RN responded that it should be with the Unit Manager (UM). The Unit Clerk (UC) who was in the nursing station also responded that the CT of the brain was not done because the resident was in and out of the facility and hospital, and the follow up was not done as well for the neuro because the CT of the brain was not done. The UC also stated that the five day [NAME] was not sent yet for results because of the same thing, the resident was in and out of the hospital. The UC confirmed that the [NAME] monitor was still at the facility and was not sent over (or returned to the office of the neurologist who provided the device). On 9/16/25 at 11:05 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) regarding the facility's process with regard to physician consultations. The LPN/UM stated that recommendations would be relayed to the resident's primary physician, and if the physician agreed with the recommendations, it would be carried out. She further stated, if the physician declined the recommendations, it would be documented in the progress notes (PN). The surveyor asked for documentation if the recommendations were carried out or not for neuro consult dated 4/25/25, and cardiology consult on 6/18/25, and she stated that she would get back to the surveyor.On 9/16/25 at 11:47 AM, the LPN/UM informed the surveyor that the resident's CT brain was done on 6/19/25 at the hospital. The surveyor asked where the result was and the follow up appointment notes, and the LPN/UM stated that the resident was out of the hospital that time in June 2025. The surveyor notified the LPN/UM that according to the resident's MDS, the resident was in the hospital 7/1/25, and not June 2025. The LPN/UM informed the surveyor that the [NAME] monitor was done at the facility and that she would follow up the results. The surveyor also asked where (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were the consult notes that the resident was seen by cardiologist and neurologist as follow up according to the recommendations, and the LPN/UM responded that she would follow up and check.On 9/16/25 at 1:05 PM, the LPN/UM provided a copy of CT head from hospital dated 6/19/25, which she confirmed that was due to resident had swelling of eyelid due to multiple falls and not due to recommendation of the Neurologist on 4/25/25. The LPN/UM stated that the [NAME] monitor and CT scan of the brain recommendations were not approved by the primary doctor. The LPN/UM confirmed that there was no documentation from the physician and the nurse that the recommendations were relayed and declined by the physician. She also stated that she was unsure why the follow up with the two consultants were not followed. She further stated that it was the facility's practice to document all those information the resident's medical records.On 9/19/25 at 12:18 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Chief Nursing Officer (CNO), Director of Operations (DoO), the [NAME] President of Operations (VPoO), and the surveyor notified them of the above concerns with Resident #2's medical records and consults that were not followed.2. On 9/16/25 at 1:31 PM, the surveyor reviewed the discharge hybrid medical records of Resident #15, and revealed:A review of the AR revealed Resident #15 had been admitted with diagnoses which included but were not limited to; cerebral infarction (stroke), encounter for palliative care, type 2 diabetes mellitus with mild non proliferative diabetic retinopathy without macular edema bilateral, aphasia (a language disorder that affects a person's ability to communicate) following cerebral infarction, major depressive disorder recurrent and specified, and unspecified psychosis not due to a subacute or known physiological condition.A review of the current personalized Care Plan (CP) with focus that the resident planned to remain for long term care, that was created and revised on 3/19/23. There was no documented evidence the resident had CP for transfer to another facility.A review of the Social Service quarterly PN with an effective date of 6/12/25, revealed that long term care remained appropriate.A review of the quarterly MDS (qMDS), with an ARD of 9/1/25, reflected C1000. Cognitive Skills for Daily Decision Making was coded #2, indicated that the resident cognition was moderately impaired. The qMDS also reflected that the resident participated in the assessment and goal setting and there was no plan for discharge.A review of the recent discharge return not anticipate Minimum Data Set (DRNAMDS), revealed that the resident had a planned transfer to hospice institutional facility.A review of the Social Service PN created on 9/11/25 at 11:51 AM, reflected that the Director of Social Services (DSS) documented that the resident was scheduled for transfer to another facility, notified the Resident Representative (RR) of transfer, transportation was arranged for pick up at 1:00 PM, and nursing was made aware of transfer. There was no documented evidence that the RR had prior notice of transfer and/or was notified of the reason of transfer to another facility.On 9/19/25 at 11:02 AM, the surveyor interviewed the LPN/UM about facility's discharge and transfer practice and policy. The LPN/UM stated that all information about resident's transfer should be documented in electronic medical records (eMR) including the notification of the RR about the reason of transfer.On 9/19/25 at 12:18 PM, the survey team met with the LNHA, DON, CNO, DoO, and the VPoO, and S#1 notified them of the above concerns with Resident #15's concerns with regard to transfer to another facility, that there was no documented evidence that the RR was notified of the transfer prior to 9/11/25 transfer and was aware of the reason of transfer. The surveyor also notified the facility management of the concerns that CP did not include information about plan to transfer the resident.On 9/22/25 at 8:46 AM, the surveyor met with the LNHA for Quality Assurance Performance Improvement (QAPI) meeting and the surveyor asked what areas of concerns that the surveyors identified and were not discussed in the facility's most recent QAPI meeting. The LNHA stated the concern of the surveyor with regard to medical records and documentation were not identified from the most recent QAPI meeting.On 9/22/25 at 11:48 AM, the survey team met with the LNHA and DON. The DON stated that she obtained a copy of the Interdisciplinary team meeting dated 9/8/25, informing the RR of the transfer. The surveyor asked why it was not presented or provided by the Director of Social Services (DSS) at the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time of interview and when the surveyor asked for it on 9/19/25. The DON stated she did not know where she found the copy and shy it was not provided by the DSS. The surveyor asked for the facility's medical records policy.A review of the facility's Medical Records and Confidentiality of Information and Personal Privacy Policy that was provided by the LNHA, with a reviewed date of 6/2025, revealed there was no information about the regulation that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-(i) Complete;(ii) Accurately documented;(iii) Readily accessible; and(iv) Systematically organized.On 9/22/25 at 12:18 PM, the survey team met with the LNHA, DON, Regional Nurse, CNO, and the DoO for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-23.2 (a)(b); 34.1(a); 35.2