STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315119	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arnold Walter Nursing & Rehabilitation Center	622 S Laurel Avenue Hazlet, NJ 07730

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44833 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to maintain a resident's dignity while providing feeding assistance. This deficient practice was identified for 1 of 29 residents observed for dignity (Resident #7), and was evidenced by the following: On 1/16/25 at 12:09 PM, during initial tour of the facility, the surveyor observed Resident #7 in bed in their room with a Certified Nurses Aid (CNA #3) providing feeding assistance to the resident. CNA #3 had the tray table with the lunch tray back and slightly to the side behind her while she stood over Resident #7 feeding them. CNA #1 was observed turning away from the resident to obtain a spoonful of food which was positioned away from the resident and she was not seated alongside the resident during this care. On 1/17/25 at 11:02 AM, the surveyor observed Resident #7 in their room, who informed the surveyor that the CNAs in the facility usually stood while assisting them with their meal. Resident #7 stated that one CNA sometimes sat on the side of the bed to assist them with feeding, which caused the resident to have to move their leg slightly so that the CNA could sit. On 1/22/25 at 10:56 AM, the surveyor reviewed Resident #7's medical record. A review of the Resident Face Sheet (an admission summary) indicated that the resident was admitted to the facility with diagnosis which included but was not limited to; legal blindness, weakness, cerebral infarction (stroke). A review of the resident's Physicians Orders Summary included a physician's order (PO) dated 10/29/2024, for a low fat, soft consistency diet. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/19/24, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the resident was cognitively intact. A review of Section GG - Functional Abilities, indicated that the resident required substantial/maximal assistance with eating, meaning the helper did more than half of the effort with feeding. On 1/22/25 at 11:59 AM, the surveyor observed CNA #2 assisting Resident #7 with their meal while standing over the resident in bed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 12:00 PM, after CNA #2 finished with the resident's feeding assistance and left the resident's room, the surveyor interviewed CNA #2, who stated that it was proper procedure while assisting a resident with eating to sit in a chair next to the resident. CNA #2 stated it was important to ensure and maintain a comfortable and dignified meal experience for the resident. On 1/22/25 at 12:45 PM, the surveyor interviewed the Director of Nursing (DON), who stated that in order to maintain a dignified meal feeding experience, staff were expected to sit alongside the resident while assisting them with eating. The DON stated staff was also to present the meal to the resident so the resident could visually see what was offered rather than be told what was served. The surveyor informed the DON of the observations made of CNA #3 and CNA #2's feeding assistance, to which the DON confirmed was not appropriate. A review of the facility's Assistance with Meal policy with a last reviewed date of 12/23/24, included . residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity for example: a. not standing over residents while assisting them with meals . NJAC 8:39-4.1(a)(12)

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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. 45208 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the resident's living environment in a clean, comfortable, homelike manner. This deficient practice was identified on 2 of 4 nursing units (A Wing and D Wing) reviewed for environmental concerns, and was evidenced by the following: 1. On 1/16/24 at 9:24 AM, the surveyor observed the A-wing nursing unit and identified the following concerns: The Shower Room was a large room with two shower stalls, three windows, and three metal wall heaters. The left shower stall had copious amount of standing water with a white milky coloring that filled half of the shower floor. Two of the three metal wall heaters had a red/orange discoloration on the heaters and on the tile under the heaters. The three window units' coverings were made of a thin paper-like material that contained holes throughout which did allow for privacy making the shower room visible from the outside. Resident Room #A-30 had a damaged window screen that did not fit into the window frame. On 1/16/25 at 11:18 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #2), who stated that facility management was aware of the standing water in A-wing's Shower Room; that the water pooled every time the water was used. LPN/UM #2 acknowledged that the water had been stagnant for two hours since the surveyor's last observation. On 1/16/25 at 11:18 AM, the surveyor interviewed the Director of Nursing (DON), who stated that LPN/UM #2 made her aware of the surveyor's concern. At that time, the surveyor and the DON toured the Shower Room together, and the DON acknowledged the shower water, the decolonization on the two heaters, and the window coverings in disrepair. The DON agreed and verbalized it was not a homelike environment for the residents. On 1/21/25 at 10:05 AM, the surveyor interviewed the Maintenance Staff (MS), who stated that there was an electronic maintenance system that all staff entered a problem or concern. The MS stated that the turn around time for maintenance work was same day or within twenty-four hours if no parts needed to be ordered. On 1/21/25 at 10:13 AM, the surveyor interviewed the Regional Maintenance Director (RMD), who acknowledged the surveyor's concerns with the Shower Room and the window screen. 44833 2. On 1/16/25 at 11:23 AM, during initial tour of the facility, the surveyor observed on the D Wing nursing unit the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The wallpaper behind the resident's bed in Resident Room #D-4, bed two, had an approximated two and a half (2.5) inch wide by approximately four and a half (4.5) feet long section ripped off exposing the wall behind. The wall/wallpaper and vinyl baseboard along the base of the wall in the hallway next to the Shower Room by Resident Room #D-5 appeared to be wrinkled and coming off the wall. A portion of the vinyl baseboard next to the bathroom door in Resident Room #D-28 was missing and the drywall appeared to be damaged with a rust-like discoloration. On 1/23/25 at 1:31 PM, the surveyor interviewed the RMD, who stated that the facility utilized an electronic work order request system that all staff members had access to in order to notify maintenance of repairs needing to be completed. The RMD further stated that the facility was responsible to ensure that the building was in good repair to maintain a comfortable, homelike environment for all residents. On 1/23/25 at 10:45 AM, the Regional Nurse, in the presence of the Director of Nursing (DON), Assistant Administrator, and survey team acknowledged the surveyor's environmental concerns. A review of the facility's Quality of Life - Homelike Environment policy dated reviewed 12/20/24, included . residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment . NJAC 8:39-31.4(a)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49094 Based on interview and review of pertinent facility documents, it was determined that the facility failed to a) revise an individual comprehensive care plan (ICCP) for a resident with floor mats and b) revise an ICCP for residents who received oxygen. This deficient practice was identified for 2 of 29 residents reviewed for care plans (Resident #71 and Resident #85), and was evidenced by the following: 1. On 1/16/25 at 10:15 AM, during the initial tour of the facility, the surveyor observed Resident #85 sleeping in their bed. Resident #85 was receiving oxygen via nasal cannula (device that gives additional oxygen through the nose) at 2 liters per minute (lpm). The surveyor observed floor mats folded up in the resident's room. On 1/17/25 at 11:12 AM, the surveyor observed Resident #85 lying in bed awake looking around the room. Resident #85 was receiving oxygen via nasal cannula at 2 lpm. The surveyor observed floor mats located on both sides of the resident's bed. The resident's bed was in a low position with the call device within reach. On 1/17/25 at 11:20 AM, the surveyor reviewed the medical record for Resident #85. A review of the Resident Face Sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; obstructive sleep apnea (sleep disorder that affects your breathing while you sleep), shortness of breath, Alzheimer's disease (brain disorder that causes memory loss), difficulty in walking, unspecified abnormalities of gait and mobility (abnormal walking pattern). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/3/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating a severely impaired cognition. A further review in Section GG, Functional Abilities, reflected the resident used a walker and wheelchair. It further reflected that the resident was completely dependent for transfers. A review of the Order Summary Report included a physician's order (PO) dated 1/8/25, for oxygen at 2 lpm via nasal cannula as needed if oxygen saturation (SPO2; percent of oxygen in someone's blood) was less than 92%. A further did not include a PO for bedside floor mats. A review of the ICCP included a focus area dated 8/14/24, that the resident was at risk for falls based on score risk (an assessment for fall risk). Interventions included but not limited to; maintain a clutter free environment, ensure proper footwear or socks with non-skid bottoms, schedule daily rest periods and routines. The ICCP did not include an intervention for floor mats to both sides of the bed. A further review revealed a focus area dated 8/21/24, that the resident had a respiratory disorder caused by chronic rhinitis (nose inflammation) and shortness of breath. Interventions included but not limited to; monitor respiratory symptoms per physician order, assess for signs and symptoms of respiratory distress, and keep head of bed elevated per physician's order. The ICCP did not include an intervention to administer oxygen. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 1/21/25 at 10:31 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #3) identified that a ICCP should be updated with interventions as changes occurred and during the quarterly care plan meetings. LPN/UM #3 stated that focus areas on the care plan included items specific to the resident such as oxygen, falls, and wounds. The surveyor then asked LPN/UM #3 if floor mats should be on a resident's care plan as an intervention if a resident was at risk for falls, and LPN/UM #3 confirmed yes. LPN/UM #3 further stated an intervention to keep the bed in low position would also be in place. LPN/UM #3 acknowledged that Resident #85's ICCP did not include floor mats as an intervention and they were at risk for falls. LPN/UM #3 acknowledged that Resident #85's ICCP did not include oxygen administration as an intervention under the respiratory focus area. LPN/UM #3 stated that she was going to update the ICCP now to include the oxygen and floor mats for Resident #85. On 1/21/25 at 10:47 AM, the surveyor interviewed the Director of Nursing (DON) who stated the ICCPs included focus areas such as skin, falls, and pain. The DON further stated that if a resident used floor mats or oxygen it would be included on the ICCP as an intervention. On 1/23/25 at 10:43 AM, the Regional Nurse (RN), in the presence of the Director of Nursing (DON), Regional Administrator, and the survey team, confirmed that floor mats and oxygen should be on the ICCP listed as interventions. 2. On 1/17/25 at 12:04 PM, the surveyor observed Resident #71 in their bedroom sitting on the side of the bed. The surveyor observed an oxygen concentrator (device that delivers oxygen) near the resident's bed. Resident #71 stated that they put on their own oxygen at night and removed it in the morning. The resident stated that the facility did not provide a bag to store the oxygen tubing in when not in use. The oxygen tubing was observed lying on the resident's bed. The surveyor did not observe any bag to store the oxygen tubing. On 1/17/25 at 11:44 AM, the surveyor reviewed the medical record for Resident #71. A review of the Resident Face Sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; chronic obstructive pulmonary disorder (lung disease that makes it difficult to breathe), shortness of breath, wheezing (high pitched sound that occurs when the airways in the lungs become narrow), seasonal allergic rhinitis (allergic reaction that causes sneezing). A review of the most recent comprehensive MDS dated [DATE], reflected that the resident had a BIMS score of 15 out of 15, indicating a cognitively intact cognition. A review of the ICCP included a focus area dated 8/10/24, that the resident had a respiratory disorder caused by wheezing. Interventions included but not limited to; give nebulizer treatments as ordered, monitor for response, and assess for signs and symptoms of respiratory distress. The ICCP did not include an intervention to administer oxygen. On 1/21/25 at 10:47 AM, the surveyor interviewed the DON, who stated the ICCP's included focus areas such as skin, falls, and pain. The DON further stated that if a resident used floor mats or oxygen it would be included on the ICCP as an intervention. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/25 at 12:05 PM, the surveyor interviewed LPN #2, who stated that Resident #71 used oxygen as needed during the night. LPN #2 further stated that she thought oxygen should be on the care plan as an intervention. On 1/23/25 at 10:43 AM, the Regional Nurse, in the presence of the DON, Regional Administrator, and the survey team, stated that floor mats and oxygen should be on the ICCP listed as interventions. A review of the facility's Care Plans, Comprehensive Person-Centered policy last reviewed 12/17/24, included . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident physical, psychosocial and functional needs is developed and implemented for each resident . 8. The comprehensive, person-centered care plan will: .b. Describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being .g. Incorporate identified problem areas .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change . A review of the facility's Policy and Procedure for the Prevention of Fall policy reviewed 12/17/24, included . It is the policy of the facility to identify specific risk factors that may indicate the resident is at risk for falls upon admission, readmission, quarterly annually, and with any significant change. Based upon the assessment the residents will have a preventative plan of care initiated as well as be revised, monitored, and evaluated throughout their stay at the facility. The interdisciplinary team will collaborate in developing, evaluating, and revising fall prevention plan of care to prevent falls/injury, or to minimize injury and/or complications if a fall prevention plan of care to prevent falls/injury, or to minimize injury and/or complications if a fall should occur .5. The preventative measures will be identified on risk assessment and will assist with the development of an individualized care plan by the assigned nurse upon admission/readmission. Preventative measures: Beds: Utilize a floor mattress as indicated and needed. Communication of risk: Residents at risk for falls will be communicated to the interdisciplinary team via the care plan . NJAC 8:39-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45208 Based on observation, interview, and record review, it was determined that the facility failed to: a) properly secure medication being administered during medication pass and b) ensure that a resident received care and services for the provision of dressing changes to a peripherally inserted central catheter (PICC) site consistent with professional standards of practice. The deficient practice was identified for 2 of 29 residents reviewed for medication administration (Resident #77 and Resident #127) . Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of 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. The evidence was as follows: 1. On 1/17/25 at 10:10 AM, Surveyor #1 and Surveyor #2 observed the Licensed Practical Nurse (LPN #3) prepare medications for Resident #127. The nurse removed a lidocaine patch (pain medication patch) from a locked drawer on the medication cart and placed it on top of the cart. LPN #3 then removed Miralax (a powdered laxative) and poured a measured amount into a plastic cup, then poured an additional measured amount into a second cup and placed both cups on the medication cart. LPN #3, with the cup containing the medication pills and one cup of Miralax powder, accompanied by Surveyor #1 proceeded into Resident #127's room to administer the medication to the resident who was in bed two by the window. Surveyor #2 stayed in the hallway next to LPN #3's unsecured cart that had the lidocaine patch and Miralax unsecured on top. There were no residents present by the cart at that time. The surveyors observed Resident #127 take their oral medications, and LPN #3 returned to the cart to retrieve the lidocaine patch and administered it on the resident. LPN #3 then returned to the cart and discarded the second Miralax cup that was left on the cart in the drug buster. On 1/17/25 at 10:35 AM, Surveyor #1 interviewed LPN #3 in the presence of the LPN/Unit Manager (LPN/UM #2), who stated that she poured two doses of Miralax because the first dose, the cap touched the powder so she felt it was an infection control concern. Surveyor #1 asked LPN #3 if it was okay to leave the lidocaine patch and Miralax on the medication cart unattended, and UM/LPN #2 responded no because there were residents that wandered and could potentially grab it off the cart. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 11:35 AM, Surveyor #1 interviewed the Director of Nursing (DON), who confirmed that the nurse should not have left the lidocaine patch and Miralax unattended because it was a safety hazard for other residents that may be in the hallway. On 1/17/25 at 1:03 PM, the surveyor reviewed the medical record for Resident #127. A review of the Resident Face Sheet (an admission summary) reflected Resident #127 was admitted to the facility with medical diagnoses which included but was not limited to; spinal stenosis lumbar region (narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs), spondylosis without myelopathy or radiculopathy lumbar sacral region (a radiographic diagnosis referring to degenerative changes in the disc), difficulty walking, and muscle weakness. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/5/24, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated a cognitively intact cognition. A review of the Order Summary Report included physician's orders (PO) dated 12/10/24, for lidocaine 4% topical patch; apply once daily to lower back and a PO dated 12/23/24, for Miralax 17 grams per dose oral powder; mix in 4-8 ounces of juice or water. On 1/23/25 at 10:34 AM, the survey team met with the DON, the Assistant Administrator, and the Regional Nurse, who all acknowledged the surveyor's concerns. A review of the facility's undated Medications policy included policy statement; medications are administered in a safe and timely manner and as prescribed . 33106 2. On 1/17/25 at 11:55 AM, the surveyor observed the resident in the room sitting in a wheelchair waiting for lunch. The surveyor interviewed Resident #77 and asked the resident if they were receiving intravenous antibiotics and the resident stated, not for a couple days. At that time, the resident showed the surveyor an intravenous (IV) access site in the left upper extremity. The IV access site had a clear plastic dressing in place and under the dressing was a small gauze dressing over the insertion site of the catheter (where the catheter goes into the resident's skin) so that site could not be assessed. There was an illegible date on the dressing. The surveyor asked the resident if the facility had changed the IV access dressing and the resident stated that it was the dressing that the company put on, when they put it in. The surveyor asked the resident when they the IV was placed and they told the surveyor that they could not remember what day it was. On 1/17/25 at 12:00 PM, the surveyor reviewed the medical record for Resident #77. A review of the Resident Face Sheet reflected the resident was admitted to the facility with the diagnoses which included but was not limited to; chronic respiratory failure, opened wound on the buttocks and methicillin staphylococcus aureus (MRSA) infection. A review of the most recent comprehensive MDS dated [DATE], indicated that Resident #77 had a BIMS score of 15 out of 15, which indicated a fully intact cognition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician's orders included a PO dated 1/4/25, to insert midline catheter for antibiotic infusion. A review of the Progress Notes included a Nurse's Noted dated 1/4/25 at 1:27 PM, which indicated that a new midline (PICC) was placed on left arm with measurements of 15 centimeters (cm); vitals were stable; and the resident was resting in bed with no distress or discomfort noted. On 1/17/25 at 12:17 PM, the surveyor reviewed the Medication Administration Record (MAR) which included a PO dated 12/19/24, to change dressing weekly for right upper arm midline with one lumen and as needed (PRN). On the day of observation, the resident had a PICC line in the left arm, not the right. There were no physician's orders to change the dressing for the left upper extremity PICC line site. On 1/21/25 at 11:03 AM, the surveyor interviewed the Registered Nurse (RN) who was providing care for Resident #77. The surveyor asked the RN if the resident had a peripherally inserted catheter (PICC) and where it was located. The RN told the surveyor the resident had one in the left arm. The surveyor asked about dressing changes and what the policy was at the facility. The RN explained that the dressings were changed weekly and as needed. The surveyor asked if the staff used a gauze dressing under the transparent dressing and the RN said no just the transparent dressing. The surveyor asked the RN to show the surveyor where the staff signed for dressing changes and the RN showed the surveyor the MAR that had an order for right arm PICC dressing changes weekly and as needed. The RN told the surveyor that the dressing should have been changed on the 12th of January and the 19th of January, but there were no nursing signatures on the MAR to indicate that it was done. At that time, the surveyor asked the RN to enter the resident's room and expose the PICC line site. The RN showed the surveyor the PICC dressing which had a date of 1/4/25, the date the left arm PICC line was inserted. The nurse stated, this has to be changed. The surveyor asked about the gauze under the dressing, and the RN said they put it there when they inserted the PICC line, and the facility did not use gauze. On 1/21/25 at 12:18 PM, the surveyor interviewed the Infection Preventionist (IP) regarding PICC line dressing changes. The IP stated that a new PICC line dressing was changed within 24 hours and then weekly. The IP stated the nurse was responsible to date and initial the dressing and sign the treatment record that it was completed. The IP also stated that physician's orders were required for PICC line dressing changes. On 1/23/25, the Regional Nurse, in the presence of the Assistant Administrator, DON, and the survey team acknowledged that Resident #77's PICC line should have been changed within twenty-four hours of admission. A review of the facility's undated Catheter Dressing Changes policy included that the facility was to change transparent semi-permeable membrane dressings as per regulation and as needed (when wet, soiled or not intact). The transparent dressing must be labeled with initials, date and time . NJAC 8:39-25.2 (c)5; 29.4(h)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arnold Walter Nursing & Rehabilitation Center	622 S Laurel Avenue Hazlet, NJ 07730

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49094 Based on observation, interview, and reviewed of pertinent facility documents, it was determined that the facility failed to a) label, date, and store respiratory equipment in a manner to prevent contamination for infection control; b) obtain a physician's order for the administration of oxygen; c.) document the assessment of vital signs as ordered for a nebulizer treatment; and d) perform tracheotomy care with aseptic (sterile) technique to prevent infection. This deficient practice was identified for 3 of 4 residents reviewed for respiratory care (Resident #71, #73, and #85) and 1 of 1 resident reviewed for tracheostomy care (Resident #115), and was evidenced by the following: 1. On 1/16/25 at 10:15 AM, during the initial tour of the facility, the surveyor observed Resident #85 sleeping in their bed. Resident #85 was receiving oxygen via nasal cannula (device that delivers additional oxygen through the nose) at 2 liters per minute (lpm). On 1/16/25 at 11:18 AM, the surveyor observed the nasal cannula tubing placed on the oxygen concentrator (device that delivers oxygen) unbagged and exposed to the air. On 1/17/25 at 11:20 AM, the surveyor reviewed the medical record for Resident #85. A review of the Resident Face Sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; obstructive sleep apnea (sleep disorder that affects your breathing while you sleep), shortness of breath, Alzheimer's disease (brain disorder that causes memory loss), difficulty in walking, unspecified abnormalities of gait and mobility (abnormal walking pattern). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/3/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating a severely impaired cognition. A review of the Order Summary Report included a physician's order (PO) dated 1/8/25, for oxygen at 2 lpm via nasal cannula as needed if oxygen saturation (SPO2; percent of oxygen in a persons blood) was less than 92%. On 1/21/25 at 10:07 AM, the surveyor observed the nasal cannula tubing draped over the resident's nightstand, not bagged and exposed to the air. On 1/21/25 at 10:31 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #3), who stated that oxygen tubing should be stored in a bag when not in use. LPN/UM #3 further stated that the tubing should be stored in a bag for infection control purposes. At that time, LPN/UM #3 accompanied the surveyor to the resident's room and confirmed that the resident's tubing was draped over the resident's nightstand, not bagged and exposed to the air. LPN/UM #3 then replaced Resident #85's oxygen tubing, dated it, and placed it in a bag. On 1/21/25 at 10:47 AM, the surveyor interviewed the Director of Nursing (DON), who stated that oxygen tubing was changed once a week on the night shift. The DON further stated that oxygen tubing should be stored in a bag when not in use for infection control purposes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/21/25 at 12:11 PM, the surveyor interviewed the LPN Infection Preventionist (IP), who stated that all oxygen tubing was required to be changed on the night shift once a week. The IP also explained that all respiratory tubing had to be labeled with a date and stored in a designated respiratory bag with the resident's name. She confirmed that if the tubing was not stored correctly in a bag and exposed to air, it could become contaminated. On 1/23/25 at 10:43 AM, the Regional Nurse, in the presence of the DON, Regional Administrator, and the survey team, confirmed that oxygen tubing should be stored in a bag when not in use to ensure it did not touch any surfaces and become contaminated. 2. On 1/17/25 at 12:04 PM, the surveyor observed Resident #71 in their bedroom sitting on the side of the bed. The surveyor observed an oxygen concentrator near the resident's bed. Resident #71 stated that they put on their own oxygen at night and removed it in the morning. The resident stated that the facility did not provide a bag to store the oxygen tubing in when not in use. The oxygen tubing was observed lying on the resident's bed, not bagged, and exposed to air. The surveyor did not observe any bag to store the oxygen tubing. On 1/17/25 at 11:44 AM, the surveyor reviewed the medical record for Resident #71. A review of the Resident Face Sheet reflected that the resident was admitted to the facility with diagnoses that included but not limited to; chronic obstructive pulmonary disorder (lung disease that makes it difficult to breathe), shortness of breath, wheezing (high pitched sound that occurs when the airways in the lungs become narrow), and seasonal allergic rhinitis (allergic reaction that causes sneezing). A review of the most recent comprehensive MDS dated [DATE], indicated the resident had a BIMS score of 15 out of 15, indicating a cognitively intact cognition. A review of the Order Summary Report did not include a physician's order for oxygen. On 1/21/25 at 10:31 AM, the surveyor interviewed LPN/UM #3, who stated that oxygen tubing should be stored in a bag when not in use. LPN/UM #3 further stated that the tubing should be stored in a bag for infection control purposes. On 1/21/25 at 10:47 AM, the surveyor interviewed the DON, who stated that oxygen tubing was changed once a week on the night shift. The DON further stated that oxygen tubing should be stored in a bag when not in use for infection control purposes. On 1/21/25 at 12:03 PM, the surveyor interviewed LPN #2, who stated Resident #71 used oxygen at night as needed. The surveyor asked LPN #2 to confirm the physician's order for the oxygen, and LPN #2 stated that there was no physicians order for the oxygen and acknowledged that there should have been. LPN #2 further stated that she would submit a physician's order for the oxygen at that time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/21/25 at 12:11 PM, the surveyor interviewed the IP, who stated that all oxygen tubing was required to be changed on the night shift once a week. The IP also explained that all respiratory tubing had to be labeled with a date and stored in a designated respiratory bag with the resident's name. She confirmed that if the tubing was not stored correctly in a bag and exposed to air, it could become contaminated. The IP further stated that any resident that required oxygen should have a physician's order. On 1/23/25 at 10:43 AM, the Regional Nurse, in the presence of the DON, Regional Administrator, and the survey team, stated that oxygen tubing should be stored in a bag when not in use to ensure it did not touch any surfaces and become contaminated. The Regional Nurse further stated that there should be a physician's order for any resident that required oxygen, and she acknowledged that there was no physician's order for Resident #71's oxygen until surveyor inquiry. A review of the facility's Respiratory Tubing policy dated reviewed 12/17/24, included . Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: .7. Store the circuit in plastic bag, marked with date and residents name, between uses . A review of the facility's Oxygen Administration policy dated reviewed 12/17/24, included .Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration (for new admission check hospital discharge summary for oxygen orders and verify with admitting MD.) 2. Review the residents care plan to assess for any special needs of the resident . A review of the facility's Physicians Orders policy dated reviewed 12/17/24, included .Policy: It is the policy of our center to write physicians orders to establish a plan of care to follow for the care of the patient. Physician's orders are grouped into types of orders. Treatment Medications and Treatment orders: All treatments should include the treatment to be used and location of where the treatment should be placed, frequency and if appropriate, how the area should be cleaned and how it should be covered. Reason for the treatment required (diagnosis). This will be reflected on the Treatment Administration Record (TAR) . 33106 3. On 1/16/25 at 10:15 AM, the surveyor observed Resident #73 lying in bed with a nebulizer machine (a small breathing machine that turns liquid medication into a mist that can be inhaled, a nebulizer allows medication to enter the lungs directly) on the bedside table with the tubing and mask undated and uncovered lying on the resident's personal belonging. The resident stated that they used the nebulizer machine at times to help them breathe better. On 1/17/25 at 11:25 AM, the surveyor observed a nebulizer machine on the bedside table with the nebulizer tubing undated and uncovered lying in the resident's drawer on the resident's personal belonging. 1/17/25 at 11:45 AM, the surveyor reviewed the medical record for Resident #73. A review of the Resident Face Sheet indicated that Resident #73 was admitted to the facility with the diagnoses which included but was not limited to; Parkinson's Disease and chronic obstructive pulmonary disease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent comprehensive MDS dated [DATE], indicated that the resident was cognitively intact and required moderate assistance with activities of daily living. A review of the physician's order (PO) dated 12/30/24, for a bronchodilator ipratropium 0.5 milligram (mg) and albuterol 3 mg (2.5 mg base) per 3 milliliters (ml) nebulization solution to be administered by inhalation route every six hours as needed for fifteen minutes. The PO instructed the nurse to obtain pre and post lungs sounds, pre and post vital signs (VS), oxygen saturation (measures oxygen levels in the blood), and enter the number of minutes that it took the nurse to administer the medication and document in the comment section of the Medication Administration Record (MAR). On 1/17/25 at 11:45 AM, the surveyor reviewed the MAR which revealed that on 1/5/25 at 9:36 AM, the resident received the nebulizer treatment ipratropium nebulization solution which required the nurse to document in the comment section of the MAR the resident's pre and post lung sounds, blood pressure, oxygen saturation, pre and post VS, and the number of minutes it to to administer the medication. In the comment section, the nurse documented that these vital signs were not collected and there were no documented pre or post lung sounds, or minutes that it took to administer the medication. On 1/17/25 at 11:55 AM, the surveyor reviewed the Progress Notes (PR) and there were no Progress Notes documented on 1/5/25, regarding why the resident received the nebulizer treatment, pre and post lung sounds, pre or post VS, or how many minutes it took to administer the medication. On 1/21/25 11:13 AM, the surveyor interviewed the LPN #5, who stated that nebulizer tubing should be labeled and dated and put into a designated respiratory storage bag to protect the tubing from contamination. LPN #5 explained that a PO was required to change and date the nebulizer tubing and the facility's process was that all respiratory tubing was changed on Thursday by the nurses on the 11:00 PM to 7:00 AM shift. LPN #5 added that if the resident's tubing had been left unbagged and lying on the resident's table or anywhere else that it should not be, it was because the resident and the resident's responsible party (RP) were constantly moving stuff in the resident's room and they were probably removing the tubing from the bag and placing it on the resident's bedside table or in the resident's bedside drawer. LPN #5 stated that Resident #73 and their RP required education on the importance of keeping the tubing free from contaminates by not placing the tubing on top or under the resident's personal belongings. At that time, LPN #5 accompanied the surveyor to the resident's room and confirmed that the resident's tubing was not labeled or dated and was laying on the bedside table with personal belongings piled on top the tubing and nebulizer machine. On 1/21/25 at 11:30 AM, LPN #5 reviewed with the surveyor Resident #73's medical record. A review of the physician's orders and Treatment Administration Record (TAR) confirmed there was not a physician's order to change the resident's nebulizer tubing. LPN #5 confirmed that it was not included on the individualized comprehensive care plan (ICCP) that the resident removed the nebulizer tubing from the respiratory bag and placed it on top of and under personal belongings and it should have been documented the resident was educated on the importance of keeping their nebulizer tubing bagged. LPN #5 reviewed Resident #73's MAR and confirmed that the resident received a nebulizer treatment on 1/5/25 at 9:36 AM, and there was no documentation in the comment section of the MAR that Resident #73's blood pressure (B/P), oxygen saturation, pulse, or respiration were obtained pre and post nebulizer treatment. There was also no documentation of pre or post lung sounds or documentation regarding how many minutes it took to administer the medication. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/21/25 at 12:07 PM, the surveyor interviewed the LPN Infection Preventionist (IP), who stated that all oxygen tubing and nebulizer tubing were required to be changed on the night shift once a week and documented on the TAR. The IP also explained that all respiratory tubing had to be labeled with a date and stored in a designated respiratory bag with the resident's name. The IP confirmed that if the tubing was not stored correctly and the tubing was not covered and protected, it could become contaminated. On 1/21/25 at 12:54 PM, the surveyor interviewed LPN/UM #3, who stated that if a resident was on a nebulizer treatment, the nurse was required to document pre and post VS to include oxygen saturation, pre and post lung sounds, and how many minutes the treatment was administered which was usually approximately 15 minutes. At that time, LPN/UM #3 reviewed Resident #73's MAR and confirmed that the nurse did not follow the PO for documentation of pre and post VS, oxygen saturations, pre and post lung sounds, or how many minutes it took to administer the medication. LPN/UM #3 stated that the nurse also did not document in the Progress Notes and confirmed that there was no order to change the nebulizer tubing weekly. LPN/UM #3 stated that the nebulizer tubing should be stored in designated respiratory bag dated with the resident's name, and if the resident had a history of removing the respiratory tubing from the bag or moving the tubing around the room, it should be included in their ICCP. On 1/23/25 at 10:54 AM, the surveyor interviewed the Regional Director of Nursing (RDON), who stated that the nurses should be documenting pre and post VS to include oxygen saturation, pre and post lung sounds, and how many minutes the treatment was administered in the supplemental (comment) section of the MAR. The RDON also added that all respiratory tubing should be dated and stored in a bag to prevent contamination of the tubing. A review of the facility's Administering medications through a small volume Nebulizer policy dated 12/20/24, included the purpose of this procedure was to safely and aseptically (free from microorganisms) administer aerosolized particles of medication into the resident's airway .staff were to obtain and document the resident's pulse, respiratory rate and lung sounds, date and time the length of the treatment and to obtain VS pre and post treatment . A review of the facility's Care Plans, Comprehensive Person-Centered policy dated 12/17/24, included a comprehensive person-centered care plan would include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs . A review of the facility's Respiratory Tubing policy dated 12/17/24, included respiratory equipment (oxygen cannula, tubing reservoir and distilled water) would be marked with date and initials and that oxygen cannula and tubing would be stored in a plastic bag when not in use . 45208 4. On 1/16/25 at 11:30 AM, the surveyor observed Resident #115 lying in bed with a tracheostomy (trach; a surgically created opening in the neck that allows air to reach the lungs) and tracheostomy collar (are used to hold tracheostomy tubes in place; they wrap around the neck and secure with either Velcro or ties) connected to an oxygen (O2) concentrator at four liter per minute (4 lpm) providing O2 therapy. On 1/21/25 at 10:40 AM, the surveyor reviewed the medical record for Resident #115. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Resident Face Sheet reflected the resident was admitted to the facility with diagnoses including acute respiratory failure with hypoxia and tracheostomy care. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 10/17/24, reflected that the resident had a BIMS score of a 15 out 15, which indicated a fully intact cognition. A review of the individualized comprehensive care plan (ICCP) included a focus area initiated 8/9/24, for enhanced barrier precautions (a set of infection control practices that use personal protective equipment (PPE) to reduce the spread of multidrug resistant organisms (MDRO's). Interventions included to provide trach care per physician's order. An additional focus area dated 8/9/24, for tracheostomy with interventions to provide trach care and maintenance per physician's order. A review of the Physician's Orders (PO) included the following: A PO dated 8/26/24, to administer oxygen at 4 lpm via trach collar continuous for 35% trach collar. A PO dated 8/8/24, to perform trach care every shift. On 1/21/25 at 11:27 AM, the surveyor observed LPN #4 perform trach care on Resident #115 and observed the following: LPN #4 performed hand hygiene using alcohol-based hand rub (ABHR) and donned PPE of a gown and gloves. LPN #4 removed the gauze dressing from the resident's trach and discarded it into the trash receptacle. Then without performing hand hygiene or changing his gloves, LPN #4 proceeded to walk across the room and [NAME] through supplies to obtain clean gauze and normal saline solution (NSS). With the same contaminated gloves, LPN #4 opened the sterile trach care kit, which he held in his left hand, and then proceeded to clean the surface of the bedside table with a germicidal wipe in his right hand. LPN #4, with the same gloves since removing the resident's trach gauze, placed a protective sheet on the bedside table and placed the trach kit on top. With no observed hand hygiene or glove change, LPN #4 proceeded to touch the sterile gauze from the trach care kit to begin cleaning the resident's trach stoma. At that time, the surveyor asked LPN #4 to stop the treatment. LPN #4 then removed his gloves, performed hand hygiene using soap and water, donned new gloves, and placed clean gauze on the resident's trach stoma. On 1/21/25 at 11:44 AM, the surveyor interviewed LPN #4, who acknowledged he did not perform hand hygiene and aseptic technique according to facility policy and regulatory standards while attempting to perform tracheostomy care. On 1/21/25 at 11:44 AM, the surveyor met with the LPN/UM #2 in the presence of LPN #4, who acknowledged the concerns the surveyor observed during trach care. On 1/21/25 at 12:00 PM, the surveyor interviewed the Infection Preventionist (IP), who stated she conducted education and performed competencies with all staff. The IP stated if they were an Agency Nurse, the unit manager went over special competencies that directly related to the resident's care. The IP acknowledged the surveyors concerns for infection control and hand hygiene during trach care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25 at 1:04 PM, the surveyor interviewed the DON, who stated that facility staff or agency should be able to perform trach care under their scope of practice and competencies were reviewed with upon entering the facility. On 1/23/25 at 10:44 AM, the survey team met with the Assistant Administrator, Regional Nurse, and DON, who all acknowledged the surveyor's concerns for trach care and infection prevention. No other documents were provided. A review of the facility's Tracheostomy Care/Tracheal Suctioning policy dated revised 12/17/24, included policy: to ensure the timely removal of secretions on the inner cannula to maintain a patent airway and help prevent infection, coupled with close monitoring of the stoma site. Procedure .tracheostomy care will be ordered & performed with aseptic technique .both tracheostomy care and tracheal suctioning will be performed with aseptic technique . A review of the facility's Infection Control Policy, Procedure, and Information policy dated revised 12/10/24, included Policy: handwashing, performed effectively by all personnel is essential for the prevention and control of infection. Procedure: Hands should be washed .before and after donning and doffing PPE when handling residents on transmission-based precautions .and after handling soiled dressing . NJAC 8:39-11.2(b); 19.4(a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 33106 Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) that a physician's ordered pain medication specified a pain level and b.) appropriate monitoring of pain with adequate assessment and re-assessment was consistently completed for a resident who exhibited pain. This deficient practice was identified for 1 of 1 resident reviewed for pain management (Resident #133), and was evidenced by the following: On 1/16/25 at 9:39 AM, the surveyor interviewed Resident #133 who was sitting at the side of the bed. The resident was cognitively intact and stated that they were admitted to the facility with a right below knee amputee (BKA). The surveyor observed that the resident had a dressing intact to the right stump area and that was wrapped in a bandage. The resident reported that they had frequent pain in the surgical area of the right stump. On 1/17/25 at 10:20 AM, the surveyor reviewed the medical record for Resident #133. A review of the Resident Face Sheet reflected the resident was admitted to the facility with the diagnoses which included but was not limited to; heart failure and right BKA. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/30/24, indicated that Resident #133 was cognitively intact and required partial to moderate assistance with activities of daily living (ADLs). The MDS also reflected that the resident occasionally had pain at a level of five on the numeric pain scale 0-10. A review of the Physician Order Activity Report (POAR) included a physician's order (PO) dated 12/23/24, for the pain medication acetaminophen (Tylenol) 325 milligram (mg) tablets; give two tablets (650 mg) by oral route every six hours as needed for pain and to monitor pain and follow up in 60 minutes. There was no documentation in the PO as to what the resident's pain level should be before the administration of the pain medication. A review of the corresponding Medication Administration Record (MAR) reflected that the resident received Tylenol on 12/24/24 at 5:52 AM. There was no documentation that there was follow-up regarding the effectiveness of the medication in 60 minutes as ordered. An additional review of the POAR included a PO dated 12/24/24, for the narcotic pain medication oxycodone acetaminophen (Percocet) 5 mg-325 mg; give one tablet by oral route every four hours as needed for moderate to severe pain (4-10). A review of the corresponding January 2025 MAR from 1/1/25 to 1/16/25, Resident #133 received pain medication on 15 out of 16 days. The MAR revealed that the facility had no documentation that the resident was assessed for a pain level, location of pain, description of pain, or if the pain medication was effective at controlling the resident's pain on the following dates: 1/1/25, 1/2/25, 1/3/25, 1/5/25, 1/6/25, 1/7/25, 1/9/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/14/25, 1/15/25 and 1/16/25. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Nursing Progress Notes reflected that there was no consistent documentation that indicated where the resident had complaints of pain, what the level the pain was, or if the pain medication that the resident received was effective at controlling the resident's pain from 1/1/25 until 1/16/25. The surveyor reviewed the POAR which reflected a PO dated 12/23/24, to monitor the resident's pain every shift according to the following pain scale: 0 = no pain, 1-4 = mild pain, 5-6 = moderate pain, 7-8 = severe pain, 9-10 = very severe horrible pain. A review of the corresponding January 2025 MAR from the dates of 1/1/25 to 1/16/25, the resident only had documented complaints of pain on 1/3/25, 1/10/25, 1/12/25, 1/15/25 and 1/16/25, however the resident was administered pain medication on the following dates: 1/1/25, 1/2/25, 1/3/25, 1/5/25, 1/6/25, 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/11/25, 1/12/25, 1/13/25, 1/14/25, 1/15/25, and 1/16/25. A review of the individualized comprehensive care plan (ICCP) included a focus area for the resident's pain. Interventions included that the resident would be assessed for pain and a baseline through pain assessment. On 1/17/25 at 9:45 AM, the surveyor interviewed the Certified Nursing Aide (CNA #1), who stated that Resident #133 only required supervision for all aspects of ADLs, and that the resident complained of severe pain in their surgical amputation site and would request to see the nurse for pain medications. On 1/17/25 at 10:11 AM, the surveyor interviewed the resident's Physical Therapist (PT), who stated that the resident had a new right knee BKA and was working on strengthening so that the resident would eventually receive a prosthetic. The PT stated that the resident complained of phantom pain in the right lower extremity and the nurse usually provided pain medication prior to attending PT. The PT stated that the resident also complained of right shoulder pain, and they complained to the PT that they had not received their pain medication prior to participating in PT. The PT stated that he was not sure if the pain medication was administered as needed (PRN) or routine. On 1/17/25 10:36 AM, the surveyor interviewed LPN #5, who explained that if a resident had complaints of pain, she tried non-pharmalogical approach to pain management, and if that was ineffective, she asked the resident what their pain level was to administer the proper as needed (PRN) medication. LPN #5 stated that pain medications were administered according to what the resident's pain level was, and the nurse was responsible to document location of pain, level of pain and type of pain. LPN #5 stated this documentation was located in the Progress Notes as well as the MAR in the comment section. LPN #5 stated the nurse was also responsible to monitor and document the effectiveness of pain medication. At that time, LPN #5 reviewed Resident #133's MAR and Progress Notes with the surveyor and confirmed there was no consistent documentation regarding the pain level the resident had, location of the pain, or if the pain medication was effective at managing the resident's pain. LPN #5 stated that the nurses were sometimes busy and forgot to document. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/17/25 at 11:56 AM, the surveyor interviewed LPN/Unit Manager (LPN/UM #3), who stated that the resident's Tylenol order should have a numeric number level for when the pain medication should be administered to the resident. LPN/UM #3 stated that when a nurse administered a pain medication, the nurse was responsible to document where the pain location was, pain level, when the pain started, and a description of the pain. LPN/UM #3 stated the nurse documented in the Progress Note and the comment section of the MAR because it was important to follow-up with the resident to assure continuity of care and to monitor the effectiveness of the pain medication given. LPN/UM #3 stated that the nurses were not documenting, it could mean lack of education. On 1/23/25 at 10:48 AM, the surveyor interviewed the Regional Director of Nursing (RDON), who stated a physician's order should contain a pain level for pain medications; all assessments of resident's complaints of pain should be documented in the supplemental documentation (comment section) located in the MAR which included the resident's pain level, description of the pain, location of the pain, and follow- up to assure the effectiveness of the pain medication administered. A review of the facility's Pain Management and Documentation policy dated 12/23/24, indicated that the facility utilized the electronic medical record (EMR) to monitor pain and pain response using the pain rating score, assess resident's pain level and monitors the resident's response to pain interventions including side effects and documents response. A review of the facility's Physician's Orders policy dated 12/17/24, included that the policy of the center was to write physician's orders to establish a plan of care to follow for the patient. The orders were to include monitoring should include height, weight, vital signs, blood sugar, pulse [oximetry]. This included entering a value for the monitoring . NJAC: 8:39-27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49094 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure the accountability of the narcotic shift count logs were completed and b.) accurately document the administration of controlled medications. This deficient practice was identified on 2 of 4 medication carts reviewed for medication storage, and was evidenced by the following: During medication storage review on 1/22/25 at 11:15 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #1), reviewed the D Wing medication cart #2's November 2024, December 2024 and January 2025 Change of Shift Controlled Medication Accountability Record (a shift-to-shift controlled substance and narcotics (narc) count sheet signed by the outgoing and incoming nurses each shift) which revealed the following: The nurses' signatures were blank for the outgoing nurse for the following shifts: For the day shift (7:00 AM to 3:00 PM) on: 11/26/24, 12/30/24, 1/6/25, and 1/17/25. For the evening shift (3:00 PM to 11:00 PM) on: 11/3/24, 11/11/24, 11/14/24, 11/19/24, 11/25/24, 12/1/24, 12/3/24, 12/9/24, 12/10/24, 12/18/24, 12/19/24, 12/25/24, 1/2/25, 1/5/25, 1/13/25, and 1/17/25. For the overnight shift (11:00 PM to 7:00 AM) on: 11/3/24 and 11/23/24. The nurses' signatures were blank for the incoming nurse for the following shifts: For the day shift on: 12/30/24 and 1/6/25. For the evening shift on: 12/5/24, 1/2/25, and 1/17/25. For the overnight shift on: 11/2/24, 11/23/24, and 11/25/24. A further review of the cart revealed the Individual Patient Controlled Substance Administration Record log (declining inventory) indicated the 1/11/25 6:00 PM (6 PM), dose of oxycodone apap 10-325 milligram (mg) tablet (a controlled medication used to treat pain) for unsampled Resident #1 was not signed out by the nurse administering the medication. At the time of observation, the surveyor interviewed LPN #1, who stated there should be no missing signatures on the change of shift accountability sheets or the narcotic inventory logs. LPN #1 further acknowledged that there were missing signatures on the narcotic declining inventory log and the change of shift accountability sheets; that the incoming and outgoing nurses should be counting the narcotics together and signing the log together to acknowledge the count was correct and accurate. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 11:45 AM, the surveyor in the presence of LPN #2, reviewed the D Wing medication cart #1's January 2025 Change of Shift Controlled Medication Accountability Record (a shift-to-shift controlled substance and narcotics (narc) count sheet signed by the outgoing and incoming nurses each shift) which revealed the following: The nurses' signatures were blank for the outgoing nurse for the following shifts: For the overnight shift on: 1/12/25 and 1/13/25. The nurses' signatures were blank for the incoming nurse for the following shifts: For the overnight shift on: 1/12/25. At the time of observation, LPN #2 stated that the change of shift accountability sheets should be completed at the time of the shift change and the count was done by the incoming and outgoing nurses. She further acknowledged that there should be no missing documentation on the change of shift accountability sheets. On 1/22/25 at 12:10 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM #1), who stated narcotic change of shift accountability logs should be completed by the outgoing and incoming nurses and should have no missing signatures. LPN/UM #1 stated that individual declining inventory sheets should be completed at the time the controlled medication was removed from inventory, and there should be no missing documentation. On 1/22/25 at 12:55 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the narcotic change of shift accountability logs were completed at shift change by the outgoing and incoming nurses. The DON further stated there should be no missing documentation or signatures on the narcotic change of shift accountability logs. The DON acknowledged that the individual declining inventory sheets should be completed and filled out for each narcotic dose dispensed immediately at the time the medication was removed from inventory. The DON acknowledged that if it was not documented it's not done. A review of the facility's undated Schedule II Controlled Substance Medication policy included .5. When a CDS medication is administered, in addition to following proper procedure for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/her initials. 6. An inventory count of all CDS medications stored on each nursing unit shall be performed at each change of shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form . A review of the facility's Medication Storage policy with a revision date of 9/6/19, included .A. With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy .C. Medications will be stored in an orderly, organized manner in a clean area . NJAC 8:39-29.4, 29.7(c)

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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. 49094 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a) properly label opened multidose medications and b) properly secure prefilled normal saline syringes. This deficient practice was identified in 2 of 4 medication carts reviewed for medication storage and labeling and 1 of 4 nursing units (D Wing) and was evidenced by the following: 1. On 1/22/25 at 11:15 AM, the surveyor, in the presence of the Licensed Practical Nurse (LPN #1), observed the D Wing nursing unit's medication cart #2. The following was observed: Two (2) opened foil pouches of ipratropium bromide 0.5 milligram (mg)/albuterol sulfate 3 mg inhalation solution (medication used to treat symptoms of lung disease), which were not dated with an opened date. One (1) prescription artificial tears bottle (medication used to treat dry eyes), which was not dated with an opened date or labeled with the resident's identifying information on the medication bottle. One (1) prescription fluticasone propionate and salmeterol inhalation powder 113 microgram (mcg)/14 mcg inhaler (medication used to treat asthma), which was not dated with an opened date or labeled with the resident's identifying information on the medication container. At that time, LPN #1 stated that once multi-dose medications were opened, the nurses dated the medication container and ensured the resident's name was on it as well as on the outside box or bag it came in to ensure proper identification of when the medication was opened and the resident it was prescribed to. On 1/22/25 at 11:45 AM, the surveyor, in the presence of LPN #2, observed the D Wing nursing unit's medication cart #1. The following was observed: One (1) opened foil pouch of ipratropium bromide 0.5 mg/albuterol sulfate 3 mg inhalation solution which was not dated with an opened date. One (1) opened prescription ipratropium bromide 0.03% nasal spray bottle (medication used to treat runny nose caused by allergies), which was not dated with an opened date or labeled with the resident's identifying information on the medication container. At that time, LPN #2 stated that multi-dose medications should be dated when the medication was opened and labeled with the resident's name on the medication container. LPN #2 acknowledged that the ipratropium bromide 0.5 mg/albuterol sulfate 3 mg inhalation solution and ipratropium bromide 0.03% nasal spray should have had a date and resident's information on the medication container. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 12:10 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1), who stated that once multi-dose medications were opened, expectation was to date it with the opened date. LPN/UM #1 further stated that the medication containers should also be labeled with the resident's identifying information to ensure the correct resident was receiving the correct medication. On 1/22/25 at 12:55 PM, the surveyor interviewed the Director of Nursing (DON), who stated that multi-dose medications should be dated when opened and have the resident's name on the medication container. The DON further stated that the resident's identifying information should be on the medication container in case it got separated from the box. A review of the facility's Medication Storage policy with a revision date of 9/6/19, included .Medications will be stored in a manner that maintains the integrity of the product, ensures the safety of the residents and is in accordance with NJ Department of Health guidelines .C. Medications will be stored in an orderly, organized manner in a clean area .E. Medications will be stored in the original, labeled containers received from the pharmacy . 44833 2. On 1/16/25 at 11:23 AM, during initial tour of the facility, the surveyor observed Resident #8 in their room resting in bed. During a brief interview with the resident, the surveyor observed two 10 milliliter (ml) prefilled normal saline solution syringes unsecured and stored in a plastic cup at the resident's bedside on top of the nightstand. On 1/22/25 at 12:55 PM, the surveyor interviewed the DON, who stated that medications, including prefilled normal saline syringes should be secured in a medication storage compartment, accessible only to nurses. The DON confirmed that the observed 10 ml syringes in Resident #8's room should have been secured or with the nurse. A review of the facility's Medication Storage policy with revision date 9/6/19, included medications will be stored in a manner that maintains the integrity of the product, ensures the safety of the residents and is in accordance with NJ Department of Health guidelines. A. with the exception of emergency drug kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy .C. Medications will be stored in an orderly, organized manner in a clean area . NJAC 8:39-29.4(a)(h)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On [DATE] at 9:23 AM, during the initial tour of the facility kitchen in the presence of the Food Service Director (FSD) and the Regional FSD (RFSD), the surveyor observed the following: The FSD performed hand hygiene at the hand washing station and was timed by the surveyor using a digital stopwatch to lather her hands with soap for 16 seconds prior to rinsing. The trash receptacle by the hand wash station was positioned under a stainless-steel shelf which had a tray of clean plastic cups stacked. When the FSD used the foot pedal to open the receptacle lid, it hit against the tray of clean cups. Paper towels at the hand washing station were not stored in the paper towel dispenser, they were stored on the stainless-steel shelf above the trash receptacle, with the first few paper towels of the stack appeared to be wet. The exhaust hood spanning above the stove and cooking area had areas where the surface was showing paint chipping. The FSD acknowledged the hood needed to be resurfaced/painted. The food preparation area by the bread toaster, there were one brown and one white cutting boards, both had extensive discoloration, stained, and pitted. The drying rack had two yellow and one red discolored, stained, and pitted cutting boards. The FSD acknowledged the cutting boards were in use and should have been discarded. The walk-in freezer contained two opened boxes of corn on the cob dated opened [DATE], and one opened box of croissants with an opened date [DATE]. The plastic bags inside the boxes were opened exposing the contents to air. The corn showed signs of what the RFSD stated was freezer burn and acknowledged it should not be that way. On [DATE] at 10:32 AM, the surveyor interviewed the FSD, who stated that hand washing should be 30 seconds of lathering outside the flow of water; the trash bin should not be able to come in contact with clean kitchen supplies; and the paper towels should be stored in the dispenser and not on the shelf. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:59 AM, the surveyor interviewed the Infection Preventionist (IP) in the presence of the Director of Nursing (DON) and the survey team, who stated that the current Centers for Disease Control and Prevention (CDC) guidelines for hand washing was a minimum of 20 seconds of soap lathering prior to rinsing. The IP further stated that having a trash receptacle in the kitchen in a position where it can come in contact with clean kitchen supplies was not appropriate for infection control. A review of the facility's Hand Washing/Waterless Hand Washing policy with a last reviewed date of [DATE], included under the section labeled procedure, .b. wet your hands with water. c. apply enough soap to cover your hands. d. apply friction to all wetted surfaces, including between the fingers, for a period of 20 seconds. e. if a nail stick is used, clean the nails under running water. f. rinse hands under running water from wrist to fingers . A review of the facility's Dietary Sanitation Policy with an effective date of [DATE], included employees must wash hands for at least 20 seconds when they come in before they start their assignment, when they walk out of the kitchen and/or as needed . A review of the facility's food service Equipment in Use policy included all kitchen equipment are either fixed or replaced as they get damaged, small ware, pots, pans, dishes, cutting boards, can opener, and so on. It is up to the dietary department head to keep replacing them and maintained cleaned, sanitized before it is in use . A review of the facility's food service Environmental policy with an effective date of [DATE], included environmental rounds are done daily, this include dumpsters, patios, loading dock, kitchen, building in general .housekeeping is responsible for providing soap and hand sanitizer plus drying towels for the building . A review of the facility's food service Cold Food policy with an effective date [DATE], included all boxes must be checked, date manufactured, date which will be expired, they must be closed, unopened, once they are in the refrigerators or freezers, they must have a received date and always closed to avoid freezer burn, they must be rotated . NJAC 8:,d+[DATE].2(g)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 44833 Based on observation, interview, and record review, it was determined that the facility failed to ensure that food brought in to residents by family and visitors were stored and handled in a safe and sanitary condition. This deficient practice was identified for 1 of 2 facility freezers reviewed during kitchen tour, and was evidenced by the following: On 1/16/25 at 9:23 AM, during initial tour of the facility kitchen, the surveyor, in the presence of the Food Service Director (FSD) and the Regional FSD (RFSD), observed a one and a half (1.5) quart container of black raspberry ice cream which was approximately three quarters (3/4) empty dated opened 9/23/24, stored in the ice cream freezer. On 1/16/25 at 9:24 AM, the RFSD informed the surveyor that this was a specific resident's personal ice cream that was being stored by the facility. The container was not labeled with a resident's name, and the RFSD stated the resident was no longer at the facility and the ice cream should have been labeled with the resident's name. The surveyor reviewed the facility's Resident Food from Outside Sources with a last reviewed date of November 2023, included food and beverages brought in from outside sources will be labeled with the resident's name and date for storage in the pantry refrigerator. The uneaten portion will be discarded after 72 hours . On 1/23/25 10:45 AM, the Regional Nurse, in the presence of the Director of Nursing (DON), Assistant Administrator, and survey team, acknowledged the ice cream should have been disposed of. NJAC 8:39-17.2(g)