STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatham Hills Subacute Care Center	415 Southern Blvd Chatham, NJ 07928

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication times of administration for a medication (Gabapentin) (used to treat nerve pain) to accommodate for dialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do so) scheduled times and was not administered 41 times from June 2025 until surveyor inquiry September 2025. 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 deficient practice was identified for one (1) resident, (Resident #2), reviewed for dialysis services and was evidenced by the following: On 9/15/25 at 9:50 AM, the surveyor interviewed Resident #2 who was in their room sitting in a wheelchair. Resident #2 stated that they were blind and were ready to go for hemodialysis. The resident added that they were picked up around 10 AM and came back to the facility around 4 PM. The surveyor reviewed the medical record for Resident #2. A review of the admission Record revealed diagnoses that included, but not limited to, end stage renal disease (ESRD) (a condition which the kidneys cannot filter waste from the blood), dependence on renal dialysis (a mechanical process used to filter waste from the blood) and complete traumatic amputation at knee level, unspecified lower leg (surgical amputation of left leg below the knee). A review of a comprehensive admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 6/12/2025, reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. A review of the resident's individualized interdisciplinary care plan revealed as a focus area, with an initiated date of 6/9/25, Resident #2 has an implanted left upper chest wall port-a-cath (an implantable medical device that provides long-term access to a vein) for hemodialysis. Another focus area revealed Resident #2 is on pain medication therapy r/t (related to) surgery (LBKA) (left below knee amputation) with an initiated date of 8/2/25 and an intervention/task included, but not limited to, Administer medication as ordered. A review of the resident's Medication Review Report (MRR) reflected a physician's order (PO) dated 6/9/25 for Hemodialysis M/W/F (Monday/Wednesday/Friday) chair time 10:50 AM at [name of dialysis facility and phone number redacted]. In addition, the MRR revealed a PO with a start date of 6/7/25 for Gabapentin Oral Tablet 100 MG (milligrams) (Gabapentin) Give 1 tablet by mouth three times a day for neuropathy (a condition that damages the nerves outside the brain and spinal cord). A review of the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 2025 electronic medication administration record (EMAR) indicated a medication administration time of 1300 (1:00 PM) that occurred during the time that the resident was out of the facility at dialysis. Further review of the EMAR revealed on 6/9/25, 6/13/25, 6/16/25, 6/18/25, 6/20/25, 6/23/25, 6/25/25 and 6/30/25 all the 1:00 PM administration documentation on those dates had a code number 3 entered for administration which corresponded to Out of facility. In addition, on 6/27/25 at 1 PM there was a code number 9 entered for administration documentation which corresponded to Other/See Nurses Notes. A total of 9 out of 24 doses for June 2025. A review of the July 2025 EMAR indicated a medication administration time of 1300 (1:00 PM) that occurred during the time that the resident was out of the facility at dialysis. Further review of the EMAR revealed on 7/2/25, 7/4/25, 7/7/25, 7/9/25, 7/11/25, 7/14/25, 7/16/25, 7/18/25, 7/21/25, 7/23/25, 7/25/25, 7/28/25 and 7/30/25 all the 1:00 PM administration documentation on those dates had a code number 3 entered for administration which corresponded to Out of facility. A total of 13 out of 31 doses for July 2025. A review of the August 2025 EMAR indicated a medication administration time of 1300 (1 :00 PM) that occurred during the time that the resident was out of the facility at dialysis. Further review of the EMAR revealed on 8/1/25, 8/4/25, 8/6/25, 8/8/25, 8/11/25, 8/13/25, 8/15/25, 8/18/25, 8/20/25, 8/22/25, 8/25/25, and 8/29/25 all 1:00 PM administration documentation for those dates had a code number 3 entered for administration which corresponded to Out of facility. A total of 12 out of 31 doses. A review of the September 2025 EMAR indicated a medication administration time of 1300 (1:00 PM) that occurred during the time that the resident was out of the facility at dialysis. Further review of the EMAR revealed on 9/1/25, 9/3/25, 9/5/25, 9/8/25, 9/10/25 and 9/15/25 all 1:00 PM administration documentation for those dates had a code number 3 entered for administration which corresponded to Out of facility. In addition, on 9/12/25 at 1:00 PM there was a code number 9 entered for administration documentation which corresponded to Other/See Nurses Notes. A total of 7 out of 15 doses. A review of the corresponding electronic progress notes (EPN) for the above dates listed in June, July, August and September revealed that the resident was out of the facility at dialysis and had not received the Gabapentin at 1:00 PM. On 9/16/25 at 10:15 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that she was full time on the 7 AM to 3 PM shift and administered medications to Resident #2. LPN #1 also stated that the resident was at dialysis on M/W/F and was unable to administer the 1 PM dose of Gabapentin and indicated that on the EMAR by coding the number 3 which reflected that the resident was out of facility. LPN #1 stated I am not sure what else I should have done. LPN #1 then added Maybe I could let my supervisor know. On 9/16/25 at 10:25 AM, the surveyor with the Unit Manager/Registered Nurse (UM/RN) reviewed the EMAR for Resident #2. UM/RN stated the 1 PM administration time for Gabapentin was when the resident was out to dialysis on M/W/F. UM/RN also stated that the medication nurse should be looking at the days and times the resident went to dialysis and the resident would not return for the 1 PM dose. UM/RN added that she thought that may have been the reason the physician's order was changed. UM/RN explained the nurse should call the physician every time there was a missed dose to find out if that was allowed or if the physician wanted to make a change and there would be a progress note documenting that. UM/RN acknowledged that there was no progress note entries regarding the physician was called when the resident missed their 1 PM Gabapentin on dialysis days. On 9/16/25 at 12:27 PM, the surveyor, in the presence of another surveyor, interviewed the Consultant Pharmacist (CP) via telephone. CP stated medication reviews were done monthly, and he was not the only pharmacist that has done reviews because he rotates his staff. CP also stated that a resident that was on dialysis should not have medications scheduled when they were out of the facility for dialysis. CP added that he would expect the medication nurse to follow the chain of command meaning that the nurse would go to the supervisor to make the change necessary. A review of the facility policy Dialysis dated as approved 2/3/25 provided by the Director of Nursing (DON) revealed The facility has established standards of care for the dialysis resident. A review of a facility policy Administering Medication Schedule/Policy dated as approved 12/2023 provided by the DON (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected Medications are administered in a safe and timely manner, and as prescribed. In addition, Medications are administered in accordance with prescriber orders, including any required time frame. A review of a facility policy Medication Errors dated as approved 3/3/25 provided by the DON reflected The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples included, but not limited to:. ii. Medication omission. NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, and review of other facility documentation, it was determined that the facility failed to ensure that a Licensed Practical Nurse followed the PO to notify physician when blood sugar was less than 70 or above 250 for 1 of 1 resident's reviewed for medication administration, (Resident #15).This deficient practice was evidenced as follows: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.On 9/11/25 at 11:15 AM, the surveyor observed Resident #15 sitting up in their chair. Resident #15 was watching television (TV). On 9/12/25 at 10:11 AM, the surveyor reviewed Resident # 15's electronic medical records (EMR) that revealed the following:The admission Record (an admission summary) revealed that Resident #15 had diagnoses that included but were not limited to; Type 2 Diabetes Mellitus (when the body cannot use insulin correctly and sugar builds up in the blood), and hypertension (high blood pressure).A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/3/25, reflected that Resident #15 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that the resident's cognition was moderately impaired. A review of care plan (CP) dated 4/1/25 with a focus that reflected Resident #15 had DM. The interventions that were included but were not limited to; diabetic medications as ordered by the doctor, and to monitor and document for side effects and effectiveness. A review of the Order Summary Report (OSR) reflected that Resident #15 had active POs as followed:Finger stick (a quick and relatively painless method for measuring blood sugar levels) blood sugar, two times a day for Insulin dependent diabetes mellitus (IDDM) before breakfast and before dinner, notify physician if sugar less than (<) 70 or above (>) 250 with a start date 4/1/25. Insulin Aspart Flex Pen 100 UNIT/ML Solution pen-injector: Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units >400 blood sugar report to MD., subcutaneously before meals and at bedtime for DM1 with a start date 7/12/25. The corresponding physician order was transcribed into the August 2025 through September 2025 electronic Medication Administration Record (eMAR). Further review of the August - September 2025 eMARs for Resident #15 revealed that nurses signed and reflected a checkmark which means that the BS was checked two times a day as per physician orders. Surveyor #1 observed there were several entries where the residents blood sugar was over 250 and where the nurses should have notified physician as per PO for the following dates and times: Date Time BS8/3/25 5 PM 2998/7/25 5 PM 2608/8/25 9 AM 2588/10/25 5 PM 2778/11/25 5 PM 307 8/12/25 5 PM 2978/18/25 5 PM 3198/20/25 5 PM 3158/26/25 5 PM 3588/28/25 5 PM 284 8/29/25 5 PM 3559/1/25 5 PM 342 9/4/25 9 AM 2889/9/25 9 AM 2699/12/25 5 PM 334A Review of August - September 2025 Nursing Progress Notes (PN) did not reflect a PN where the nurses had written that the physician was notified when Resident #15's BS were above 250. During an interview with the surveyor on 9/15/25 at 10:42 AM, the Licensed Practical Nurse (LPN) stated that if there was a PO for fingerstick and to notify the physician for BS below 70 pr above 250 she would notify the physician and then document in her PN. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The LPN further stated that documentation was important for continuous care and the next shift nurses would have an idea of what kind of care was provided to the resident during the previous shift. The surveyor reviewed the August eMAR with LPN #1 where she had documented BS above 250 for 8/8/25, 8/11/25, 8/18/25 and 8/29/25. LPN #1 stated, Usually the nurse practitioner is here, and we just tell her. The LPN further stated, I should have documented but I am not sure if I did. And if you did not document, you did not do it. During an interview with the surveyor on 9/15/25 at 11:03 AM, the North Unit Registered Nurse / Unit Manager (RN/UM) stated the nurses would do finger stick before administering insulin. In the presence of the surveyor, the RN/UM reviewed the PO for Resident #15. The RN/UM stated the nurses would inform the physician if the BS was below 70 or above 250 and then document in PN. The RN/UM stated she expected nurses to write a PN after they reported abnormal BS to the physician. In the presence of the surveyor, the RN/UM reviewed nursing PN's for Resident #15. The RN/UM stated that she did not see any notes when the BS was out of the parameters and that the physician was notified. During an interview with Surveyor on 9/15/25 at 12:42 PM, the Director of Nursing (DON) stated, a lot of times, we communicate with the doctors via telephone or text message. The DON further stated that the nurses should document so that everybody was on the same page and that documentation was important for other nurses and doctors to see the communication notes. The surveyor mentioned that there were two orders for blood sugar checks for Resident #15. The DON stated there should not be two orders and if the nurses observed two separate orders for BS, the nurses should call the doctor to get clarification. On 9/16/25 at 1:23 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON to present above mentioned concerns. The DON acknowledged that the nurses should have called the physician when BS were out of parameters and documented. The DON further stated the nurses should have called the physician to get clarification for the duplicate orders to check BS.A review of the facility provided policy Medication Orders revision date 11/2014, included under Supervision by a Physician: 3. Orders must be written and maintained in chronological order.A review of the facility provided policy Insulin Administration revision date 1/2025 included under Steps in the procedure: 2. Check blood glucose per physician order or facility protocol. A review of the Charge Nurse/LPN Job Responsibility included but were not limited to; Nursing Care Functions: Communicate with primary care physician and members of the comprehensive care planning team regarding the status of residents; follow up on critical labs, order requests and physician notification. The section Charting and Documentation Functions: Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures. On 9/17/25 at 10:09 AM, the survey team met for an Exit Conference with the LNHA, DON, RN/UM, and Infection Preventionist/Assistant DON (IP/ADON). The DON stated, I have really nothing to say. The DON acknowledged that it should not have happened. NJAC 8:39-27.1 (a), 29.2 (d)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and review of pertinent facility documents, it was determined that the facility's Consultant Pharmacist's (CP) failed to identify and address irregularities for a.) a medication prescribed for neuropathy (damage, disease, or dysfunction of one or more nerves that can cause burning or shooting pain, numbness, and tingling) was not administered 41 times from 6/7/25 through 9/15/25 when the resident was consistently out of the facility to attend dialysis treatments at 1 PM. This was identified for 1 of 1 residents reviewed for dialysis (Resident #2); and b.) inadequate monitoring and documentation for the reason an as needed anti-anxiety medication (Xanax) was administered. This was identified for 1 of 5 residents, (Resident #6), reviewed for unnecessary medications. The deficient practice was evidenced as follows; REFER to F698 1. On 9/15/2025 at 9:50 AM, the surveyor observed Resident #2 in their room seated in a wheelchair, dressed and groomed. The resident stated they were waiting to be transported to a dialysis treatment (treats kidney failure by filtering waste products and excess fluid from your blood). Resident #2 stated, they were scheduled for a 10 AM pick up on Monday, Wednesday and Friday and returned at approximately 4 PM. The resident stated that they were diabetic, legally blind and had a left leg amputation. A review of the residents admission Record (an admission summary) reflected diagnoses which included but were not limited to; absence of leg below the knee, type 2 Diabetes Mellitus, end stage renal (kidney) disease and dependence of renal dialysis. A review of a comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 6/12/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the residents cognition was intact. A review of the Medication Review Report, reflected the resident had a physician's order (PO) for Gabapentin Oral Tablet 100 mg, Give 1 tablet by mouth three times a day for neuropathy, dated 6/6/25 and to start 6/7/25. It further reflected it was discontinued and replaced with two additional PO's whereby doses were scheduled for the morning and bedtime, dated 9/15/25. A review of the electronic Medication Administration Records (eMARs) from 6/7/25 through 9/15/25, reflected the PO as noted above to be given at 9 AM, 1 PM and 5 PM, with a start date of 6/7/25 and a discontinuation date of 9/15/25. During the month of June 2025, nine out of 24 days the residents 1 PM dose was not given due to the resident being out of the facility. For the same reason the following 1 PM doses were unable to be administered: in July 2025, the resident missed 13 out of 31, in August 2025, the resident missed 12 out of 31 doses and in September 2025, the resident missed seven out of 15, 1 PM doses. This added up to a total of 41 missed doses. A review of the Drug Regimen Reviews, reflected the residents' medications were reviewed by a CP on the following dates 6/9/25, 6/12/25, 7/11/25 and 8/8/25. The surveyor reviewed the facility provided Nursing Summary Report's, which reflected the CP recommendations after their drug regimen reviews. The CP provided recommendations dated 6/9/25, 8/8/25 and 9/5/25; none of which identified or addressed the PO for gabapentin to be administered at 1 PM, when the resident was out of the facility. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/16/2025 at 12:27 PM, the surveyor interviewed the CP via phone in the presence of two additional surveyors. He stated that he or his staff conducted resident medication reviews on admission and monthly thereafter. The CP stated that residents that leave the facility for dialysis treatments should not have medications scheduled for administration while out of the facility. He further stated that he would expect the nurse to identify this and to follow the chain of command to address the concern. The CP stated that medication reviews were documented in the Evaluation tab in the electronic medical record (EMR). He stated they document the medication review was completed and whether or not any recommendations were made. The CP added, If recommendations were made nursing is provided a Nursing Summary Report with the findings. The surveyor informed the CP as to the resident specific concerns. He offered no further information. REFER to F605 2. On 9/12/2025 at 11:22 AM, the surveyor interviewed a resident representative (RR) in the presence of Resident #6 in their room. RR stated they had no concerns with the care the staff was providing at the facility. RR added the resident had a mind of (redacted) own and does not remember things and gets confused. The surveyor observed the resident was well groomed and drinking sips of water on their own from a cup and when finished would give the cup to the RR. The surveyor also observed the resident telling the RR approximately three (3) times during the interview, they needed to go to the bathroom and the RR explained each time to the resident they had a catheter, that it was new and probably felt funny but did not have to be taken to the bathroom. The resident responded each time okay and would continue taking sips of water. The surveyor then observed the resident repositioning themselves in the wheelchair and the RR stated that sometimes the resident tried to stand on their own but was not [NAME]. The surveyor reviewed the medical record for Resident #6. A review of the resident's admission Record revealed diagnoses which included, but not limited to, traumatic subdural hemorrhage with loss of consciousness status unknown (a brain injury from trauma), aphasia (a disorder that affects how you communicate), muscle weakness (generalized), dysarthria (weakness in the muscles used for speech) and anarthria (inability to produce speech sounds due to dysfunction of muscles controlling speech), other abnormalities of gait and mobility, unspecified psychosis not due to a substance or known physiological condition (a mental health condition causing distorted thought and behaviors), dementia in other diseases classified elsewhere, mild, with behavioral disturbance and Alzheimer's Disease, unspecified. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 9/19/25, reflected the resident had a brief interview for mental status (BIMS) score of three (3) out of 15, indicating that the resident had a severely impaired cognition. A review of the September 2025 electronic medication administration record (EMAR) had a physician's order (PO) dated 8/28/25 for Xanax Oral Tablet 0.25 milligram (MG) (Alprazolam) Give 1 tablet by mouth every 8 hours as needed (PRN) for Anxiety for 14 days. with a start date of 8/28/25. Further review of the EMAR revealed Xanax administration four (4) times on the following dates and times: 9/3/25 at 19:30 (7:30 PM), 9/4/25 at 10:23 AM and 19:57 (7:57 PM), and 9/6/25 at 18:26 (6:26 PM). The EMAR also revealed the PO dated 8/28/25 was discontinued on 9/11/25 and another PO dated 9/11/25 indicated Xanax Oral Tablet 0.25 milligram (MG) (Alprazolam) Give 1 tablet by mouth every 6 hours PRN for Anxiety for 14 days. was administered three (3) times on the following dates (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and times: 9/11/25 at 18:41 (6:41 PM), 9/13/25 at 19:18 (7:18 PM) and 9/14/25 at 9:39 AM. A review of the corresponding nursing progress notes for the dates identified above for the Xanax administration revealed the following: -on 9/3/25 at 19:30 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days. - on 9/3/25 at 22:10 (10:10 PM) indicated PRN administration was: Effective. -on 9/3/25 at 22:41 (10:41 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention. -on 9/4/25 at 10:23 AM indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days. Resident is very anxious and when redirected was unsuccessful. - on 9/4/25 at 14:38 (2:38 PM) indicated PRN administration was: Effective. -on 9/4/25 at 19:57 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days. - on 9/4/25 at 21:58 (9:10 PM) indicated PRN administration was: Effective. -on 9/4/25 at 22:01 (10:01 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention. -on 9/6/25 at 18:26 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days. - on 9/6/25 at 19:39 (7:39 PM) indicated PRN administration was: Effective. -on 9/6/25 at 19:52 (7:52 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention. -on 9/11/25 at 17:53 (5:53 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention. -on 9/11/25 at 18:41 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 6 hours as needed for Anxiety for 14 days. -on 9/13/25 at 19:18 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 6 hours as needed for Anxiety for 14 days. Resident was restless. -on 9/13/25 at 19:47 (7:47 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention. - on 9/13/25 at 22:02 (10:02 PM) indicated PRN administration was: Effective. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-on 9/14/25 at 9:39 AM indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days. - on 9/14/25 at 10:21 AM indicated PRN administration was: Effective. Further review of the nursing progress notes revealed an inconsistency on 9/5, 9/7, 9/8, 9/9, 9/10 and 9/12 there were skilled services nursing notes that indicated similar documentation; Resident is exhibiting signs/symptoms of delirium has inattention. and Xanax was not administered on those dates. On 9/15/2025 at 11:12 AM, the surveyor interviewed Registered Nurse (RN)/UM who stated when a PRN medication being used for anxiety was administered there would be a progress note indicating what behaviors the resident was exhibiting to indicate the need for the medication. RN/UM was aware that Resident #6 had anxiety and stated the resident could get very agitated, yells, wants to go home or wants to call a family member and frequently asked to go to the bathroom but has a catheter. RN/UM added that the resident had to be redirected but sometimes that had not worked. RN/UM also stated that the nurses document in the EBMR the targeted behaviors the resident exhibits and enter the number of episodes the behavior was exhibited and there would also be a progress note explaining what happened. At that time, the surveyor, with the RN/UM, reviewed the EMAR for Resident #6. RN/UM verified the administration of Xanax PRN on 9/3/25 and acknowledged that there was no progress note explaining why the Xanax PRN was needed. RN/UM also reviewed the EBMR for the date of 9/3 and shift that the Xanax PRN was administered and stated that there was no documentation as to the behaviors exhibited or non-drug interventions tried. RN/UM then stated that she would have to check the other dates the Xanax PRN was administered. On 9/15/2025 at 11:35 AM, RN/UM stated that she had looked through the progress notes and EBMR and could not find the documentation as to why the Xanax PRN was administered. On 9/16/2025 at 10:01 AM, the Director of Nursing (DON) explained that the nurses were able to electronically enter targeted behaviors in the EBMR which was similar to the EMAR for documentation of the number of times a behavior was exhibited. The DON further explained a nursing progress note should indicate what took place for the need for the use of a PRN medication for behaviors. The DON also stated that anxiety had to be explained as to what the behaviors were that were exhibited and that would be in the progress notes. A review of the EBMR for the corresponding dates and shift times for the administration of Xanax PRN revealed the following: For the targeted behavior of Fighting entries were as follows; -on 9/3/25 the 3 PM to 11 PM shift was blank for the number of times the behavior occurred and interventions. - on 9/4/25 the 7 AM to 3 PM shift was zero (0) for the number of times the behavior occurred and interventions. For the 3 PM to 11 PM shift had the number 2, and the intervention was redirect. -on 9/6/25 the 3 PM to 11 PM shift had the number 3, and the intervention was one on one, activity (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/25 at 2:07 PM, the surveyor was provided by the DON, two (2) forms titled Note to Attending Physician/Prescriber completed by the CP dated 9/11/26 which correlated to the electronic CP Drug Regimen Review indicating that there were recommendations made. The two (2) forms titled Note to Attending Physician/Prescriber were not regarding the documentation for the need for the use of Xanax PRN. On 9/16/2025 at 11:49 AM, the surveyor in the presence of another surveyor interviewed the Consultant Pharmacist (CP) who stated that he was the CP for the facility as well as rotating his staff so that there were always fresh eyes reviewing. CP added that he performed onsite inspections and chart auditing as well as remote electronic chart auditing. CP explained a review of behavior monitoring for a resident on a psychotropic medication involved correlating the medications with the MDS and if the resident was a candidate for a gradual dosage reduction. CP further explained he attended monthly meetings to discuss residents on psychotropic medications and made sure that the PO for a PRN psychotropic medication had stop order dates and reviewed the utilization to see if the medication could be discontinued or changed to routine use. CP stated that Xanax ordered PRN for anxiety was an appropriate indication for use and the nurses were responsible for documenting how a resident expressed anxious behaviors. CP stated that anxiety was a broad-spectrum term. CP also stated there was a verbal discussion of the residents on psychotropic medications at the meetings and does not look at behavior documentation. CP acknowledged that behavior documentation should correlate with the need for a PRN psychotropic medication. CP was informed of Resident # 6's Xanax PRN use and inadequate documentation and stated that he would review. There was no additional information provided by the CP. On 9/16/2025 at 1:22 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The above concerns regarding the documentation for the need and non-pharmacologic interventions tried for Xanax PRN use were reviewed. The DON stated there were monthly meetings to verbally discuss all residents on a psychotropic medication that she attended with the CP, nurses and psychiatric nurse practitioner. The DON added that they do not go over the EBMR. On 9/17/2025 at 10:11 AM, the survey team met with the LNHA, DON, Infection Preventionist and RN/UM. The DON stated that she talked to the nurses that had administered the Xanax PRN, and they all spoke to the resident constantly wanting to go (meaning leave the facility), screaming and getting up out of the wheelchair to walk on their own. The DON added the nurses had not documented the behaviors. The DON and RN/UM acknowledged the documentation of behaviors and failed non-pharmacologic interventions had not correlated to the need for the Xanax PRN to be administered. The DON also stated that the Psychiatric Consult indicated that the resident was having behaviors. The DON acknowledged that the CP attended the monthly meetings discussing the residents on psychotropic medications and should report any irregularities with the documentation. The DON acknowledged that the CP had not made any recommendation regarding the documentation of the need for Xanax PRN. The DON stated during the monthly meeting, they should review what behaviors are documented, how many times and what non-drug interventions were tried. A review of the facility policy Pharmacy Services dated as approved 12/20/24 provided by the DON reflected The facility shall contract with a licensed consultant pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. In addition, The consultant pharmacist, in collaboration with the dispensing pharmacy and the facility, oversees the development (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of procedures related to pharmacy services, including (but not limited to): .c. administration of medications. A review of the facility policy Medication Regimen Review dated as approved 6/11/25 provided by the DON reflected The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. In addition, The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: c. duplicative therapies or omissions of ordered medications; NJAC 8:39-29.3(a)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and review of pertinent facility documents, it was determined that the facility failed to maintain proper food service sanitation practices and properly store potentially hazardous foods to prevent the development of food borne illness. This deficient practice was evidenced by the following: On 9/11/25 at 10:20 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and another surveyor and observed the following: The walk-in freezer had a solid piece of ice on the floor on the right side of a rack under the fan. The FSD stated that during the defrosting stage ice seemed to build up. An opened cardboard box labeled puff pastry was observed with ice buildup on top. The box was removed from the freezer by the FSD to further inspect. When opened, the sheets of puff pastry were observed to be half covered by clear plastic packaging and two solid pieces of ice were in direct contact with the exposed puff pastry. The FSD stated, this is not safe practice. I apologize. There was a hard plastic rack with pots and pans that were air drying. The rack had a pinkish brown dry film on the surfaces between the tines of the rack. The FSD acknowledged the discolored film on the rack. On 9/11/25 at 12:45 PM, the surveyor observed the nourishment pantry on the south nursing unit with another surveyor. A review of the temperature log for the refrigerator revealed inconsistent monitoring and documentation of temperatures. The log indicated the temperature was to be recorded in the morning and evening. There were missing entries on the mornings of 9/4, 9/5, 9/6, 9/7, and 9/11. There were missing entries on the evenings of 9/2, 9/4, 9/6 and 9/7. On 9/17/25 at 11 AM, the surveyor interviewed the FSD in the presence of another surveyor. The FSD stated, the ice building up that we saw during our tour was when the walk-in freezer automatically goes through a defrost cycle, usually about twice a day. The FSD acknowledged that when the freezer went into the automatic defrosting cycle, water dripped down and would refreeze on the items below. The FSD stated the ice buildup the surveyor observed was not from a recent defrost cycle but has been there. During this same interview, the FSD stated that he was recently made aware that it was his departments responsibility to monitor and record the temperatures of the refrigerators in the pantries. He added that it was the kitchen staff's responsibility to check the refrigerators to make sure the temperature does not go into the danger zone (temperatures between 41 degrees Fahrenheit (F) and 135 degrees F allows the rapid growth of pathogenic microorganisms that can cause foodborne illness). The FSD acknowledged that there could be potentially hazardous foods stored in the pantry refrigerators and that it was important to ensure that temperatures were in acceptable ranges for food safety. A review of facility provided policy General Sanitation of Kitchen Created 2013, reflected that The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. A review of an undated facility provided policy Cleaning Instructions: Freezers, reflected that Freezers will be defrosted as needed (when frost is greater than or equal to 1/4 inch thick, the freezer should be defrosted), or per the manufacturer's instructions. A review of facility provided policy Food Storage Created 2024, reflected that Food is stored in an area that is clean, dry, and free from contaminants. Within this policy, item number 15 Frozen Foods: contained the following: a. All freezer units are always kept clean and in good working condition. b. Freezer temperatures should be checked at least two times a day. Check for proper functioning of the unit at the same time. A review of an undated facility provided policy Freezer & Refrigerator Temperature Form, reflected Recording frequency: Check and record temperatures at least twice per day, such as at the start and end of a shift. A review of an undated facility provided policy Pantry Policy, reflected that The facility maintains infection control measures to prevent the spread of food borne illness. NJAC 8:39-17.2(g)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident's environment, equipment, and living area in a safe, sanitary, and homelike manner. This deficient practice was identified in 1 of 2 nursing units (South Unit room [ROOM NUMBER]) observed for environment, and was evidenced by the following:On 9/11/25 at 11:50 AM, the surveyor observed in room [ROOM NUMBER], a tube feeding pump (moves the formula through the feeding tube into the stomach at a controlled rate) soiled with a yellow and brown substance. The surveyor also observed two floor mats that were heavily soiled with black and brown substances. On 9/15/25 at 12:58 PM, the surveyor observed the tube feeding pump was no longer in room [ROOM NUMBER]. The surveyor observed that the floor mats were still heavily soiled with a brown and black substance. On 9/15/25 at 1:15 PM, the surveyor showed the Licensed Practical Nurse (LPN) the soiled mats. The LPN confirmed the mats were soiled and should have been cleaned by the housekeeping staff or the maintenance staff. The LPN confirmed that the nurses were responsible for ensuring that the tube feeding pump was cleaned properly. The LPN stated that the pump had been removed from room [ROOM NUMBER]. On September 15, 2025, at 1:30 PM, during an interview with the surveyor, the Registered Nurse Unit Manager confirmed that feeding pumps should be cleaned by nurses for infection control purposes. On 9/16/25 at 1:22 PM, the survey team discussed the above observations and concerns with the Director of Nursing and Licensed Nursing Home Administrator. The surveyor showed the DON a picture of the soiled Tube Feeding Pump. The DON confirmed that it should have been cleaned properly by the nurse who administered the feeding. NJAC 8:39-27.1 (a)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Refer to F756Based on observation, interview and record review, it was determined that the facility failed to ensure a resident was free from unnecessary administration of an as needed psychotropic medication, (Xanax) (an anti-anxiety medication), by adequately documenting and monitoring non-drug interventions that were attempted and failed prior to administration and exhibited targeted behaviors identified for the need for medication use. The deficient practice was identified for one (1) of five (5) residents, (Resident #6), reviewed for unnecessary medications and was evidenced by the following:On [DATE] at 11:06 AM, the surveyor interviewed the certified Nursing Aide (CNA #1) who stated that she had been working at the facility for approximately one month and was assigned to Resident #6. CNA #1 stated that the resident required total care (meaning that the resident required help with hygiene and dressing), could follow cues, require assistance when standing and pivoting but was not [NAME]. She explained the resident was pleasant and able to tell her what they wanted and could answer questions at the moment but was confused and had no safety awareness. CNA #1 was unable to speak to behaviors that the resident had and stated the resident could self-propel and sometimes would go to other rooms and would try to stand up unassisted. On [DATE] at 11:15 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that she was the nurse administering medications to Resident #6. LPN #1 stated the resident could become combative at times when they did not want to do something, explaining the resident had no understanding that they could not walk on their own and wanted to go home. LPN #1 added the resident was confused, thinking that they were not supposed to be here and had an indwelling urinary catheter (a tube that remains inserted into the bladder to collect urine) and kept asking to go to the bathroom to urinate. LPN #1 also explained the resident had anxiety related to being unable to go home and could escalate and became combative or pushed staff. LPN #1 also stated that usually the resident was in the activity area and could tell you want they wanted and answer questions but would not remember. LPN #1 also stated that the resident was compliant with taking their medications. On [DATE] at 11:22 AM, the surveyor interviewed a resident representative (RR) in the presence of Resident #6 in their room. RR stated they had no concerns with the care the staff was providing at the facility. RR added the resident had a mind of (redacted) own and does not remember things and gets confused. The surveyor observed the resident was well groomed and drinking sips of water on their own from a cup and when finished would give the cup to the RR. The surveyor also observed the resident telling the RR approximately 3 times during the interview, they needed to go to the bathroom and the RR explained each time to the resident they had a catheter, that it was new and probably felt funny but did not have to be taken to the bathroom. The resident responded each time okay and would continue taking sips of water. The surveyor then observed the resident repositioning themselves in the wheelchair and the RR stated that sometimes the resident tried to stand on their own but was not [NAME].The surveyor reviewed the medical record for Resident #6.A review of the resident's admission Record revealed diagnoses which included, but not limited to, traumatic subdural hemorrhage with loss of consciousness status unknown (a brain injury from trauma), aphasia (a disorder that affects how you communicate), muscle weakness (generalized), dysarthria (weakness in the muscles used for speech) and anarthria (inability to produce speech sounds due to dysfunction of muscles controlling speech), other abnormalities of gait and mobility, unspecified psychosis not due to a substance or known physiological condition (a mental health condition causing distorted thought and behaviors), dementia in other diseases classified elsewhere, mild, with behavioral disturbance and Alzheimer's Disease, unspecified.A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [DATE], reflected the resident had a brief interview for mental status (BIMS) score of three (3) out of 15, indicating that the resident had a severely impaired (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition.A review of the individualized care plan report (ICPR), created and revised on [DATE], revealed a focus area Resident #6 uses psychotropic medications r/t (in relation to) Behavior management with interventions to Monitor/record occurrence of for targeted behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. Another intervention was Offer nonpharmacologic interventions such as conversation, hand massage, diversional activities, music therapy, redirection, reassurance, education on deep breathing and relaxation techniques, or assist to a quieter environment.A review of the [DATE] electronic medication administration record (EMAR) had a physician's order (PO) dated [DATE] for Xanax Oral Tablet 0.25 milligram (MG) (Alprazolam) Give 1 tablet by mouth every 8 hours as needed (PRN) for Anxiety for 14 days. with a start date of [DATE]. Further review of the EMAR revealed Xanax administration four (4) times on the following dates and times: [DATE] at 19:30 (7:30 PM), [DATE] at 10:23 AM and 19:57 (7:57 PM), and [DATE] at 18:26 (6:26 PM). The EMAR also revealed the PO dated [DATE] was discontinued on [DATE] and another PO dated [DATE] indicated Xanax Oral Tablet 0.25 milligram (MG) (Alprazolam) Give 1 tablet by mouth every 6 hours PRN for Anxiety for 14 days. was administered three (3) times on the following dates and times: [DATE] at 18:41 (6:41 PM), [DATE] at 19:18 (7:18 PM) and [DATE] at 9:39 AM.A review of the corresponding nursing progress notes for the dates identified above for the Xanax administration revealed the following:-on [DATE] at 19:30 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days.- on [DATE] at 22:10 (10:10 PM) indicated PRN administration was: Effective.-on [DATE] at 22:41 (10:41 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention.-on [DATE] at 10:23 AM indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days. Resident is very anxious and when redirected was unsuccessful.- on [DATE] at 14:38 (2:38 PM) indicated PRN administration was: Effective.-on [DATE] at 19:57 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days.- on [DATE] at 21:58 (9:10 PM) indicated PRN administration was: Effective.-on [DATE] at 22:01 (10:01 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention.-on [DATE] at 18:26 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days.- on [DATE] at 19:39 (7:39 PM) indicated PRN administration was: Effective.-on [DATE] at 19:52 (7:52 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention.-on [DATE] at 17:53 (5:53 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention. -on [DATE] at 18:41 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 6 hours as needed for Anxiety for 14 days.-on [DATE] at 19:18 indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 6 hours as needed for Anxiety for 14 days. Resident was restless.-on [DATE] at 19:47 (7:47 PM) indicated a skilled services nursing note Resident is exhibiting signs/symptoms of delirium has inattention.- on [DATE] at 22:02 (10:02 PM) indicated PRN administration was: Effective.-on [DATE] at 9:39 AM indicated an administration note Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety for 14 days.- on [DATE] at 10:21 AM indicated PRN administration was: Effective.Further review of the nursing progress notes revealed an inconsistency on 9/5, 9/7, 9/8, 9/9, 9/10 and 9/12 there were skilled services nursing notes that indicated similar documented Resident is exhibiting signs/symptoms of delirium has inattention. and Xanax was not administered on those dates.On [DATE] at 11:01 AM, the surveyor interviewed LPN #2 who stated that she had worked at the facility approximately 2 years and floats between units and was the medication nurse for Resident #6. LPN #2 stated that she was aware Resident #6 had a PO for Xanax PRN but was unsure if she had ever needed to administer the medication. LPN #2 reviewed the EMAR and stated that the resident had received the Xanax PRN but (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she had not administered the medication. LPN #2 added that she would indicate in the electronic behavior monitoring report (EBMR) what behaviors the resident was having to warrant the Xanax PRN administration. LPN #2 was unsure if a progress note was needed but stated the Unit Manager (UM) would know. On [DATE] at 11:12 AM, the surveyor interviewed Registered Nurse (RN)/UM who stated when a PRN medication being used for anxiety was administered there would be a progress note indicating what behaviors the resident was exhibiting to indicate the need for the medication. RN/UM was aware that Resident #6 had anxiety and stated the resident could get very agitated, yells, wants to go home or wants to call a family member and frequently asked to go to the bathroom but has a catheter. RN/UM added that the resident had to be redirected but sometimes that had not worked. RN/UM also stated that the nurses document in the EBMR the targeted behaviors the resident exhibits and enter the number of episodes the behavior was exhibited and there would also be a progress note explaining what happened. At that time, the surveyor, with the RN/UM, reviewed the EMAR for Resident #6. RN/UM verified the administration of Xanax PRN on [DATE] and acknowledged that there was no progress note explaining why the Xanax PRN was needed. RN/UM also reviewed the EBMR for the date of 9/3 and shift that the Xanax PRN was administered and stated that there was no documentation as to the behaviors exhibited or non-drug interventions tried. RN/UM then stated that she would have to check the other dates the Xanax PRN was administered. On [DATE] at 11:35 AM, RN/UM stated that she had looked through the progress notes and EBMR and could not find the documentation as to why the Xanax PRN was administered.On [DATE] at 10:01 AM, the Director of Nursing (DON) explained that the nurses were able to electronically enter targeted behaviors in the EBMR which was similar to the EMAR for documentation of the number of times a behavior was exhibited. The DON further explained a nursing progress note should indicate what took place for the need for the use of a PRN medication for behaviors. The DON also stated that anxiety had to be explained as to what the behaviors were that were exhibited and that would be in the progress notes.A review of the EBMR for the corresponding dates and shift times for the administration of Xanax PRN revealed the following:For the targeted behavior of Fighting entries were as follows;-on [DATE] the 3 PM to 11 PM shift was blank for the number of times the behavior occurred and interventions.- on [DATE] the 7 AM to 3 PM shift was zero (0) for the number of times the behavior occurred and interventions. For the 3 PM to 11 PM shift had the number 2 and the intervention was redirect.-on [DATE] the 3 PM to 11 PM shift had the number 3 and the intervention was one on one, activity and redirect.-on [DATE] the 3 PM to 11 PM shift had an X for the number of times the behavior occurred and interventions.-on [DATE] the 3 PM to 11 PM shift had an X for the number of times the behavior occurred and interventions.-on [DATE] the 7 AM to 3 PM shift was blank for the number of times the behavior occurred and any interventions.For the targeted behavior of Hitting/scratching/pinching entries were as follows;-on [DATE] the 3 PM to 11 PM shift was blank for the number of times the behavior occurred and interventions.- on [DATE] the 7 AM to 3 PM was zero (0) for the number of times the behavior occurred and interventions. For the 3 PM to 11 PM shift had the number zero (0) and the intervention was redirect.-on [DATE] the 3 PM to 11 PM shift had an X and the intervention was redirect.-on [DATE] the 3 PM to 11 PM shift had an X for the number of times the behavior occurred and interventions.-on [DATE] the 3 PM to 11 PM shift had an X for the number of times the behavior occurred and interventions.-on [DATE] the 7 AM to 3 PM shift was blank for the number of times the behavior occurred and interventions.The EBMR also revealed an inconsistency that there were dates ([DATE] and [DATE]) with entries that there were occurrences of the identified behaviors above and the resident had not received Xanax PRN.There were no other entries of behaviors occurring or interventions.On [DATE] at 1:32 PM, the surveyor, with the RN/UM, further reviewed Resident #6's EBMR. UM/RN explained the nurses were supposed to enter numbers and not X's to show the number of times a behavior was exhibited by the resident and there was a section to indicate what is done meaning any interventions that were tried for the identified behavior. RN/UM added that there should also be a progress note explaining what occurred and that the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions tried had not worked so there was a need for the medication to be administered. RN/UM acknowledged that Resident #6's EBMR and progress notes had not correlated to why the Xanax PRN was administered and there was no documentation to indicate that the interventions had failed.On [DATE] at 11:49 AM, the surveyor in the presence of another surveyor interviewed the Consultant Pharmacist (CP) who stated that he was the CP for the facility as well as rotating his staff so that there were always fresh eyes reviewing. CP added that he performed onsite inspections and chart auditing as well as remote electronic chart auditing. CP explained a review of behavior monitoring for a resident on a psychotropic medication involved correlating the medications with the MDS and if the resident was a candidate for a gradual dosage reduction. CP further explained he attended monthly meetings to discuss residents on psychotropic medications and made sure that the PO for a PRN psychotropic medication had stop order dates and reviewed the utilization to see if the medication could be discontinued or changed to routine use. CP stated that Xanax ordered PRN for anxiety was an appropriate indication for use and the nurses were responsible for documenting how a resident expressed anxious behaviors. CP stated that anxiety was a broad-spectrum term. CP also stated there was a verbal discussion of the residents on psychotropic medications at the meetings and does not look at behavior documentation. CP acknowledged that behavior documentation should correlate with the need for a PRN psychotropic medication. CP was informed of Resident # 6's Xanax PRN use and inadequate documentation and stated that he would review.There was no additional information provided by the CP.On [DATE] at 1:22 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The above concerns regarding the documentation for the need and non-pharmacologic interventions tried for Xanax PRN use were reviewed. The DON stated there were monthly meetings to verbally discuss all residents on a psychotropic medication that she attended with the CP, nurses and psychiatric nurse practitioner. The DON added that they do not go over the EBMR. On [DATE] at 10:11 AM, the survey team met with the LNHA, DON, Infection Preventionist and RN/UM. The DON stated that she talked to the nurses that had administered the Xanax PRN and they all spoke to the resident constantly wanting to go (meaning leave the facility), screaming and getting up out of the wheelchair to walk on their own. The DON added the nurses had not documented the behaviors. The DON and RN/UM acknowledged the documentation of behaviors and failed non-pharmacologic interventions had not correlated to the need for the Xanax PRN to be administered. The DON also stated that the Psychiatric Consult indicated that the resident was having behaviors. The DON stated during the monthly meeting, they should review what behaviors are documented, how many times and what non-drug interventions were tried.A review of the electronic Psychiatric Progress Note dated [DATE] for 9:50 AM revealed cc (chief complaint): f/u (follow up): anxiety and Seen per nursing request. Per nursing having periods of anxiety, at times severe, exit seeking behaviors, poor safety awareness. No overt aggression. Will change Xanax to Q6H (every 6 hours) PRN.A review of the facility policy dated as revised [DATE] for Medication Orders provided by the DON reflected PRN Medication Orders-When recording orders for medications, specify the type, route, dosage, frequency, strength and the reason for administration.A review of the facility policy dated as revised [DATE] for Psychotropic Medication Use provided by the DON reflected Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Antipsychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics. Non-pharmacologic approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose and allow for discontinuation, in an effort to discontinue these medications. A review of the facility policy dated as revised [DATE] for Behavioral Assessment, Intervention and Monitoring provided by the DON reflected Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. Under General Guidelines, Behavioral pr Psychological Symptoms of Dementia (BPSD) describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. A. Appropriate assessment and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors, and those that cannot. Current guidelines recommend the use of non-pharmacologic interventions for BPSD. Under Management, When medications are prescribed for behavioral symptoms, documentation will include: a. rationale for use, b. potential underlying causes of behavior; . e. specific target behaviors and expected outcomes;. NJAC 8:39-11.2(b), 27.1(a), 29.2(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #403805Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that written notice of a resident's transfer to a hospital was provided to a family member or guardian for 1 of 4 residents (Resident #102) reviewed for hospitalization.This deficient practice was evidenced by the following: A review of Resident #102's admission Record reflected the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to; post operative care of a surgical wound of the right buttock, an antibiotic-resistant infection of the surgical wound site and a history of a ruptured aneurysm (a rupture of a weakened area of a blood vessel) in the brain. The admission Record further reflected the resident's mother was listed as his/her emergency contact and court appointed guardian. A review of Resident #102's admission Minimum Data Set (MDS), an assessment tool, dated 3/14/2025 reflected the resident had a severely impaired cognition and was dependent on staff for all activities of daily living (ADLs) care. A review of Resident #102's medical record reflected the resident was transferred to the hospital on 3/18/2025 at 10:00AM, for further evaluation of low blood pressure, rapid heart rate and elevated body temperature. On 09/15/2025 at 10:10 AM, the surveyor interviewed the Unit Manager (UM), for the North Unit. The UM confirmed she did not provide written notice that Resident #102 was transferred to a hospital to the resident's guardian. On 09/15/2025 at 12:30 PM, the surveyor interviewed the facility's Licensed Social Worker (LSW). The LSW confirmed she had not provided written notice of Resident #102's was transfer to the resident's guardian. On 09/12/2025 at 10:12 PM, the surveyor discussed the concern with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA confirmed the facility had not provided written notice that Resident #102 was transferred to a hospital to the resident's guardian. A review of the facility policy, Emergency Transfer or Discharge, dated 3/12/2025, revealed.Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures . Notify the representative (sponsor) or other family member. N.J.A.C. 8.39 27.1(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan (CP) that included the use of antipsychotic medication for a diagnosis of schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, changing how people think, feel and act). The deficient practice was identified for 1 of 20 residents (Resident #3) reviewed for Care Plans.This deficient practice was evidenced by the following: On 9/12/25 at 11:57 AM, the surveyor observed Resident #3 in the common area, in a wheelchair, waiting for lunch.The surveyor reviewed the admission Record (or face sheet, an admission summary) which revealed that the resident had been admitted to the facility with diagnoses that included schizoaffective disorder.A review of the Comprehensive admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ADR) of 8/23/25, revealed the resident had a score of 12 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. The MDS also reflected that the resident had a diagnosis of schizophrenia (which included schizoaffective disorder) and was receiving antipsychotic medication.A review of Resident #3's physician orders (PO) revealed a PO, dated 8/19/25, olanzapine 10mg, give one tablet at bedtime for schizoaffective disorder (Olanzapine is an atypical antipsychotic medication used primarily to treat schizophrenia and bipolar disorder, balancing brain chemicals like dopamine and serotonin.).A review of Resident #3's care plan (CP) with a start date of 8/19/25, revealed that Resident #3 did not have a care plan addressing the diagnosis of schizoaffective disorder or for the use of an antipsychotic medication.On 9/15/25 at 10:37 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated that the diagnosis of schizoaffective disorder and the use of antipsychotic medications should absolutely be addressed on the care plan. On 9/16/25 at 10:20 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Comprehensive Care Plans with an approved date of 1/13/25. The policy statement included A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Under the policy interpretation and implementation section of the policy it stated, 1.The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident and 2. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment (Admission, Annual or Significant change in Status), and no more than 21 days after admission.On 9/16/25 at 1:21 PM, the surveyor met with the LNHA and the Director of Nursing (DON) to review facility concerns found during the survey. The DON stated Resident #3 should have had a care plan addressing the diagnosis of schizoaffective and the use of an antipsychotic medication. NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # NJ403814Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 4 of 5 residents (Resident #4, 10, 43, and 64) observed for incontinence care on 1 of 2 Nursing units (South unit).This deficient practice was evidenced by the following:On 9/16/25 at 7:40 AM, the surveyor completed an incontinence tour on the South Nursing Unit and observed the following:1.) On 9/16/25 at 7:40 AM, the surveyor, accompanied by the Certified Nursing Assistant (CNA #1), observed Resident #10 in bed. CNA #1 exposed Resident #10's incontinence brief, and the surveyor observed that it was saturated with urine and feces. The surveyor observed that the bladder pad that was inserted in the brief was also saturated with urine and feces. CNA #1 confirmed that the brief and bladder pad were saturated with urine and feces. Resident #10 stated that she had not been changed since the previous night at approximately 9:00 PM. The resident further stated that he/she would like to be changed more often.A review of Resident #10's admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; Urinary Tract Infection, chronic kidney disease, and urinary retention.A review of Resident #10's Annual Minimum Data Set (MDS), an assessment tool dated 6/202/5, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated Resident #10's cognition was intact. The MDS further revealed that the resident was dependent on staff for personal hygiene, and he/she was frequently incontinent of bladder and always incontinent of their bowels. Section E revealed that Resident #10 did not refuse evaluations or activities of daily living care.A review of Resident #10's Individualized Care Plan (CP) initiated on 1/23/25 had a focus area that included [Resident] requires assistance with functional mobility and ADLs, with interventions that included but were not limited to; dependent on staff for toileting hygiene and personal hygiene; [Resident] is on URGE bladder incontinence medication (medication for overactive bladder) initiated on 1/28/24 with interventions that included but were not limited to; check the resident every 2 hours and as required for incontinence. 2.) On 9/16/25 at 7:50 AM, the surveyor, accompanied by CNA #1, observed Resident #43 in bed. CNA #1 exposed Resident #43's incontinence brief, and the surveyor observed that it was saturated with urine. CNA #1 confirmed that the brief was saturated with urine.A review of Resident #43's admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; Multiple Sclerosis (a chronic autoimmune disease) and an overactive bladder.A review of Resident #43's MDS dated [DATE], revealed Resident #43 had a BIMS score of 6 out of 15, which indicated severely impaired cognition. The MDS further revealed that the resident was dependent on staff for personal hygiene, and he/she was incontinent of bowel and bladder. A review of Resident #43's CP initiated on 11/14/23 had a focus area that included [Resident] requires assistance with ADLs, with interventions that included but were not limited to; dependent on staff for personal hygiene; and a CP initiated on 9/16/22 with a focus area that indicated Resident is at risk for a urinary tract infection with interventions that included but were not limited to; check at least every 2 hours for incontinence. 3.) On 9/16/25 at 7:53 AM, the surveyor, accompanied by CNA #1, observed Resident #64 in bed. CNA #1 exposed Resident 64's incontinence brief, and the surveyor observed that it was wet with urine. CNA #1 confirmed that the brief was wet. The resident stated that they had not been changed recently and further stated that the last change may have been last night.A review of Resident #64's admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; acute kidney failure and diabetes mellitus.A review of Resident #64's Quarterly MDS, dated [DATE], revealed that Resident #64 had a BIMS score of 15 out of 15, indicating that the resident's cognition was intact. The MDS further revealed that the resident was dependent on staff for toileting hygiene, and he/she was frequently incontinent of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bladder and always incontinent of bowel. A review of Resident #64's CP initiated on 5/3/24 had a focus area that included [Resident] requires assistance with ADLs, with interventions that included but were not limited to; dependent on staff for toileting hygiene. 4.) On 9/16/25 at 7:57 AM, the surveyor, accompanied by CNA #1, observed Resident #4 in bed. CNA #1 exposed Resident 4's incontinence brief, and the surveyor observed that it was saturated with urine and feces. CNA #1 confirmed that the brief was saturated with urine and feces. A review of Resident #4's admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: acute kidney failure with tubular necrosis (damage to the renal tubule cells which impairs the kidney's ability to filter blood) and diabetes mellitus.A review of Resident #4's most recent MDS, dated [DATE], revealed that Resident #4's cognitive skills for daily decision making were severely impaired. The MDS further revealed that the resident was dependent on staff for personal and toileting hygiene, and he/she was frequently incontinent of bowel and bladder. A review of Resident #4's CP initiated on 6/12/25 had a focus area that included [Resident] requires assistance with ADLs, with interventions that included but were not limited to; dependent on staff for toileting hygiene. At that same time, during an interview with the surveyor, CNA #1 stated that incontinence care should be provided every 2 hours on all shifts and that it did not appear to have been done.On 9/16/25 at 9:30 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager stated that incontinence rounds should be conducted 3-4 times on all shifts.On 9/16/25 at 10:15 AM, during an interview with the surveyor, the staffing coordinator called the CNA (CNA #2), who was assigned to Residents #10 and #4 on the 11-7 AM shift. The CNA stated that she had 17 residents on her assignment and that she had provided incontinence care for them. On 9/16/25 at 10:20 AM, the staffing coordinator called the CNA (CNA #3) who was assigned to care for Residents #43 and #64 on the 11-7 AM shift. CNA #4, who had 17 residents assigned to their care during the 11-7 AM shift, did not return the call.On 9/16/25 at 1:22 PM, the survey team discussed the above observations and concerns with the Director of Nursing and Licensed Nursing Home Administrator.A review of the facility's Activities for Daily Living policy dated 2/3/25 reflected .the facility will provide activities of daily living for those needed for self-care: bathing, dressing, toileting . NJAC 8:39-27.1 (a), 27.2 (h)