STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315068	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dwellside Care and Rehab	3025 Chapel Avenue West Cherry Hill, NJ 08002

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure the environment was clean, sanitary, and homelike for four out of 11 sampled residents (Resident (R)4, R17, R18, R27) who resided on the second floor ([NAME] unit). Specifically, the only shower room on the second floor ([NAME] unit) and common area floors on the second floor were unclean. Additionally, food carts with partially eaten meals from the previous day were observed in the hallway on the first floor. Findings include: Review of the facility's Homelike Environment policy dated August 2024 revealed, Residents are provided with a safe clean, comfortable and homelike environment . The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary, and orderly environment . 1. Residents residing on the second-floor reported concerns about cleanliness and the condition of the shower room on the second floor: a. During an interview on 02/24/25 at 2:21 PM R4 stated the shower room that he/she utilized for showers on the second floor was used as a storage area for scales, equipment, clothing from residents who had discharged , and soiled incontinence briefs were stored in the shower room creating terrible odors at times. R4 stated cleanliness on the second floor was also a concern and reported that the hallway had not been mopped for four days. R4 stated the flooring in the common areas was disgusting. R4 reported there were concerns with the housekeeping shifts not being filled on the second floor. Review of R4's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/17/24 located in the electronic medical record (EMR) under the MDS tab revealed R4's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. b. During an interview on 02/24/25 at 3:32 PM, R17 stated The shower is a mess. R17 stated staff used the shower room as a storage area and he/she was not able to take a shower today due to the clutter and stated, It was totally dirty. R17 stated there were two mats on the floor in the shower stalls, a shower bed in one shower stall and two chairs in the second shower stall. R17 stated the room was such a mess he/she did not end up taking a shower. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R17's quarterly MDS with an ARD of 10/29/24 located in the EMR under the MDS tab revealed R17's cognition was intact with a BIMS score of 15 out of 15. c. During an interview on 02/24/25 at 4:08 PM, R18 stated he/she did not take showers, reporting he/she could not stand or walk. R18 stated the staff wanted him/her to lay on a gurney on top of a foam pad to be showered. R18 stated the foam pad on top of the gurney was not adequately cleaned. When staff had taken him/her in there, the pad he was supposed to lay on was wet, soggy, and unclean. R18 stated he/she had complained about this to staff and had refused to take showers ever since. Review of R18's quarterly MDS with an ARD of 12/12/24 located in the EMR under the MDS tab revealed R18's cognition was intact with a BIMS score of 15 out of 15. d. During an interview on 02/26/25 at 6:29 AM, R27 stated the shower room was unclean. R27 stated he/she sat on a shower chair when taking him/her shower and a few times the shower chair had not been wiped off and there was stuff all over the floor. R27 stated someone's clothes were stored in the shower room in a pile. Review of the admission MDS with an ARD of 01/16/25 located in the EMR under the MDS tab revealed R27's cognition was intact with a BIMS score of 15 out of 15. 2. During an observation on 02/24/25 at 2:00 PM, the hallways of the [NAME] unit were observed with numerous areas of sticky food/beverage spills and small white particles mostly concentrated on the floor by the walls. The dining common area had a large spill of several feet in length and approximately one foot in width near the windows. During an observation on 02/24/25 at 4:00 PM, the [NAME] shower room was made with Licensed Practical Nursing (LPN)15. The shower room had three shower stalls. Each shower stall contained equipment. The first stall had a shower bed with two shower pads, one solid foam and one with fabric on top. The fabric pad was soiled with white residue, verified by LPN15 who agreed it was not clean. There were shower chairs in the other two shower stalls. There was garbage on the floor such as an empty plastic garbage bag and wadded up paper towels. LPN15 stated the Certified Nursing Assistants (CNAs) showered residents and it was the only shower room for [NAME] which had a typical census of 57 residents. LPN15 stated housekeeping staff cleaned the shower room once a day, including sterilizing the shower pad daily. LPN15 stated CNAs were to clean up after each shower that was provided. The second shower stall was missing the floor drain; the hole approximately two inches in diameter was not covered. The area at the back of the shower room was used for dressing residents per LPN15. This area was cluttered and in a state of disarray with multiple pieces of equipment including two Geri chairs, a walker on top of one of the Geri chairs, curled up floor mats, two scales, and two large 55-gallon garbage cans. One garbage can did not have the lid on it; it contained garbage. LPN15 put the lid on the can and stated the lid should be on the can. The second can was opened by LPN15, and it was a third full of soiled linen including soiled incontinence briefs that were not individually bagged and it smelled when the lid was removed. On one of the Geri Chairs, there was a pile of clothing (at least 20 pieces) that overflowed onto the floor where there were about another 10 pieces of clothing in a pile on the floor. LPN15 verified the shower room was not clean and needed to be organized with excess equipment/items removed. LPN15 verified residents' clothing should not be stored in the shower room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/24/25 at 4:05 PM, there was a large sticky area, approximately 12 inches in diameter, in the hallway on [NAME] between room [ROOM NUMBER] and 230. There was also a sticky area in hallway between 231 and 230 about 12 inches in diameter. During an observation on 02/25/25 at 11:19 AM, the floors in the [NAME] hallways were observed with lots of sticky looking areas of food/beverage spills. During an observation on 02/27/25 at 1:13 PM, the surveyor and Housekeeping/Laundry Supervisor observed the [NAME] floors of both hallways and the dining room. There were numerous sticky areas, multiple smaller areas of accumulated spills, and small white flecks throughout the hallways and dining room floors. The Housekeeping/Laundry Supervisor stated the small white flecks were paint chips. The Housekeeping/Laundry Supervisor stated the floors needed a lot of attention; she stated they are not clean. There were sticky areas throughout the dining room floor. During an observation on 02/27/25 at 1:18 PM the surveyor and Housekeeping/Laundry Supervisor entered the [NAME] shower room. There was a balled-up paper towel, plastic pieces, and breadcrumbs on the floor. One of the garbage cans contained soiled incontinence briefs. The Housekeeping/Laundry Supervisor stated the shower room should be cleaner than it was and there should not be soiled incontinence briefs placed into the garbage bin. 3. During an interview on 02/25/25 at 2:45 PM, LPN1 stated some residents were showered on the shower bed on top of one of the pads. LPN1 stated the shower pad should be disinfected with purple top wipes after being used. LPN1 stated she went into the shower room on the afternoon of 02/24/25 and stated it was disorganized. LPN1 stated the extra wheelchairs, and walker had been removed and should not be stored there. LPN1 stated a resident's clothing was stored in the shower room but it was not normal to store residents' clothing in the shower room. LPN1 stated there were times when she had scraped stuff off the floors and the shower rooms were not as clean as it should be. During an interview on 02/27/25 at 11:57 AM, CNA8 stated the CNAs were responsible for cleaning and sanitizing the shower chairs/bed. She further stated the shower room should be maintained in a clean and tidy manner. During an interview on 02/27/25 at 12:50 PM, the Housekeeping/Laundry Supervisor stated there should be two housekeepers per day on the [NAME] unit and a Floor Tech to clean the common area floors. The Housekeeping/Laundry Supervisor stated one staff member had been out with illness. She further stated the common areas should be cleaned daily and each housekeeping was responsible for about 16 rooms. The Housekeeping/Laundry Supervisor stated that every day the Floor Tech. cleaned the floors. The Housekeeping/Laundry Supervisor stated after each shower the CNAs should wipe down the area. The Housekeeping/Laundry Supervisor stated that extra equipment should not be stored in the shower room. She stated her housekeeping staff went into the shower room first thing in the morning to ensure cleanliness and to check for garbage. The Housekeeping/Laundry Supervisor stated she had heard residents' concerns about housekeeping and the shower room from resident council meetings. During an interview on 02/27/25 at 6:21 PM, the Director of Nursing (DON) stated a lack of cleanliness had been brought up by the resident council. The DON stated clothing and extra equipment should not be stored in the shower room. The DON stated the CNAs should clean up after themselves after giving showers. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 02/26/25 at 6:10 AM of the hallway between A and B wing outside of the dining room doors revealed two carts stacked full of dirty dishes and old food. The carts were placed outside the dining room door that was locked. During an interview on 02/26/25 at 6:15 AM with Unit Manager/Licensed Practical Nurse (LPN)11 revealed she was the nursing supervisor on duty. She stated she was aware that the carts had been left there but she wasn't sure why. She did not offer any additional information. During an interview on 02/26/24 at 6:20 AM with Certified Nurse Aide (CNA)1 revealed the nursing supervisor had the key to access the room and that the dinner carts should have been stored in the dining room overnight. She stated the carts should not have been left in the hallway where residents had access to them. During an interview on 02/26/24 at 6:28 AM with Dietary Aide (DA) revealed he was a dishwasher and had just got to work. He stated the carts are usually placed in the back of the kitchen and not in the hallway for them to clean the dishes in the morning. He stated they should not have been left in the hallway like this. During an interview 02/26/25 at 5:10 AM the Director of Nursing (DON) stated the carts should not have been left in the hallway outside dining room door. The DON said the carts should have been left inside a locked area by the back of the dining room behind a locked door. He said staff should be rounding every hour to ensure things like this do not happen it was a hazard and puts residents at risk. N.J.A.C. 8:39-4.1a(11)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** NJ00176090, NJ00175919, NJ00171909, NJ00169026, NJ00165303, NJ00181236, NJ00179553, NJ00179421, NJ00175629, NJ00177976, NJ00183043, NJ00167029, NJ00165390, NJ00165211, NJ00164234, NJ00181173, NJ00183473, N00183733. Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure three residents (Resident (R)21, R22, and R24) were free from physical abuse by R20 out of a total sample of 32 residents. Due to the vulnerable nature of the nursing home population, the potential for serious injury or serious physical or psychosocial impairment from being physically abused by R20 existed, and the likeliness of R20 hitting another resident in the facility was high and required immediate action to prevent further events of physical abuse by R20. In addition, R20 physically assaulted three staff members Certified Nursing Assistant (CNA)4, Licensed Practical Nurse (LPN)16, and LPN1). The facility's Administrator and Regional Director of Nursing (DON) were informed on 02/26/25 at 3:33 PM of the Immediate Jeopardy related to the failure to ensure R21, R22, and R24 were free from abuse from R20. The Immediate Jeopardy began on 01/04/25 at 6:30 AM, which was the second resident-to-resident physical assault. On 02/27/25 at 2:32 PM, the facility provided an acceptable Immediate Jeopardy Removal Plan. The survey team verified the implementation of the facility's IJ Removal Plan on 02/27/25 at 6:40 PM, which included the following: The Director of Nursing (DON) immediately implemented 1:1 Monitoring for Resident #20 on all shifts. The in-service included the staff member assigned for 1:1 monitoring and will not be assigned other duties. Resident # 20 will remain on 1:1 monitoring per the physician's order indefinitely. The 1:1 monitoring will be for 24 hours, including the 7-3PM, 3-11 PM, and 11PM-7AM shifts. On 2/26/25, the DON initiated verbal education for all working nursing staff, including agency staff. The in-service included is as follows: a Staff member will be assigned for 1:1 monitoring and will not be assigned to any other duties. 2, The Unit manager and supervisors will ensure 1:1 is implemented and maintained at all times. Nursing staff reporting to duty will be educated by the supervisor/ designee prior to working unit 100% of the nursing staff education is completed. A staff member will be assigned to 1:1 monitoring and will not be assigned to any other duties. All newly hired nursing staff will be educated during orientation by Human resources on 1:1 monitoring per the facility's policy. The staff who received the education will verbalize understanding by signing the in-service as an acknowledgment of the education provided. After the Immediate Jeopardy was removed, the deficiency remained at a G scope and severity for actual harm due to R24 voicing that he/she was afraid and kept his/her door closed. Findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Abuse, Neglect, and Exploitation policy dated 10/21/24 revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include . certain resident to resident altercations . Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking . Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R20 was admitted to the facility on [DATE]; diagnoses included Alzheimer's disease, dementia, major depressive disorder, mood (affective) disorder, and hallucinations. Review of the annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/14/25 located in the EMR under the MDS tab revealed R20 was moderately impaired in cognition with a BIMS score of eight out of 15. R20 was independent in mobility and walked 150 feet independently. R20 did not exhibit behavior during the assessment period. The progression of R20's aggressive behavior was as follows: a. Review of the Reportable Event Record/Report form dated 06/17/24 and provided by the facility revealed the type of incident was resident-to-resident abuse, and it occurred on 06/15/24 at 6:10 PM. The incident was called into the State Survey Agency on 06/16/24 at 11:33 AM. The description of the event read, On 06/15/24 at about 6:10 PM, C.N.A [CNA4] in his/her w/c [wheelchair] between the A and B bed. The CNA [CNA4] called for help, resident [R20] was taken out of the room to calm his/her down . Review of the undated Investigation Summary provided by the facility verified the incident occurred as described on the Reportable Event Record/Report form dated 06/17/24, in which R20 became agitated, flailed his/her arms which came in contact with R21's head and arms. The Investigation Summary indicated both residents were assessed for injury, and no injuries were noted. The Investigation read, In conclusion, the incident was unintentional. [R20] accidentally hit [R21] when flailing his/her arms . On 06/17/24 both residents were interviewed by this writer, they had no recollection of the incident. [R21] was moved to a different room, however, on Wednesday, 06/19/24, he/she verbalized that he/she missed his/her roommate and requested to go back to his/her room . Review of R20's Care Plan revised on 06/15/24 was included in the Event Reporting file dated 06/15/24 and revealed a problem of [R20] is/has potential to be physically aggressive, refusing care, and strong desire to be independent r/t [related to] dementia, poor impulse control . 06/15/24 [R20 unintentionally hit another resident [R21]. The goal was for R20 to not harm himself/herself or others. Intervention in pertinent part[s] included psych consult, medication review, giving choices, and documenting behavior and interventions. CNA4 was an agency staff member. The facility did not have a phone number for CNA4, who witnessed the incident, and an interview was not conducted with CNA4. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Review of a Nurse's Note dated 11/17/24 at 10:56 PM revealed, Resident [R20] was received (sic) in the hallway ambulating. Later he/she walked into room [ROOM NUMBER] and was scattering things in the room . In an attempt to redirect him/her to his/her room he/she punched me [LPN16] on my face. During an interview on 02/26/25 at 4:24 PM, LPN16 stated he was the nurse for the resident who resided in room [ROOM NUMBER] on 11/17/24 when the incident with R20 occurred. LPN16 stated another nurse called him to go to room [ROOM NUMBER] to remove R20 from the room, adding that the nurse told him R20 was combative. LPN16 stated that R20 was in the bathroom in room [ROOM NUMBER] and went to use the resident's (who resided in room [ROOM NUMBER]) toothbrush. LPN16 said there were two other staff (a nurse and a CNA) in the room [ROOM NUMBER]. LPN16 stated he tried to prevent R20 from using the toothbrush, and he/she punched him/her in the face. LPN16 stated he quit trying to get him/her to come with him/her out of the bathroom. LPN16 stated it was painful, and he sustained a cut to his nose from being punched. During an interview on 02/26/25 at 2:12 PM, the DON stated that he was not aware of this incident. c. Review of a Nurses Note dated 12/11/24 at 10:25 PM in the EMR under the Progress Notes tab revealed, This nurse [LPN]1 was called by one of the aides reporting that patient [R20] had entered another patient's room and was barricading himself/herself in room # . This nurse [LPN1] went to room # . and attempted to redirect the patient [R20] out of the room. Patient then proceeded to grab this nurse's left ear and punch his/her closed fist in the face twice. This nurse stepped away and asked patient [resident] to leave the room at which point the patient [R20] placed this nurse in a choke hold and continued to physically assault this nurse. This nurse called the unit manager to deescalate situation. During an interview on 02/25/25 at 2:45 PM, LPN1 stated R20 was strong and was aggressive to staff and residents. LPN1 stated R20 punched her in the face twice and put her in a chokehold on 12/11/24 when she tried to redirect R20 out of another resident's room. LPN1 stated she did not think it was safe for residents with R20 continuing to reside in the facility. LPN1 stated she reported the incident to the supervisor on duty. During an interview on 02/26/25 at 2:12 PM, the DON stated that he was not aware of this incident. d. Review of the Reportable Event Record/Report form dated 01/05/25, provided by the facility revealed the event occurred on 01/04/25 at 6:30 AM and was classified as resident-to-resident abuse. The description of the event read, Nurse reported to supervisor that during 6 AM med [medication] pass on 01/04/24, CNA observed a physical altercation between the two residents [R20 and R22]. [R20] had no visible injuries and [R22] had visible bruising to left eye area and left side of the face and mouth. [R22] was transported to [the] hospital for evaluation and returned with no new orders. [R20] was escorted to crisis with police and returned with no new orders. Physician and family members were contacted and made aware. 1:1 supervision applied to [R20] as primary intervention for incident . Review of the undated CNA Statement provided by the facility revealed CNA5 documented, I was doing my rounds and I asked [R21] where was his/her roommate [R20] and he/she (sic) was just here. Walked out of the room, heard talking so I went in the room and [R20] was on top off (sic) [R22] with his/her hands on [R22's] neck. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the undated Investigation Summary revealed . Upon further investigation, the CNA stated that both residents were both seen in their individual bedrooms at 0430 [4:30 AM] and upon another round @ 0500 [5:00 PM], residents were seen in a physical altercation in [R22] s room. Following [the] return from crisis, staff attempted to transfer [R20] to another room however he/she refused and became combative with staff. Room change was then offered to [R22], and his/her family agreed to room change temporarily for safety. [R22] was moved to another unit, [R20] was placed on q [every] 15 [15 minutes] checks and was then evaluated via telehealth by psych who gave [an] order to remove q 15 checks and recommended med [medication] increase pending lab results . [R21 and [R20] have no previous issues, and this incident is isolated. It is concluded that [R20] may have entered [R22]'s room in a moment of confusion, which then caused [R22] to get out of bed and approach him/her to remove him/her from his/her bedroom. This may have led to the altercation . Both residents also did not recall the incident when interviewed the following day . Interventions were separating the residents immediately, skin evaluations, police notification, physician notification, families notified, [R22] transported to the emergency department and R20 transported to crisis. Increased supervision was removed on 01/06/25. Review of R22's Weekly Skin Evaluation dated 01/04/25 revealed R22 had a scratch on his/her right arm, sore on his/her right lower arm, two bruises on his/her left front thigh, a swollen area under his/her eye, eyeball that was red, swollen right side of his/her face, scratches on the front of his/her face, scratches on the side of his/her face, a scratch on the neck on the left side, and a swollen left lip. The narrative read, Resident was attacked by another resident [R20]. He/She has injuries to his/her face and left eye. Scratches on his/her face, left neck, right arm, and a bruise on his/her left thigh . Review of R20's Weekly Skin Evaluation dated 01/05/25 revealed R20 had an abrasion to the front of his/her right knee. The narrative read, The abrasion is a result of physical altercation with peer. First aid Triple Antibiotic applied. No pain verbalized or observed. Review of the Order Summary Report current through 02/25/25 in the EMR under the Order tab revealed the physician ordered a psych consult for R20 for aggression and violent behavior on 01/08/25. Review of the investigation file revealed Statewide Clinical Outreach Program for the Elderly (S-COPE) was conducted on 01/13/25 Review of the S-COPE clinical consultation form dated 01/13/25 revealed R20 jumped on another resident and had his/her hands around the resident's neck. No injuries were sustained. S-Cope support was requested. The form read, Risk factors: No risk at [the] time of assessment for harming others. Recommendations included monitoring interactions with residents, monitoring for unmet needs, and follow up with psychiatry with ongoing concerns of behavior. Training recommended included staff training on Resident Aggression in LTC. CNA5, an agency staff, was called on the phone on 02/26/25, and a message was left by the surveyor. CNA5 did not return the call, and CNA5, who was a witness to the incident, was not interviewed. LPN14, an agency staff assigned to R20 on 01/04/25, was called on 02/26/25; there was no answer, and voice mail was not activated to leave a message. LPN14 was not interviewed. There was no written statement by LPN14 regarding the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/25 at 2:04 PM, the DON stated he completed the investigation and stated R20 was sent to the psych portion of the ER [emergency room] following this incident. The DON stated it was common, as in this case, that the hospital reported the resident had dementia, and they sent R20 back to the facility. The DON stated R20 was initially on 1:1 observation, then 15-minute checks, and then the Psychiatrist recommended the discontinuation of 15-minute checks. The DON stated R20's Depakote [seizure medication with off label use for behaviors] was increased after this incident. The DON verified there were no additional staff statements and no staff training after the incident (as recommended in the S-COPE evaluation). The DON stated both residents had histories of behaviors. During an interview on 02/27/25 at 7:03 PM, the DON was asked if the abuse was substantiated as this was not documented on the Investigation Summary. The DON stated he was not sure if it was substantiated. e. Review of the Reportable Event Record/Report form dated 02/20/25 provided by the facility revealed the incident was classified as resident-to-resident abuse that occurred on 02/19/25 at 5:45 PM and was reported to the state on 02/19/25 at 7:40 PM by the DON. The Reportable Event Record/Report revealed that the incident occurred in R24's bedroom, and it was reported to the DON that R20 had wandered into R24's bedroom. Staff intervened and attempted to redirect R20 out of the room. R20 became combative and a physical altercation started between the residents. Both residents were separated, and Emergency Medical Services (EMS) was called. R24 was transported to the hospital for evaluation and returned on 02/20/25 with no new orders or injuries. EMS was requested to send R20 to crisis, but they refused. R20 was placed on 1:1 supervision immediately. Skin evaluations were completed, and new skin issues were noted; however, what the skin issues were was not documented. Interventions included separating the residents, skin evaluations, pain evaluations, police notification, emergency contacts and physician notified, 1:1 supervision implemented, emergency psych telehealth consult ordered, psychosocial evaluation and S-COPE consult, as well as emotional support being provided. Review of LPN15's Employee Statement revealed the incident occurred at 5:30 PM as follows, Resident was last seen in [the] hallway going to dayroom for dinner. Was notified by aide that resident [R20] was in R24's room following a physical altercation and refusing to leave the room. Resident became physically aggressive with staff upon entry. Physical altercation resulted in another resident [R24] being injured and sent to the hospital with hematoma to the back of his/her head. Review of R20's Weekly Skin Evaluation dated 02/19/25 and provided to the surveyor revealed R20 was not documented with any skin issues/abnormalities. Review of R24's Weekly Skin Evaluation dated 02/19/25 and provided to the surveyor revealed R24 was observed with a medium sized knot to the back of his/her head that hurts even more per the facial pain scale. R24 was noted with swelling on the back of his/her head and the narrative read, Resident hit back of head when he/she fell. Sent to ER for evaluation and treatment. Review of the Emergency Department report dated 02/19/25 and provided by the facility revealed R24's diagnoses of, closed head injury, initial encounter, disorder of spinal cord in neck, hematoma of occipital region of scalp . Review of the Order Summary Report dated 02/20/25 in the EMR under the Orders tab revealed a physician's order on this date for, 1:1 observation every shift for observation and monitor and document. (continued on next page)

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	315068	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dwellside Care and Rehab	3025 Chapel Avenue West Cherry Hill, NJ 08002

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation on 02/26/25 at 6:09 AM, R20 was in his/her room. R20's roommate was in bed with his/her eyes closed. There was no CNA providing 1:1 in the room, and no CNA was observed in the hallway outside R20's room. A second observation on the same day, 8:15 AM through 8:30 PM, revealed that R20 was under continuous 1:1 observation. During an interview on 02/26/25 at 2:12 PM, the DON stated that there should be 1:1 on all shifts. The DON stated usually R20 was a lovely lady/man, but when anyone tried to redirect him/her, there was no stopping him/her. The DON stated that it was his/her personality. During an interview on 02/26/25 at approximately 5:15 PM, R24 recalled the incident on 02/19/25. R24 stated he/she was eating dinner in his/her room, and R20 came into his/her room and told him/her that it was his/her bed. R24 stated he/she told R20 no; it was not his/her room and asked him/her to leave. R24 stated that R20 tried to grab a small bag at the head of the bed with his/her cell phone in it. R24 stated that two staff members came into the room and tried to get R20 to go out, but R20 said No and would not leave. R24 stated he/she got up and walked to the door and R20 followed him/her, the staff having already left the room. R24 stated he/she was standing by the door, and R20 pushed him/her, and he/she fell in the hallway, hitting the back of his/her head on the floor, which caused him/her pain to the back of his/her head. R24 stated the police came, and he/she was asked by the nurse if they wanted to go to the hospital, which he/she stated he/she did. R24 stated the incident on 02/19/25 was not the first time R20 came into his/her room uninvited. R24 stated, a few days before that, R20 came into his/her room, went into his/her bathroom, and stayed there for about 30 minutes. R24 reported it to the CNA and asked if she could see what R20 was doing. R20 eventually left the room. R24 stated after the incident on 02/19/25, he/she was in the dining area, and she saw R20 walking around and did not see any staff with him/her. R24 stated he/she was nervous about that. R24 stated he/she was traumatized by the incident on 02/19/25. R24 stated he/she was keeping the door to his/her room closed so people wouldn't come in. R24 stated none of the staff came and asked him/her to give them a statement of what occurred on 02/19/24 or came to discuss how he/she was doing. Review of R20's Psychiatric Progress Note dated 02/20/25 and provided by the facility, revealed recommendations were made regarding R20 to consider supportive and non-pharmacological approaches, redirect, provide support, provide comfort, reduce stimulation, treat medical issues, encourage participation in activities, and social engagement. The recommended medication changes were to add Depakote 125 q day at 2:00 PM and increase the bedtime dose to 250 mg, with the morning dose remaining unchanged. Review of the Order Summary Report current through 02/25/25 in the EMR under the Orders tab revealed the recommended changes to Depakote were ordered. LPN15 was called on 02/26/25, and a message was left. LPN15 did not return the surveyor's call, and she was not interviewed. CNA6 was called on 02/26/25 at 3:57 PM, and a message was left. CNA6 did not return the surveyor's call and was not interviewed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/25 at 6:19 AM, CNA7 stated she had an assignment of residents, including R20. CNA7 stated there was no permanent CNA completing 1:1 on the night shift; 1:1 for R20 was completed on the day shift and evening shift only. CNA7 was in the hallway after coming out of a different resident's room and stated she had a chair she sat in outside of R20's room for extra supervision when she was not providing care or doing rounds. During an observation on 02/26/25 at 7:00 AM, R20 was observed in his/her room. There were no staff in the room providing 1:1 observation. At this time, the day shift CNA came on duty and went to R20's room. During an interview on 02/26/25 at 10:55 AM, the Medical Director stated wandering and aggressive residents were a big concern, and they looked at each case and patient individually. The Medical Director stated he was not aware of any residents that were currently having a problem with wandering or of resident-to-resident abuse incidents. The Medical Director stated he would like to be involved in the plan to address these incidents. The Medical Director reviewed R20's Physician's Orders and stated the 1:1 should be on all shifts per the orders. The Medical Director stated he was not the attending physician of R20. During an interview on 02/26/25 at 5:10 PM, the Administrator stated 1:1 required staff to be in the resident's line of sight. During an interview on 02/27/25 at 11:57 AM, CNA8 stated that R20 tended to be aggressive towards staff and could also be aggressive towards residents. CNA8 stated that R20 said, Don't you dare at times when trying to provide care or redirect, and he/she was very quick and aggressive. CNA8 stated that the main approach was to redirect R20 when he/she became aggressive and to keep him/her busy to prevent behaviors. During an interview on 02/27/25 at 3:01 PM, LPN9 stated R24 was traumatized by the incident with R20. During an interview on 02/27/25 at 6:39 PM, the DON stated he had spoken with R24 on the phone after the incident occurring on 02/19/25. The DON stated R24 reported to him that R20 wandered into his/her room and the staff tried to get R20 out. The DON stated R24 told him R20 pushed him/her down. The DON stated R24 had not reported R20 coming into his/her room previously and trying to get his/her cell phone. The DON stated he was aware that there were wanderers on the [NAME] unit. The staff had talked with families, offered stop signs to residents to place on their doors, put photos on the doors so residents knew which room was theirs. The DON stated the wandering occurred mostly in the evenings, and they could not restrain residents. The DON stated they had consulted psych and did tele-visits for R20. The DON stated the facility was seeking placement elsewhere for R20, although his/her family was not open to it. The DON stated R20 would be more appropriate in a behavioral facility so her behaviors could be better managed. Additionally, the DON stated that their regular night shift nurse was sick on 02/26/25, and the night 1:1 supervision was not provided. The DON stated that LPN17 should have assigned a CNA for 1:1 supervision for R20 and should not have given that CNA any other assignment. The DON verified that there was a charge nurse working the night shift who also could have caught the error of R20 not having a staff member assigned for 1:1 supervision. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	N.J.A.C. 8:39-4.1(5)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure abuse investigations were thoroughly investigated for three out of five investigations reviewed affecting four out of 32 sampled residents (R20, R21, R22, and R24) Specifically, the facility failed to interview the alleged victims, perpetrators, witnesses, and failed to determine whether abuse occurred, the extent, the cause, and failed to ensure complete and thorough documentation was maintained. This created the potential for abuse to occur unchecked. Findings include: Review of the facility's, Abuse, Neglect, and Exploitation policy dated 10/21/24 revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . Written procedures for investigations include: . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause and 6. Providing complete and thorough documentation of the investigation . 1. Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R20 was admitted to the facility on [DATE]; diagnoses included Alzheimer's disease, dementia, major depressive disorder, mood (affective) disorder, and hallucinations. Review of the annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/14/25 in the EMR under the MDS tab revealed R20 was moderately impaired in cognition with a BIMS score of eight out of 15. R20 was independent in mobility and walked 150 feet independently. R20 did not exhibit behavior during the assessment period. Review of R21's annual MDS with an ARD of 01/08/25 in the EMR under the MDS tab revealed R21 was moderately impaired in cognition with a BIMS of 10 out of 15. Review of the 06/15/24 Reportable Event file provided by the facility revealed there were two witness statements in the file, one from Certified Nursing Assistant (CNA)4 and one from Licensed Practical Nurse (LPN)13: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated CNA Statement from CNA4 revealed, [R20] was trying to enter room while [R21] was being changed. [R20] expressed interest in going to another hallway upstairs to his/her children. I [CNA4] attempted to shut the door as [R21] was exposed/naked, in an attempt to protect his/her privacy. [R20] busted through the door, I redirected him/her towards the dining room, and he/she started to swing his/her fists, stating 'don't touch me.' I asked [R20] to please calm down, guiding his/her hands in a downward motion, to keep from being punched again, and to protect [R21], as he/she was sitting in his/her wheelchair next to me. [R20] is quite strong and began to swing again, hitting [R21] in the top of his/her head, [R21] put his/her arms up to block [R20] and [R20] also hit [R21] in his/her arm. I called for help once [R21] wasn't being attacked as I saw the nurse heading to room [ROOM NUMBER]. Nurse came immediately and attempted to remove [R20] from the room. [R20] then tried to hit the nurse and ended up punching me [CNA4] in the stomach. We then removed the other resident [R21] to keep him/her safe . The CNA statement did not document CNA4's name. Nowhere in the investigation file was CNA4's name documented. Review of the Witness Statement from LPN13 read, This nurse [LPN13] was called to room [R21's room] by CNA [CNA4]. CNA then informed this nurse that resident [R20] was attempting to enter room during CNA changing roommate [R21] and at some point, made it in swinging his/her arms where other resident [R21] was then hit in the arm and head. This nurse [LPN13] attempted to redirect resident [R20]. However, resident started swinging his/her arms again at this nurse however CNA [CNA4] was hit in stomach. This nurse removed other resident [R21] out of room for safety. Review of the undated Investigation Summary provided by the facility verified the incident occurred on 06/15/24. There was no documentation of the actual statements taken from either R20 or R21 on 06/15/25 or thereafter, in the Report Event File dated 06/15/24. Neither of the residents' skin assessments following the incident on 06/15/24 were in the Reportable Event 06/15/24 file. The skin assessments for R20 and R21 were requested. The skin assessment for R21 was not provided. During an interview on 02/26/25 at 2:01 PM the Director of Nursing (DON) confirmed that there were no additional witness statements and confirmed CNA4's name was missing from the document. 2. Review of the Reportable Event Record/Report form dated 01/05/25 revealed the event occurred on 01/04/25 at 6:30 AM and was classified as resident-to-resident abuse. The description of the event read, Nurse reported to supervisor that during 6 am med [medication] pass on 01/04/24, CNA [CNA5] observed a physical altercation between the two residents [R20 and R22]. [R20] has no visible injuries and [R22] had visible bruising to left eye area and left side of the face and mouth. [R22] was transported to hospital for evaluation and returned with no new orders. [R20] was escorted to crisis with police and returned with no new orders. Physician and family members contacted and made aware. 1:1 supervision applied to [R20] as primary intervention for incident . Review of the undated CNA Statement provided by the facility revealed CNA5 documented, I was doing my rounds and I asked where was his/her roommate [R20] was, and he/she (sic) was just here. Walked out of the room, heard talking so I went in the room and [R20] was on top off (sic) [R22] with his/her hands on [R22's] neck. This was the only witness statement associated with the incident. There was no name, signature, or date on the statement by CNA5. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request was made on 02/25/25 to the Administrator for any additional witness statements for the reportable event that occurred on 01/05/25. None were provided. There was no witness statement from the nurse involved in the incident and there were no statements taken from the residents involved (R20 and R22). Review of the undated Investigation Summary provided by the facility revealed, there were no statements from the residents describing what happened; it is unknown how it was determined that R22 may have gotten out of bed and approached R20 to remove him/her from the bedroom. The witness statement CNA5 did not document this. In addition, the Investigation Summary did not indicate whether abuse occurred. During an interview on 02/26/25 at 2:04 PM, the DON verified there were no additional witness statements for the incident occurring on 01/05/25. Even though CNA5 observed R20 with his/her hands on R22's neck and R22 sustained injuries to his/her face, neck, arm, thigh, eyeball, and lip from the incident, during an interview on 02/27/25 at 7:03 PM, the DON was asked if the abuse was substantiated as this was not documented on the Investigation Summary. The DON stated he was not sure if abuse was substantiated. 3. Review of the Reportable Event Record/Report form dated 02/20/25 provided by the facility revealed the incident was classified as resident-to-resident abuse that occurred on 02/19/25 at 5:45 PM and was reported to the state on 02/19/25 at 7:40 PM by the DON. The Reportable Event Record/Report revealed the incident occurred in R24's bedroom and it was reported to the DON that R20 wandered into R24's bedroom. Staff intervened and attempted to redirect R20 out of the room. R20 became combative and a physical altercation started between the residents. Both residents were separated, and Emergency Medical Services (EMS) was called. R24 was transported to the hospital for evaluation and returned on 02/20/25 with no new orders or injuries. EMS was requested to send R20 to crisis, but they refused. Review of LPN15's Employee Statement revealed the incident occurred at 5:30 PM as follows, Resident [R20] was last seen in hallway going to dayroom for dinner. Was notified by aide that resident [R20] was in [R24's room] following a physical altercation and refusing to leave the room. Resident [R20] became physically aggressive with staff upon entry. Physical altercation resulted in [R24] being injured and sent to the hospital with hematoma to the back of his/her head. This was the only witness statement in the Reportable Event file dated 02/19/25. There was no witness statement by CNA6 who was involved/assigned per the facility's undated/untitled document of staff who were working. Nowhere in the file was CNA6's name documented. There was no documentation in the Reportable Event file dated 02/19/25 of R24's witness statement. Review of R24's admission MDS with an ARD of 01/18/25 in the EMR under the MDS tab revealed R24 was intact in cognition with a BIMS score of 13 out of 15. During an interview on 02/27/25 at 6:39 PM, the DON stated he had spoken with R24 on the phone after the incident occurring on 02/19/25. The DON stated R24 reported to him that R20 wandered into his/her room and the staff tried to get R20 out. The DON stated R24 told him R20 pushed him/her down. The DON confirmed all documents including witness statements for the 02/19/25 incident was provided and there was no additional information to provide. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	N.J.A.C. 8:39-9.4

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to monitor and assess a resident's skin around a cast and notify the physician timely when necrotic skin was found around the cast for one of one (Resident (R)14) reviewed for timely monitoring and assessments of 32 sampled residents. This failure resulted in harm when R14 was sent to the hospital, surgery was required, and a maggot infestation was found under the cast. Findings include: Review of R14's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed that R14 had been admitted to the facility initially on 10/14/22 with the diagnosis of dementia and diabetes mellitus. The resident passed away at the facility on 01/25/25. Review of R14's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 04/17/23 revealed that he/she had a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated he/she was severely cognitively impaired. Review of R14's Progress Notes dated 04/23/23 at 4:25 AM, located under the Progress Note tab in the EMR, revealed that the resident had an unwitnessed fall. The resident was assessed; his/her right wrist was noted with swelling, and he/she was unable to flex it. Emergency Medical Services (EMS) was notified, and the resident was transferred to the emergency room (ER). The Progress Note further revealed at 10:31 AM, and the resident returned to the facility with a diagnosis of right wrist fracture with a wrap to immobilize his/her right arm. At 11:56 AM, the resident was sent to the hospital to have a cast placed on his/her right arm due to him/her taking the wrap off continuously. At 8:16 PM, the resident was admitted to the hospital for surgery of his/her right wrist. The resident returned to the facility on [DATE] with a right hand cast in place. There was no further documentation of any assessments or monitoring of the resident's arm, wrist, or skin around the cast until 06/18/23. Review of R14's Progress Note dated 06/18/23 revealed that the resident complained of pain in his/her arm. After the cast was assessed, necrotic skin and an opening under the cast were noted around the resident's wrist. The supervisor was notified. There was no further documentation or assessment of the resident's skin until 06/20/23. Review of R14's Progress Note dated 06/20/23 at 12:55 PM revealed, a foul odor was noted from the resident's right arm cast. The physician was notified and an order was received for Keflex (antibiotic) for 10 days. There was no documentation showing that the physician had been notified of the necrotic tissue found two days prior. Review of R14's Progress Note dated 06/22/23 at 8:19 AM revealed the resident was noted with a persistent foul odor on his/her right arm. The physician was made aware, and the resident was sent to the ER and admitted with a right wrist infection. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R14's admission Worksheet located under the MISC tab in the EMR dated 06/29/23 revealed the resident returned to the facility with the diagnosis of right wrist infection, status post hardware removal and maggot infestation. An attempt was made to contact Licensed Practical Nurse (LPN)18, who was identified by the Director of Nursing (DON) as the Nursing Supervisor on 06/18/23 when the necrotic skin was identified. A voice message and no return call was received prior to the survey's on exit 02/27/25. An attempt was made to contact LPN19 on 02/26/25 at 2:57 PM, who had been assigned to the care of R14 from 04/23/23 to 06/23/23. A voice message was left, but no return call was received prior to the survey's exit on 02/27/25. An attempt was made to contact LPN20 on 02/26/25 at 4:10 PM, who had previously been the B wing Unit Manager where R14 had resided. A voice message was left, but no return call was received prior to the survey's exit on 02/27/25. During an interview on 02/26/25 at 5:50 PM, LPN8 stated, I know that he/she [R14] broke his/her arm, and we sent him/her [R14] out to the hospital. He/She [R14] came back and kept picking at the ace wrap, and then we had to send him/her [R14] back out to the hospital, at which time he/she had a cast on his/her arm. I remember that he/she [R14] had to go to the hospital to have it debrided, and then he/she came back to us. An attempt was made to contact the Medical Doctor for R14 on 02/27/25 at 4:00 PM. A voice message was left, but no return call was received prior to the survey's exit on 02/27/25. During an interview on 02/27/25 at 7:00 PM, the DON was asked his expectations of the nurses caring for a resident, such as R14 with a cast, and he stated, 'I would rather not speak to this as I was not the DON at that time. N.J.A.C. 8:39-3.2 (a)(b)

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	315068	A. Building B. Wing	02/27/2025

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Dwellside Care and Rehab	3025 Chapel Avenue West Cherry Hill, NJ 08002

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of facility policy, the facility failed to ensure that one of two medication carts on A Hall was secure when staff were not present. This had the potential to affect all residents on that hall who could have accessed the cart. Findings include: Review of the facilities policy titled, Security of Medication Cart, revised August 2024 revealed, medication carts must be secured during medication pass to prevent unauthorized entry. During an observation on 02/26/25 at 6:07 AM revealed a medication cart sitting in the front of the nurse's station outside the hallway down from resident rooms [ROOM NUMBERS] was not locked and the computer screen was also open and upright revealing 14 resident names. There was one certified nurse's aide walking down the hallway. During an interview on 02/26/25 at 6:11 AM Licensed Practical Nurse (LPN) 6 walked up from another hallway and stated she knew the cart was unlocked. She said there were no families visiting or residents up during the 11 PM to 7 AM shift so she wasn't as careful with locking the cart as she was during the morning or evening shifts. However, she agreed the medication cart should be locked regardless of what shift it was. During an interview on 02/26/25 at 5:10 PM the Director of Nursing (DON) stated he would defer to the facility policy. He stated the cart should have been locked unless a nurse was at the cart. He also expected nursing staff to ensure they ensure privacy and HIPPA to maintain the privacy of the resident information. N.J.A.C. 8:39-29.4(h)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, record review, review of Resident Council Meeting Minutes, and policy review, the facility failed to provide palatable food to eight out of 32 sampled residents (Residents (R)4, R17, R18, R26, R1, R28, R6, and R30). Additionally, there were complaints from Resident Council Meetings without responses. The food was not at an appetizing temperature when residents received their meals, the food was bland, food was not prepared appropriately, and condiments were not available or served. This created the potential for weight loss and resident dissatisfaction. Findings include: Review of the facility's undated Food Preparation Guidelines policy revealed, It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status . Food palatability refers to the taste and/or flavor of the food. Proper (safe and appetizing) temperature means both appetizing to the resident and minimizing the risk for scalding and burns .Food shall be prepared by methods that conserve nutritive value, flavor and appearance. 1. Resident interviews revealed concerns about the food: a. During an interview on 02/24/25 at 2:21 PM, R4 stated he/she was not served sweetener with hot beverages. R4 stated he/she did not like his/her lunch; the noodles were dry, and vegetables were mashed up/overcooked and it was terrible. R4 stated he/she could not get relish, ketchup, or mustard for hot dogs. R4 stated he/she was recently served fish sticks that were so hard he/she could not cut them and could not chew them. R4 stated that one night last week he/she was served bean soup with only three beans in his/her bowl of soup. Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/17/24 located in the electronic medical record (EMR) under the MDS tab revealed R4's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. b. During an interview on 02/24/25 at 3:32 PM, R17 stated, Condiments are few and far between. R17 stated sometimes he/she was not served creamer or any type of sugar with his coffee. Review of the quarterly MDS with an ARD of 10/29/24 located in the EMR under the MDS tab revealed R17 was intact in cognition with a BIMS score of 15 out of 15. c. During an interview on 02/25/25 at 11:11 AM, R18 stated he/she could not eat the food and further stated, It looks and tastes horrible. Review of the quarterly MDS with an ARD of 10/29/24 located in the EMR under the MDS tab revealed R18's cognition was intact with a BIMS score of 15 out of 15. d. During an interview on 02/26/25 at 7:05 AM, R26 stated his/her breakfast was, cold as ice. During a subsequent interview on 02/26/25 at 1:15 PM, R26 stated his/her lunch meal consisting of grilled cheese sandwiches and greens was cold and he/she sent it back. Review of the annual MDS with an ARD of 01/27/25 located in the EMR under the MDS tab revealed R26 was moderately impaired in cognition with a BIMS score of 11 out of 15. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. During an interview on 02/25/25 at 11:44 AM, R1 stated, The food is horrible. There is no seasoning. R1 stated he/she was recently served pea soup with three 3 peas in the soup. R1 stated he/she would like to have salt and pepper but did not receive or was not offered either. Review of the quarterly MDS with an ARD of 12/28/24 located in the EMR under the MDS tab revealed R1 was unimpaired in cognition with a BIMS score of 15 out of 15. 2. Review of Resident Council Minutes revealed that dietary/food service concerns were not discussed in resident council in 2024 until 05/2024 at which time Food Service was added. Concerns with the taste, temperature, and/or appearance of the food in Resident Council Minutes between 05/2024 and 12/2024 included: a. Review of Resident Council Minutes dated 05/29/24 revealed a resident report, Food is poor. b. Review of Resident Council Minutes dated 06/26/24 revealed residents' comments including Hamburger without cheese . c. Review of Resident Council minutes dated 11/27/24 revealed, Food Committee Meeting to be reschedule to discuss food reference, breakfast is the only good meal . Food Committee meeting is not effective 3. Menu Committee Minutes were requested for 2023 through February 2025. Four months of Food Committee Minutes were provided (April 2024, July 2024, August 2024, and February 2025). Review of the Food Committee Minutes revealed concerns with the palatability of food included: a. Review of Menu Committee Minutes dated 04/17/24 revealed new concerns including hot food being served cold and cold food being served warm and condiments missing on the trays. Action taken was, Staff are trained in holding temperatures, batch cooking, reheating foods. QAPI, test trays, competencies, and monitoring started. Food temperatures still an issue at this meeting. b. Review of Menu Committee Minutes dated 07/17/24 revealed a resident did not like what was for dinner. He/She called down to change the meal and it was the same one. The response was that the menu was still in effect. Another resident reported there were no condiments for breakfast and there was no cheese served on a hamburger. There was no response to this comment. c. Review of the Menu Committee Minutes dated 08/2024 revealed concerns of no ketchup or mustard with a hot dog meal. Two residents reported their food was cold. A resident reported the pork chops were too salty. A resident reported there was no cheese for hamburgers. A resident reported the rice was cooked too hard. A resident reported no jelly was available with an English muffin. Residents reported artificial sugar was missing and there was no salad dressing available. The response to these comments was to order jelly and condiments. d. Review of handwritten Menu Committee Minutes dated 02/19/25 revealed concerns with cold food and the lack of availability of salt and pepper. There was no documentation of the response to these concerns. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R6's tray card for lunch on 02/26/25 revealed he/she was prescribed a liberalized diabetic no added salt diet and should be served a pepper packet. During an interview on 02/25/25 at 1:00 PM with the DM in the first-floor dining room, he verified salt and pepper packets had not been provided to residents in the first-floor dining room. The DM stated the small ceramic condiment containers should be filled with condiments such as salt and pepper packets and a condiment containers should be placed on each table in the dining room prior to meal service. The DM stated he was short staffed for lunch and it hadn't been done (condiment containers filled and placed on the tables) prior to meal service. During an observation on 02/26/25 revealed the second food cart was delivered to the second floor at 1:03 PM. There were 19 residents in the second-floor dining room. During an observation at 1:16 PM revealed all trays served from the second cart on the second floor were served at 1:16 PM and a pureed test tray was evaluated with LPN18. The pureed chili was thin and spread across the plate and the temperature was 115 degrees F. The surveyor and LPN18 sampled it and agreed it was lukewarm. The pureed bread was pasty, verified by LPN18. The pureed corn and mashed potatoes were bland, verified by LPN 18. The juice was cool but not cold at 63 degrees F and the applesauce was cool but not cold at 61 degrees F. 5. During an interview on 02/25/25 at 2:45 PM, LPN1 stated residents complained to her about the food. LPN1 stated the food looked terrible and she could not always identify what was being served. LPN1 stated the vegetables were overcooked and residents had recently been served fish sticks that were so hard, they could not be broken in half. LPN1 stated that at least once a day, the residents asked for condiments. LPN1 stated condiments were not routinely available. During an interview on 02/25/25 at 5:14 PM, CNA3 stated she served residents their meals and condiments like ketchup or mustard might or might not be provided. CNA3 stated there was usually one condiment packet on the tray such as sugar or sugar substitute packet. During an interview on 02/27/25 at 11:57 AM, CNA8 stated sometimes the kitchen ran out of condiments and they were not included on the meal trays. During an interview on 02/27/25 at 2:24 PM, LPN9 stated residents reported to her that sugar substitute was not always available. LPN9 stated it should be sent on the residents' meal trays. During an interview on 02/27/25 at 4:08 PM, the DM stated he had been working on the menus. The DM stated residents hated rice for example so he was trying to get this changed. The DM stated the residents had not told him the food was bad. The DM stated he had heard complaints about the food not being hot enough. The DM stated he had fielded four or five Menu Committee Menus but did not have minutes for all the meetings because he did not have time to write them all up. The DM stated food temperatures as served to residents should be 140 degrees F for hot food and 40 degrees F or below for cold foods. The DM stated that the rice on 02/25/25 for lunch looked, a little sticky. The DM verified that the dietary staff put condiments on the residents' trays or in the condiment holders in the dining room and nursing staff was not responsible for this. The DM stated he had been working on getting condiments ordered so they would be available to residents. (continued on next page)

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