

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Lakeside Blvd Bayville, NJ 08721	
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2716119 Based on observations, interviews, review of the medical record, and other pertinent facility documentation, it was determined that the facility failed to protect a resident from self-harm and provide adequate supervision for a resident (Resident #100) with a history of suicidal ideations with plans to cut their wrist prior to admission to the facility, who cut their wrist while residing in the facility. This deficient practice was identified for 1 of 6 residents reviewed for accidents (Resident #100). According to the progress notes, on 1/11/2026 at 10:30 PM, the resident was noted by facility staff with a two-inch laceration to their right wrist that was bleeding profusely. The resident stated, I thought that I was going home, but they said I was not. During an interview with the Licensed Practical Nurse (LPN #1) on 1/21/2026, LPN #1 stated that the Certified Nursing Aide (CNA #1) during their rounds observed that the resident was bleeding, and when LPN #1 went to the resident's room, the resident was holding their right wrist with toilet paper to reduce the bleeding. LPN #1 stated that Resident #100 disassembled a razor that they found in the shower, and that LPN #1 was unaware that the resident had a history of self-injurious behaviors. A review of the admitting facility's paperwork included on 8/27/2025, Resident #100 called 911 and informed the police officer that they were having suicidal ideations and wanted to cut themselves with a razor. A review of the resident's medical record at their current facility including, their care plan and physician's orders, did not include any safety interventions put in place to protect the resident from self-harm. The facility's failure to provide adequate supervision and protect Resident #100 from self-harm, who had a history of suicidal ideations, placed Resident #100, as well as all residents at risk of self-harm. This has the likelihood of serious physical harm, injury, impairment, or death and resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 1/11/2026 at 10:30 PM, when Resident #100 cut themselves on their right wrist with a razor and was bleeding profusely. The facility Administration was notified of the IJ on 1/22/2026 at 4:57 PM. The facility submitted an acceptable Removal Plan (RP) on 1/23/2026 at 11:40 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 1/27/2026. The facility further failed to ensure all residents with a history of suicidal ideations a.) who were placed on monitoring were monitored; b.) their behavioral monitoring sheets were completed; and c.) they did not have access to metal utensils, razors, or other sharp objects. This deficient practice was identified for 3 of 6 residents reviewed for accidents (Resident #11, Resident #75, and Resident #95). The evidence was as follows:Part A A review of the facility's Safety and Supervision of Residents policy, dated revised July 2017, included our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Facility-Oriented Approach to Safety: 1. Our facility-oriented approach to safety addresses risks for groups of residents. Individualized, Resident-Centered Approach to Safety: 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and (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
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented; and e. Documenting interventions .Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment . A review of the facility's admission Criteria policy, dated revised March 2019, included our facility admits only residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation: 1. The objective of our admission criteria policy are to .b. admit residents who can be cared for adequately by the facility . A review of the facility's Sharps Disposal policy, dated revised January 2012, included the facility shall discard contaminated sharps into designated containers .Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers . A review of a Facility Reported Event (FRE) submitted to the New Jersey Department of Health (NJDOH), revealed that on 1/11/2026 at approximately 10:30 PM, Resident #100, who had a psychiatric history, presented with a self-inflicted injury to the right wrist discovered during rounding. The resident had a history of metabolic encephalopathy (brain dysfunction), acute kidney failure, depression, falls, diabetes mellitus, and schizophrenia. The facility indicated the resident had no previous behaviors and no plan of care was developed prior to the incident. The immediate interventions included bleeding control, vital sign assessment and evaluation of current safety risk, and activating the emergency response/911. The resident was transferred to the emergency room. An environmental safety check was completed, and sharp objects were removed to prevent further access. A review of the Resident #100's admission Referral Packet from the resident's previous facility included the following documents: A Progress Note dated effective 9/3/2025 at 2:30 PM, revealed that on 8/27/2025, Resident #100 called 911 and informed police officers that they were having suicidal ideations and wanted to cut themselves with a razor. The police officers arrived at the facility and transferred the resident to the hospital as per physician's order. The resident returned to the facility and was placed on every 15-minute checks, and later placed on one-to-one (1:1) monitoring, and all potential items such as razors, cords, etc. were removed from the resident's room. Resident #100's individual comprehensive care plan (ICCP) from the previous facility, included a focus area dated 8/27/2025, that the resident was at risk for self-harm related to suicidal thoughts and ideation. The interventions included but were not limited to; administer medications as ordered; monitor for effectiveness and side effects, including worsening thoughts of self-harm; belts, razors, sharp objects removed from the resident's room, and dietary to send plastic utensils and paperware for meals, and ensure all utensils are collected after meals. On 1/20/2026 at 10:12 AM, the surveyor reviewed the current medical record (MR) for Resident #100, which revealed the following: (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the admission Record, an admission summary, revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; depression, schizophrenia, and intellectual disabilities. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 12/28/2025, included the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident's cognition was moderately impaired. A review of Resident #100's ICCP included a focus area dated 10/31/2025, that the resident was at risk for an alteration in mood and well-being. Interventions included to administer medications as ordered; monitor/document for side effects and effectiveness; and to monitor for potential signs of distress. The ICCP did not include that the resident was at risk for self-harm related to their recent history of suicidal ideations with a plan prior to admission into the facility and any related interventions. A review of the Order Summary Report (OSR) dated as of 1/11/2026, included the following physician order (PO): A PO dated 9/17/2025 at 8:52 PM, for aspirin (a blood thinner) enteric coated (EC; a special layer of coating on a tablet) daily for deep vein thrombosis (DVT; a medical condition where a blood clot forms in the vein). A PO dated 9/17/2025 at 8:52 PM, for Eliquis (a blood thinner) 2.5 milligrams (MG) by mouth two times per day. A PO dated 1/11/2026 at 10:38 PM, to send the resident out to the local hospital for evaluation. The physician's orders did not include any special monitoring for the resident's behaviors related to their history of suicidal ideations with a plan (history of attempts). A review of the Progress Notes included a nurse's note (NN), dated 1/11/2026 at 11:02 PM, [Resident #1] was noted by CNA (CNA #1) during hourly rounds the resident sustained injury. This writer entered room and noted resident had an injury to the right wrist. Resident stated, I thought I was going home, but they said I'm not. It was noted that resident had a 2 inch laceration to the right wrist which was noted to be bleeding profusely. Resident was noted to have slurred speech, diaphoretic, but able remain conscious. Nurse stat was initiated and this writer held constant pressure to residents wound while fellow nurse applied [oxygen] and obtained vitals. 911 was called. On 1/20/2026 at 12:47 PM, the surveyor interviewed CNA #1, who stated he regularly cared for Resident #100, and he was not sure of the resident's recent history of suicidal ideation with a plan. CNA #1 confirmed that he worked the evening shift on 1/11/2026, and at approximately 10:30 PM that evening, when he went to do his final rounds before his shift ended, he went into Resident #100's room and saw a trail of blood on the floor. CNA #1 continued that he immediately called the nurse (LPN #1), who checked on the resident, and informed him that the resident cut themselves with a razor, and to notify the nursing staff to call emergency services/911. CNA #1 also stated that he did not know how the resident obtained the razor because they never asked for one on that shift, and that the razors were kept under lock and key in the nurse's storage room. CNA #1 stated he had to go to the nurse to obtain a razor, and that residents cannot have a razor in their possession unless they were (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the admission Record face sheet (an admission summary) reflected the resident was initially admitted to the facility in September of 2022 with diagnoses which included chronic kidney disease, morbid obesity and major depressive disorder. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/6/2025, reflected the resident had a brief interview for mental status score of 12 out of 15, which indicated a moderately impaired cognition. Further review revealed the resident reported over the last two weeks, they had experienced little interest or pleasure in going things nearly every day, had felt depressed or helpless nearly every day, had trouble with sleep nearly every day. When asked if they had thoughts of hurting themselves, they reported no, never. A review of the individualized person-centered care plan reflected a focus area initiated 1/22/2026, for risk of self-directed violence: History of Suicide ideation. Interventions included environmental safety checks, no sharp objects (remove as needed), encourage relaxation techniques (deep breathing, imagery, decreased stimuli). Monitor for changes in mood, affect, sleep, appetite or behaviors (restlessness, agitation, anxiety. Psych follow-up. Assess for suicidal ideation every shift and PRN (as needed). Implement suicide precautions per MD (physician) order when indicated. A review of the Order Summary Report, included an order dated 1/22/2026 for one to one monitoring for 24 hours. On 1/23/2026 at 1:22 PM, the surveyor in the presence of Certified Nurse Aide #8 (CNA #8) knocked on the resident #11's closed door. There were no staff observed either outside the door or in the room monitoring the resident. The surveyor and CNA #8 performed a room safety check and no razor blades or sharp objects were found in the resident's room. The resident stated they had been in their room all day because they weren't well and had an upset stomach. On 1/23/2026 at 1:38 PM, the surveyor interviewed CNA #8 who stated their assignment did not include Resident #11's room. On 1/23/2026 at 1:41 PM, the surveyor interviewed CNA #9 who stated they had received an in-service education regarding a new policy involving the procedure for razor use as well as identifying residents that may be depressed and also on removing sharp objects from resident's rooms. CNA #9 also stated Resident #11's room was not on her assignment. On 1/23/2026 at 1:49 PM, the surveyor interviewed CNA #10 who stated Resident #11 was on her assignment that day. CNA #10 stated she had received an education recently regarding removal of sharp objects from resident rooms and a new procedure for signing out razors. When asked what it meant for a resident to be on one to one supervision, CNA #10 stated it meant a resident was having behaviors and that a staff member must stay with them. When asked if there were any residents on the unit currently on one to one monitoring she stated no. On 1/23/2026 at 2:01 PM, the surveyor interviewed Licensed Practical Nurse #2 (LPN #2) who stated she had received education on the new process for signing out razors to ensure resident safety. When asked what one to one monitoring was, LPN #2 stated it was usually when a resident was having behaviors and could be a risk to themselves or others, a staff member would need to keep eyes on them at all times. In addition, we need to fill out the monitoring sheets, whoever is watching the resident, usually every 15 minutes. When asked if any residents were currently on one to one monitoring LPN #2 stated Resident #11 was on one to one monitoring, but the order had been (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discontinued that morning. When asked who was monitoring Resident #11 this morning LPN #2 stated CNA #8 had been assigned during lunch she believed. On 1/23/2026 at 2:10 PM, the surveyor re-interviewed CNA #8 who confirmed he had not been assigned a one to one that day. On 1/23/2026 at 2:03 PM, surveyor #2 interviewed LPN/UM #2 who stated she had received education regarding identifying suicidal ideations. LPN/UM #2 confirmed Resident #11 was on one to one monitoring. Surveyor #2 and LPN/UM #2 went into Resident #11's room and LPN/UM #2 confirmed there were no staff present in the room monitoring the resident. RN/UM #2 stated Resident #11 would not permit it. Resident #11 was present and stated no, I won't, and confirmed no one had been sitting with her. RN/UM #2 was unaware which staff member had been assigned to monitor Resident #11. RN/UM #2 stated since Resident #11 would not tolerate a one to one, then she should call the physician to get a new order for close monitoring instead. On 1/23/2026 at 3:29 PM, the surveyor interviewed the Director of Nursing (DON), who stated that a resident should always be monitored when they were on 1:1 supervision and they should never be left alone. The DON added that the resident should not have metal utensils because they could harm themselves with it, and that the resident's behavior should be documented timely. ^ 3. A review of the admission Record (AR), an admission summary, indicated that Resident #95 was admitted to the facility with the diagnoses which included but was not limited to dementia, malignant neoplasm of the thyroid gland and alcohol abuse. A review of the quarterly MDS dated [DATE], indicated that the resident had scored of 9 out of 15 on the Basic Interview for Mental Status (BIMS) which reflected moderate cognitive impairment. The MDS also indicated that the resident was independent with activities of daily living (ADLs) and exhibited not behaviors during the review period. On 1/23/2026 at 12:28 PM. the surveyor reviewed Resident #95's electronic medical record (EMR). The facility identified the resident as an at-risk resident due to a history of suicidal ideation. A review of the physician orders dated 1/22/26 reflected a physician's order for the resident to have one-to-one monitoring for a duration of 24 hours. The surveyor reviewed six months of Progress Notes (PN) and there was no documentation indicating that Resident #95 expressed or voiced any suicide ideations while residing in the facility or to facility staff. A review of the ICCP revealed a Focus Area dated 3/25/21 which identified a long psychiatric history with a history, including suicidal ideation and history of suicidal attempts. Interventions included the following: -Monitor thyroid levels and reassure the resident that correct medication dosage was being administered. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Provide diversions to address obsessive thoughts including snacks, music, smoking and activities. -Remind the resident of 12 step program with date and times. - Ensure no sharp objects per psychiatric recommendations and remove as needed. -Monitor for any return of suicidal ideations. -Maintain safety for all and remove objects that can harm. Attempt to de-escalate resident and attempt to have resident verbally contract for safety and notify physician and psychiatry promptly. On 1/23/2026 at 12:53 PM, the surveyor interviewed LPN #3, who stated that the facility administration had provided education regarding a new policy on razor blades and sharps. She stated that the policy indicated that all razor blades were not to be stored anywhere on the unit. The policy specified the storage of sharps and there were to be no sharps stored anywhere on the unit. She further stated that all sharps were to be stored in central supply and that no sharps were to be accessible on the unit at any time. The LPN explained that if a resident required shaving, the nurse was responsible for retrieving the razor blade from central supply, providing it to the CNA, and ensuring the razor blade was returned immediately following use. She stated that residents were not permitted to handle razor blades at any time. She further explained that razors were signed out in a sharps inventory log maintained in central supply. On 01/23/2026 1:05 PM, the surveyor inspected Resident #95's room and handled razor and three unopened packages of razor blades, each containing four razor blade heads, located on the windowsill in the resident's bathroom. The surveyor also observed a large nail clipper sitting on the shelf inside bathroom stall. At the time of observation, a staff member was present in the resident's room monitoring the resident. On 1/23/2026 at 1:12 PM, the surveyor interviewed the staff member who identified herself as a Monitor. The Monitor stated she was assigned to monitor Resident #95 and reported that she had been informed the resident had a history of attempting to harm themselves. She stated that she was not provided with instructions regarding her responsibilities while monitoring the resident and was not instructed to conduct environmental checks every 15-minutes. The Monitor further stated she had not received any in-service education in the previous 24 hours. On 1/23/2026 at 1:08 PM, surveyor interviewed a CNA #11, who stated he received in-service education on reporting residents who express suicidal thoughts to administration. He stated that razor blades were required to be signed out and obtained from central supply and that there should be no sharps accessible anywhere on the unit. On 1/23/2026 at 1:18 PM, the surveyor interviewed a CNA #12 who stated that he was educated on sharps. He stated that the staff routinely checked all residents' drawers for sharps. He further stated that if a resident was identified as a suicide risk, no sharps were permitted in the resident's room and that any expression of suicidal ideation must be reported immediately. On 1/23/2026 at 1:24 PM, the surveyor interviewed CNA #13 who was the primary CNA for Resident #95. The CNA stated		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of medical records and pertinent facility documentation, it was determined that the facility failed to ensure that a cognitively impaired resident (Resident #2), who was dependent on staff for activities of daily living (ADLs) a.) received appropriate interventions to prevent the development of a facility-acquired full thickness pressure injury; b.) ongoing skin assessments were completed and documented in accordance with a physician's order; c.) hospice recommendations for pressure reducing devices were communicated to the physician; and d.) consistently follow-up documentation to monitor the progression or resolution of the skin breakdown. On 11/22/25, Resident #2 was identified as having a Stage 1 reddened area on their sacrum, that subsequently progressed to a full thickness wound and the wound measured on 1/18/26, as 10 centimeters by 7.5 centimeters by 7.5 centimeters (10 cm x 7.5 cm x 7.5 cm) by the Wound Care Nurse Practitioner (NP) during their initial assessment. This deficient practice was identified for 1 of 1 resident reviewed for wounds (Resident #2), and was evidenced by the following: A review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol policy, dated revised April 2018, included that the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers for example immobility, recent weight loss and history of pressure ulcers. In addition, the nurse shall describe and document/report the following: a.) Full assessment of pressure sore including location, stage, length width, depth, presence of exudate [fluid drainage] or necrotic [dead] tissue; b.) Pain assessment; c.) Resident's current mobility status; d.) Current treatments to include support surfaces and all active diagnoses; e.) The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches and dressings. A review of the facility's Prevention of Pressure Injuries policy, dated revised April 2020, included Risk Assessments.2. Use a standardized pressure injury screening tool to determine and document risk factors; 3. Supplement the use of a risk assessment tool with assessment of additional risk factors. Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge; 2. During the skin assessment, inspect: a. Presence of erythema; b. temperature of skin and soft tissue; and c. edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care ADLs: a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema).b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.).Prevention.Support Surfaces and Pressure Redistribution: 1. Select appropriate surfaces based the resident's risk factors, in accordance with current clinical practice. A review of the facility's undated Care Planning-Interdisciplinary Team policy indicated that comprehensive, person-centered care plans are based on resident assessments and developed by the interdisciplinary team. A review of the facility's Care Plans, Comprehensive Person-Centered policy, dated revised March 2022, 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.The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.e. reflects currently recognized standards of practice for problem areas and conditions.When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. On 1/15/26 at 11:36 AM, the surveyor observed Resident #2 sitting in a reclining chair in the dayroom. A Certified Nursing Assistant (CNA) who was present at that time in the dayroom stated that the resident had an excoriation (skin damaged from scratching or picking) on the buttocks area. At that time, the surveyor did not observe the resident sitting on an anti-pressure device. The surveyor further observed that the resident's mattress in their room was not an (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	anti-pressure mattress. On 1/21/26 at 10:59 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #3), who stated that skin assessments were done for residents on shower days. LPN #3 stated that the nurse initialed on the Treatment Administration Record (TAR) that the assessment was done and then documented on the skin observation tool (SOT), located in the computer, exactly what they observed. LPN #3 stated that if she observed a wound, she documented the measurements and description of the wound. LPN #3 stated that she would notify the physician, Unit Manager, and consult the wound consultant team. LPN #3 also stated that a risk management form was completed, and statements would have to be obtained. LPN #3 further stated that treatments would be ordered, and interventions would be put in place to aid in wound healing to prevent development of further breakdown. LPN #3 revealed that the development of the care plan and interventions was the responsibility of the nurse that identified the wound. On 1/21/26 at 11:10 AM, the surveyor interviewed CNA #4, who stated Resident #2 did not speak or talk, they required complete washing and dressing and had bowel and bladder incontinence. CNA #4 revealed that the nurses performed treatments on the resident's buttocks because the resident had a wound. CNA #4 described the wound as red and odorous. The surveyor reviewed Resident #2's Electronic Medical record (EMR) which revealed the following: A review of the admission Record, an admission summary, indicated that Resident #2 was admitted to the facility with the diagnoses that included but were not limited to; metabolic encephalopathy (broad term for brain dysfunction caused by systemic illness, such as diabetes, liver/renal failure, or infection, rather than a direct brain injury), acute respiratory failure, and schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia (psychosis) and a mood disorder, like bipolar disorder or depression). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 10/22/25, indicated that Resident #2 had short- and long-term memory deficits with severe impairment in decision making. The MDS further indicated that the resident was dependent on staff for all aspects of activities of daily living (ADLs) and was at risk for pressure ulcers; however, the resident did not have a pressure injury at that time. The MDS also indicated that the resident was receiving hospice services. A review of the Interdisciplinary Care Plan (ICP) included a focus dated 5/12/25, that the resident had the potential for alteration in skin integrity related to scratching and picking of their right temporal area (temple) and a wound to the sacrum (lower back) measuring [10 cm x 7 cm x 5 cm]. (There was no date of the initial development of the wound.) The goal indicated that the skin would heal by the next review of 4/14/26. Interventions included Dietician consult; keep nails short and clean; keep skin clean and dry; use skin barrier with each change; and skin checks two times a week per policy. There were no interventions initiated for the resident's actual skin breakdown including treatments or pressure relieving devices. A review of the physician's orders (PO) included a PO dated 7/21/25, for hospice services. A review of the treatment orders included a PO dated 10/8/25, for skin assessments to be done twice weekly on shower days during the day shift on Wednesday and Saturday for skin monitoring. The order specified that the nursing staff were to complete the Skin Observation Tool (SOT) during these assessments. A review of the corresponding November 2025, December 2025, and January 2026 TARs revealed that skin assessments were performed on the following dates: 11/1/25, 11/5/25, 11/8/25, 11/12/25, 11/15/25, 11/19/25, 11/22/25, 11/26/25, 12/3/25, 12/6/25, 12/10/25, 12/13/25, 12/17/25, 12/20/25, 12/23/25, 12/26/25, 12/29/25, 1/3/26, 1/7/26, 1/10/26, 1/14/26, and 1/17/26. A review of the corresponding November 2025 SOTs did not include a description of the resident's skin condition on 11/5/25, 11/12/25, 11/19/25, and 11/26/25. The SOT dated 11/22/25, indicated that the resident had a reddened sacral area, that the physician was notified, and a new treatment order was obtained. There were no measurements of the reddened area documented on the SOT, and the following SOT on 11/26/25, did not include the reddened area. A further review of the treatment orders included a PO dated 11/23/25, to cleanse the sacral area with normal saline solution (NSS), pat dry and apply hydrocolloid dressing (used to manage a variety of lightly exuding wounds, such as pressure ulcers, leg ulcers, burns, and surgical wounds) every three days and as needed (prn) (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	if soiled or dislodged. A review of the corresponding November 2025, December 2025, and January 2026, TARs revealed the nurses were signing that the treatment was completed as ordered until the order was discontinued on 1/8/26. A review of the corresponding SOTs from the time the treatment was ordered (11/23/25), until the treatment was discontinued (1/8/26), there was only one SOT completed on 11/29/25. On 11/29/25, it was documented, Continues to receive treatment for prior skin issue to sacrum. There was no documentation on the SOT that included measurements or a description of the resident's sacral skin condition. A review of the Hospice Communication Note (HCN) dated 11/28/25, indicated that the resident had redness on their back, but the note did not specify the location of the affected area. The note further indicated that the mattress was not functioning properly and included recommendations for a gel cushion for the wheelchair and a foam mattress. There was no documentation that the facility implemented the hospice recommendations, and the Interdisciplinary Care Plan (ICP) was not updated to reflect the recommendations. A review of the subsequent HCNs did not include the redness on the resident's back on 12/12/25, 12/17/25, 12/22/25, 1/2/26, and 1/9/26. The HCN dated 12/15/25, documented that the resident's skin was intact. A review of the Physician's Progress Notes dated 11/3/25, 12/5/25, and 1/14/26, reflected that the physician documented that the resident's skin was normal with no rash, lesion, or ulcer. This contradicted the PO dated 11/23/25, for the treatment to the resident's sacral area. A review of the Dietary Note dated 12/17/25 at 9:41 AM, indicated that a treatment continued to the resident's sacral area which was complicated by incontinence and episodes of agitation versus lethargy, shearing and prolonged pressure increasing risk with continued treatment. The Dietician continued to document that the resident had altered skin integrity and that the goals were to support skin integrity. A review of the January 2026 TAR included a PO dated 1/11/26, to cleanse the sacral area with NSS, pat dry and apply hydrocolloid dressing every three days and prn if soiled or dislodged until discontinued on 1/14/26. The only SOT that was documented in the EMR providing a description of the resident's skin was dated 1/10/26, which indicated that the resident had an excoriation on the sacral area with no signs of infection and scant to no exudate and no surrounding erythema. The SOT also indicated that the physician was made aware and a new treatment was ordered. A review of the Progress Note (PN) dated 1/10/26 at 1:13 PM, indicated that the resident had an excoriation on the sacrum/coccyx area and the physician was made aware, and a new order was obtained and carried out. The ICP was not updated at that time to include any interventions to prevent or protect the resident from further deterioration of the resident's skin. A further review of the January 2026 TAR included a PO dated 1/14/26, to apply silicone foam dressing to boney prominence as needed every day shift for preventative treatment. There was no site indicated on the order. A review of the SOT dated 1/15/26, indicated that Resident #2 had two pressure ulcers measuring 1cm x 0.5 cm and 1.5 cm x 1.0 cm. Neither wound included the depth. The SOT further indicated that a treatment was in place, and a wound care consultant was notified to assess the resident's wounds. A review of the Skin/Wound Note dated 1/15/26 at 9:32 AM, indicated that wound rounds were conducted for Resident #2 and the resident was assessed as having two wounds on their left buttocks measuring 1.0 cm x 0.5 cm and 1.5 cm x 1.0 cm and that treatment would continue. A review of the PN dated 1/15/26 at 4:46 PM, indicated that while the nurse was applying the hydrocolloid dressing to the sacral area around 2:30 PM, skin abrasions were noted on the sacral area measuring 1.0 cm x 0.5 cm and 1.5 cm x 1.0 cm. A new dressing order in place to apply medihoney, and calcium alginate to the wound and cover with silicone foam dressing. The author documented that a message was left with the physician, and they were awaiting reply and that the family was notified. The ICP was updated on 1/15/26, with the new intervention for a wound care consult to be provided. There were no additional skin protection interventions initiated or documented on the care plan. A review of the Wound Care Consultant evaluation dated 1/18/26, indicated that the resident had one sacral wound measuring 10 cm x 7.5 cm x 7.5 cm. The consultation indicated that the resident had end of life skin failure. The skin on the sacral area was described as half dark, non-blanchable with half raw epithelial skin. There were no (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	recommendations indicated in the consultation. On 1/21/26 at 11:28 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #1), who explained that when the nurses signed the TAR, they were attesting that they performed the treatment as ordered. LPN/UM #1 stated that when a nurse performed a skin assessment, they were required to complete the skin observation tool (SOT) in the EMR which included the description of the wound and the measurement of the wound. At that time, LPN/UM #1 reviewed the SOT in Resident #2's EMR, and she did not have a response as to why there were so many skin observations that were not documented. LPN/UM #1 stated that at the time the nurse identified that a resident was developing a Stage 1 reddened area on the resident's sacrum, the nurses were required to call the physician to obtain a treatment order. LPN/UM #1 also stated that the nurse was responsible for obtaining a wound care consult so the wound care team could obtain an actual description and measurement of the wound, and possibly identify the cause of the wound. LPN/UM #1 stated that preventative skin care interventions should have been put in place on the ICP to prevent deterioration of the skin and to enhance healing, and that all the nurses were responsible for updating the ICP. At that time, LPN/UM #1 reviewed Resident #2's ICP in the presence of the surveyor, and she did not have a response as to why the ICP was not updated with preventative protective skin care interventions when the staff identified that the resident was at risk for pressure ulcer development and had started to develop a pressure ulcer in November of 2025. LPN/UM #1 further stated that the Hospice Nurse knew the resident had a wound and that the resident was never provided with an anti-pressure mattress. The surveyor then showed LPN/UM #1 a recommendation from hospice for a gel cushion to the resident's wheelchair and a foam mattress, and she did not have a response as to why these interventions were not obtained. LPN/UM #1 also did not have a response as to why an anti-pressure mattress was never provided for the resident when the Stage 1 wound was identified in November 2025 by the nursing staff. LPN/UM #1 stated that she reviewed the physician's orders, and an air mattress was ordered 1/20/26, but it should have been ordered when the resident developed the initial Stage 1 reddened area to prevent further deterioration. On 1/22/26 at 8:30 AM, the surveyor attempted to conduct a telephone interview with Resident #2's Responsible Party, but there was no answer. A message was left. On 1/22/26 at 8:50 AM, the surveyor observed LPN/UM #1 perform Resident #2's wound care on the sacrum with assistance from CNA #4. The surveyor observed the wound to encompass the entire sacral area and had yellow/black/brown tissue, a foul odor and a scant amount of brown exudate (drainage). The resident did not appear to be in any pain or discomfort. On 1/22/26 at 10:22 AM, the surveyor conducted a telephone interview with Resident #2's physician who was also identified as the facility's Medical Director (MD). The MD stated that when notified that a resident was developing skin breakdown, he would initiate a wound care follow-up because a Stage 1 wound could turn into a Stage 2 and so on and so forth. The MD was questioned concerning his visits with Resident #2, and he stated that he documented his notes on paper and not in the EMR. The MD then abruptly ended the call and stated that he would call the surveyor back. On 1/22/26 at 11:21 AM, the surveyor conducted a telephone interview with Resident #2's Hospice Service and interviewed the Executive Director (ED) and Clinical Director (CD). Both parties explained that the Hospice Nurses who had documented their visits in Resident #2's medical record on 11/28/25, 12/12/25, 12/15/25, 12/22/25, 1/2/26, and 1/9/26, were no longer employed by the hospice service. The CD stated that the Hospice Nurse's responsibilities included assessing the residents' skin and making recommendations accordingly. The CD stated that she would review Resident #2's records. The CD explained that if the Hospice Nurse made recommendations for skin protective devices on 11/28/25, then the facility's nurses were responsible to call the resident's primary care physician to obtain orders for those recommendations. On 1/22/26 at 11:34 AM, the surveyor conducted a telephone interview with the Wound Care Nurse Practitioner (Wound NP), who stated that Resident #2 was newly consulted by her on 1/18/26, for a new wound. The Wound NP stated that typically, the Wound NP staged the wounds, but when a resident was on hospice, the Wound NP usually did not stage the wounds. The Wound NP stated that the facility told her that the (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident's wound was new, and they did not explain to her that the resident had an existing Stage 1 wound dating back to November 2025. The Wound NP stated that she did not have any information and could not say what happened to the resident's skin in November 2025. The Wound NP stated that Stage 1 wounds were not typically seen on wound rounds and that to this date, her impression was that the resident had a [NAME] wound which was a skin ulcer that appeared in people in the final weeks of their life. The Wound NP further stated that, At this point, the resident has no healing potential. On 1/22/26 at 12:10 PM, the surveyor interviewed CNA #4, who was present during Resident #2's wound treatment observation completed on 1/22/26 at 8:50 AM. CNA #4 stated that Resident #2 had an open wound on their sacral area for approximately one month that she was aware of. On 1/23/26 at 10:17 AM, the surveyor conducted a follow-up interview with the MD, who stated that he would have expected the staff to order a wound care consult when the resident was first identified as having a Stage 1 wound or excoriation on the sacral area. The MD stated that he did not know why the staff did not document the resident's skin condition on the skin observation tools (SOT). The MD further stated that if the hospice recommended anti-pressure devices for the resident, such as a gel cushion for the wheelchair or an anti-pressure mattress, he would have expected the Hospice Nurse to not just write the recommendations in their notes, but to verbally communicate the recommendation to the nurses to ensure that the nurse called the physician to get an order for the devices. The MD stated he was not aware that the resident's pressure ulcer was deteriorating, and the nurses did not tell him. The MD added that when he reviewed the resident's orders and there was an order for duoderm (hydrocolloid dressing), he assumed that the area stayed the same. The MD also stated that during his visit, he did not roll the resident over to observe the resident's skin, so therefore he did not know that the resident had an opening on the sacral area. The surveyor then questioned the MD regarding the treatment order dated 1/14/26, that indicated a silicone dressing should be applied to boney prominence during the day shift, and the MD confirmed that it was an incomplete treatment order. The MD stated that the order should have specified a site where the silicone dressing was to be applied, otherwise how would the nurse know where to apply it. On 1/27/26 at 1:16 PM, the surveyor interviewed the Assistant Director of Nursing (ADON), who confirmed that when hospice gave recommendations for anti-pressure devices for Resident #2, the MD should have been notified, and orders should have been obtained. The surveyor reviewed Resident #2's treatment orders with the ADON and she confirmed that a treatment order required a site of application so that the nurses knew where the treatment was to be performed. The ADON further stated that if Resident #2 was identified as a risk for skin breakdown, an ICP should have been developed and updated to include interventions to prevent skin breakdown. In addition, if skin redness or breakdown occurred, the care plan needed to be updated with additional interventions to prevent further deterioration of the skin. The ADON also stated that the skin observation tool (SOT) should be completed when ordered to get an accurate description of the resident's skin, to get a baseline, support early detection of pressure ulcers and allow staff to intervene before conditions worsen. NJAC 8:39-27.1(e)		

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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. Based on observation, interview, and documentation review, it was determined that the facility failed to follow proper sanitation practices for dishware and kitchen equipment to prevent microbial growth in accordance with professional standards for food service safety. The deficient practice was evidenced by the following: On 1/15/26 at 10:20 AM, the surveyor toured the kitchen with the Director of Service Director (FSD) and observed that the three-compartment sink quaternary chemical sanitization solution indicated 200 parts per million (ppm) concentration. The surveyor interviewed the FSD regarding proper sanitization using sanitizer, and stated that a quaternary ammonium compound required concentration levels between 150-200 ppm. The surveyor requested that the FSD verify the sanitizer concentration level using a test strip. However, the FSD was unable to conduct the test and admitted that test strips were not available. The FSD further indicated that he would obtain the test strips immediately. The FSD confirmed that the kitchen should never run out of the sanitizer strips as the chemical sanitization process destroys harmful bacteria and prevents foodborne illnesses. On 1/22/26 at 4:26 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that she expected kitchen staff to properly sanitize kitchen equipment and dishware. The LNHA further stated that sanitizing was important for infection prevention and safety. A review of the facility's Sanitization policy updated February 2025, included the following .3). All equipment, food contact surfaces and utensils shall . sanitized using hot water and/or chemical sanitizing solutions, 5). Sanitizing of utensils and removable parts of equipment., and 9). Manual washing and sanitizing .c). Chemical sanitizing solutions may consist of: (3). Quaternary ammonium compound 150-300 ppm.NJAC 8:39-17.2(g)		

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NAME OF PROVIDER OR SUPPLIER Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Lakeside Blvd Bayville, NJ 08721	
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interviews, review of medical records and other pertinent facility documentation, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that staff, as well themselves, failed to ensure the facility's policies and procedures were implemented to ensure resident safety and well-being by failing: a.) protect residents who were previously identified to be at risk for self-harm and suicidal ideations b.) properly assess, monitor and implement the provision of a wound treatment c.) secure and maintain resident specific medications at all times e.) maintain an accurate accountability for controlled medications. The deficient practice had the potential to affect all residents who resided on 3 of 5 nursing units (nursing units 5, 6 and 7) and was evidenced by the following: A review of the undated facility Administrator job description revealed the following: The Long-Term Care Administrator oversees the daily operations of a specialized facility focused on behavior and mental health. This role is responsible for ensuring compliance with regulatory standards, maintaining a high standard of care, managing staff, and fostering a supportive environment for residents and employees. The Administrators is a strategic leader who balances operational efficiency, financial management, and compassionate care delivery. Duties and responsibilities included: plan, develop, organize, implement, evaluate and direct programs and activities. Review policies and procedures that govern the operations of the facility. Meet with department directors to discuss use of departmental policies and procedures and establish rapport in and among departments so that each can realize the importance of teamwork. Interpret the facility's policies and procedures to employees, residents, family members, visitors, government agencies, etc , as necessary. Review the facility's policies and procedures periodically at least annually and make changes as necessary to ensure continued compliance with current regulations. Assume the administrative authority, responsibility and accountability of directing the activities and programs in the facility. Refer to F686G; F689J; F755E and F761 D 1.) The facility failed to ensure that a cognitively impaired resident (Resident #2), who was dependent on staff for activities of daily living (ADLs) received appropriate interventions to prevent the development of a facility-acquired full thickness pressure injury; ensure ongoing skin assessments were completed and documented in accordance with a physician's order; ensure hospice recommendations for pressure reducing devices were communicated to the physician; and consistently follow-up documentation to monitor the progression or resolution of the skin breakdown. On 11/22/25, Resident #2 was identified as having a Stage 1 reddened area on their sacrum, that subsequently progressed to a full thickness wound and the wound measured on 1/18/26, as 10 centimeters by 7.5 centimeters by 7.5 centimeters (10 cm x 7.5 cm x 7.5 cm) by the Wound Care Nurse Practitioner (NP) during their initial assessment. A review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol policy, dated revised April 2018, included that the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers for example immobility, recent weight loss and history of pressure ulcers. In addition, the nurse shall describe and document/report the following: a.) Full assessment of pressure sore including location, stage, length width, depth, presence of exudate [fluid drainage] or necrotic [dead] tissue; b.) Pain assessment; c.) Resident's current mobility status; d.) Current treatments to include support surfaces and all active diagnoses; e.) The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches and dressings. A review of the facility's Prevention of Pressure Injuries policy, dated revised April 2020, included Risk Assessments. 2. Use a standardized pressure injury screening tool to determine and document risk factors; 3. Supplement the use of a risk assessment tool with assessment of additional risk factors. Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge; 2. During the skin assessment, inspect: a. Presence of erythema; b. temperature of skin and soft tissue; and c. edema. 3. Inspect the skin on a daily basis (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	when performing or assisting with personal care ADLs: a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema).b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.).Prevention.Support Surfaces and Pressure Redistribution: 1. Select appropriate surfaces based the resident's risk factors, in accordance with current clinical practice. A review of the facility's undated Care Planning-Interdisciplinary Team policy indicated that comprehensive, person-centered care plans are based on resident assessments and developed by the interdisciplinary team. A review of the facility's Care Plans, Comprehensive Person-Centered policy, dated revised March 2022, 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.The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.e. reflects currently recognized standards of practice for problem areas and conditions.When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 2.) The facility failed to protect a resident from self-harm and provided adequate supervision for a resident (Resident #100) with a history of suicidal ideations with plans to cut their wrist prior to admission to the facility, who cut their wrist while residing in the facility. According to the progress notes, on 1/11/2026 at 10:30 PM, the resident was noted by facility staff with a two-inch laceration to their right wrist that was bleeding profusely. The resident stated, I thought that I was going home, but they said I was not. During an interview with the Licensed Practical Nurse (LPN #1) on 1/21/2026, LPN #1 stated that the Certified Nursing Aide (CNA #1) during their rounds observed that the resident was bleeding, and when LPN #1 went to the resident's room, the resident was holding their right wrist with toilet paper to reduce the bleeding. LPN #1 stated that Resident #100 disassembled a razor that they found in the shower, and that LPN #1 was unaware that the resident had a history of self-injurious behaviors. A review of the admitting facility's paperwork included on 8/27/2025, Resident #100 called 911 and informed the police officer that they were having suicidal ideations and wanted to cut themselves with a razor. A review of the resident's medical record at their current facility including, their care plan and physician's orders, did not include any safety interventions put in place to protect the resident from self-harm. The facility's failure to provide adequate supervision and protect Resident #100 from self-harm, who had a history of suicidal ideations, placed Resident #100, as well as all residents at risk of self-harm.A review of the facility's Safety and Supervision of Residents policy, dated revised July 2017, included our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Facility-Oriented Approach to Safety: 1. Our facility-oriented approach to safety addresses risks for groups of residents . Individualized, Resident-Centered Approach to Safety: 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions with all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented; and e. Documenting interventions .Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment . A review of the facility's admission Criteria policy, dated revised March 2019, included our facility admits only residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation: 1. The objective of our admission criteria policy is to .b. admit residents who can be (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cared for adequately by the facility . A review of the facility's Sharps Disposal policy, dated revised January 2012, included the facility shall discard contaminated sharps into designated containers .Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers . 3.)The facility failed to provide pharmaceutical services in accordance with professional standards to ensure accountability of controlled substance medications were consistently conducted for prompt identification of loss or potential narcotic diversion; develop policy and procedures for the emergency electronic backup machines (electronic backup machine; EBM; ensure emergency medications were always available for administration; ensure consistent reconciliation of dispensed and administered controlled dangerous substances (narcotic medications) were accurately documented and discrepancies were immediately investigated.On 1/16/25 at 9:13 AM, during the observation of the EBM cycle count, conducted by the RN/IP and the DON, the surveyor observed two (2) house stock control countdown (declining) sheet for Morphine Sulfate 20 milligrams (mg)/1 milliliter (ml) with a quantity of 15 ml per bottle that were delivered, and signed received, on 12/17/25. At that time, the EBM machine did not reflect a drug listing for Morphine 20 mg/ml. Further observation of the cycle count revealed two (2) boxes were stored in the non-narcotic portion of the EBM. The RN/IP and the DON pulled the boxes from the EBM machine and discovered the two (2) boxes were empty and neither could find where the Morphine bottles were. The DON called the LPN/ UM who signed/received the two (2) Morphine bottles on 12/17/25. At that time, the LPN/UM stated she was present when the pharmacy provider removed the two (2) bottles of Morphine from the boxes and saw him place the Morphine bottles in one (1) of the top drawers but could not identify exactly where it was placed. At that time, the surveyor observed the RN/IP and the DON scrolled through the drug list inventory on the EBM for the Morphine 20mg/ml and did not find that Morphine 20 mg/ml was listed to locate the physical bottles of Morphine. On 1/16/25 at 10:07 AM, the surveyor discussed the concern with the DON that in the event a resident needed Morphine medication from the signed/delivered date of 12/17/25 the staff would not be able to administer the medication. The DON informed the surveyor that she would contact the pharmacy provider to locate the two (2) bottles of Morphine that were missing. On 1/16/25 at 1:20 PM, during a follow-up meeting with the surveyor, the DON stated that she had spoken with the pharmacy representative who confirmed he had placed the bottles in the top drawer. At that time, the DON could not explain why Morphine 20mg/ml was not included in the medication drug list of the EBM. The DON stated she could not show the Morphine bottles to the surveyor because she had no access to the top drawer. At that time, the DON was asked in the event of a power outage or an electrical failure, how would she access EBM to provide emergency medications to the resident(s) who needed the medication. At that time, the DON informed the surveyor that she could not locate her keys for the EBM, she did not know which keys it was and even if she found the keys, that she did not know how to use them. On 1/21/26 at 9:32 AM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the DON stated that the facility had no process to audit the cycle count and contributed to the delivered Morphine to be unidentified as inaccessible for administration from the time of signed/delivery on 12/17/25 to the time of surveyor inquiry. At that time, the DON stated that there was a software problem that caused the Morphine to not be included in the drug listing inventory of the EBM and that the pharmacy provider was researching the problem. On 1/21/26 at 9:32 AM, in the presence of the survey team, and the LNHA, the DON stated that the nurses who had filled out the Narcotic Controlled Count down sheet were in-serviced to ensure all lines were filled out. The DON confirmed and acknowledged that the facility did not have a process to audit the narcotic medication reconciliation process and contributed to the undetected discrepancies. On 1/23/26 at 3:34 PM, during a meeting with the survey team, the LNHA and the DON, no further information was provided. A review of the 2016 facility policy titled; [brand redacted] Implementation Guide included Discrepancy Handling included that discrepancy resolution should be clearly stated in the facility's policies and procedures. The department director should be notified of unresolved discrepancies. Unexplained (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	losses should be reported to security, the Drug Enforcement Agency (DEA). 4.) The facility failed to properly store, and secure medication left at a resident's bedside (Resident #13).On 1/20/26 at 10:36 AM, the surveyor in the presence of another surveyor was making rounds on the fifth floor. The surveyors observed Resident #13 lying in bed, eyes closed, fully dressed with a blanket over their legs. On the bedside table was a clear plastic cup containing a clear liquid and a plastic medicine cup with two round pills, one pink-colored pill, and one slightly smaller light orange pill. The resident had their privacy curtain pulled to the side of their footboard on the bed, inhibiting access to the nightstand. Resident did not respond to surveyor inquiry.On 1/20/26 at 10:37 AM, surveyor #2 went to find the nurse and the Certified Nursing Aide (CNA) assigned to Resident #13, while surveyor #1 stayed with the resident. When CNA #2 arrived at the room and was shown the pills in the medicine cup on the nightstand she stated the medication should not be left there, that usually the resident was supposed to take their medication while the nurse was in the room.On 1/20/26 at 10:41 AM, the surveyor interviewed the Licensed Practical Nurse #5 (LPN #5) who acknowledged the medications found at the bedside and stated she had given Resident #13 their medications in the hallway and not in their room, that the medication in the cup was not from her morning medication pass. LPN #5 confirmed medications should not be left at the bedside and should be secured in a medication cart.On 1/20/26 at 11:01 AM, the surveyors interviewed the fifth floor Registered Nurse Unit Manager #2 (RN/UM #2) who acknowledged the medications on the bedside table, she was unable to identify the pills in the medicine cup. RN/UM #2 confirmed there should be no medications left unsecured at the resident's bedside. She stated the medication administration process was the nurse must observe the resident has taken the medication, to ensure the resident is therapeutic as well as medication was not left around for another resident to take. RN/UM #2 then took the medications to secure them.On 1/20/26 at 1:14 PM, the Director of Nursing (DON), RN/UM #2 and LPN #5 went to the medication cart to review the orders and identify the pills left in the medication cup. Upon review the DON determined the medications were Aspirin 81 mg (milligram) chewable tablet (a medication used to prevent blood clots) and Vitamin B12 100mcg (micrograms) tablet (a supplement used for vitamin deficiency). The DON confirmed medications should not be left at the bedside because they must be secured for the safety of all the residents.A review of the facility's undated Storage of Medications policy included. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.The nursing staff is responsible for maintaining medications storage and preparation areas in a clean, safe and sanitary manner.On 1/23/2026 at 10:14 AM, the surveyor interviewed the facility Medical Director (MD) who stated that he was not notified by the facility Licensed Nursing Home Administrator (LNHA) that there was Immediate Jeopardy (IJ) at the facility during survey. The MD stated that he was the attending physician for Resident #100, and he was not aware that the resident had been previously identified with suicidal tendencies prior to admission. The MD stated that a razor blade was not something that the resident should have been able to easily get a hold of. The MD further stated, especially with this population because you do not want to take a risk to be on the safe side., because the residents are all schizophrenic, but some are controlled.On 1/27/26 at 3:39 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the Assistant Director of Nursing (ADON) and the survey team. The LNHA stated that the Director of Nursing (DON) was responsible for the controlled medication back up inventory. The LNHA stated that she had just become aware that there was an issue with the accountability of controlled medications in the back up inventory. The LNHA stated that her role was to audit, monitor, and QAPI (Quality Assessment and Performance Improvement), which I have just become aware of the issue. The LNHA maintained that she was not made aware of any missing controlled medications by the clinical team.When the surveyor asked the LNHA what her role and responsibility was to ensure the safety of residents who were previously identified with suicidal ideas prior to admission she stated that it was a clinical and admissions (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	process, and her role was to make corrective actions to that process. The LNHA further stated that her role was to now to make corrective actions to that process, and audit, monitor, and update trending information. When the surveyor asked the LNHA what her role and responsibility was to ensure that residents received appropriate skin interventions to prevent the development of pressure ulcers the LNHA stated she was responsible for identifying patient safety and quality of care that needed to be put into place. The LNHA further stated that we have clinical consultants who review the clinical information. The LNHA further stated we now have a new consultant.		

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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. Based on observation and interview, it was determined that the facility failed to provide a safe, clean, comfortable and home-like environment. This deficient practice was identified for 3 of 5 (three of five) nursing units, [the third (3rd), fifth (5th), sixth (6th)] inspected and was evidenced by the following: On 1/16/2026 at 11:37 AM, during the initial tour of the facility, the surveyor observed the following on the third floor nursing unit: Room (RM) 306's rest room had a broken toilet paper holder. RM 309 C had a frayed protective mat wrapped with duct tape applied to the end of the bed. RM 313, the creases of the bathroom tiles had a brown substance on them, a broken toilet paper holder, and the toilet paper was located next to a soiled trash bin. RM 315 had a light switch box that was rusted and had flaked areas. The wall had areas of elevation that appeared to have been water damage. RM 316 had holes in the wall, a broken toilet paper holder, and a roll of toilet paper was located on a covered bathtub. RM 317 had a hole in the wall and there were other damaged areas on the walls. On 1/21/26 at 12:16 PM, the surveyor toured the sixth (6th) floor nourishment room with the Licensed Practical Nurse/Unit Manager (LPN/UM #1) and observed the right pantry side door was broken. On 1/22/26 at 12:21 PM, the surveyor observed chipped paint on the wooden bathroom organizer and a rusty metal shower room organizer was hanging on the pipe on the third (3rd) floor shower room. On 1/21/26 at 11:26 AM, the surveyor interviewed LPN #2, who stated that the residents' restrooms should have toilet paper holders and that the toilet paper should not be placed on the bathtub cover. LPN #2 further stated that rooms should be more presentable. On 1/21/26 at 12:22 PM, the surveyor interviewed LPN/UM #1, who stated that the pantry door should not be broken to prevent residents taking items and also for infection control purposes. On 1/21/26 at 2:00 PM, the surveyor interviewed the Director of Maintenance (DOM), who confirmed that all rooms should have functioning toilet paper holders, the toilet paper should never be placed anywhere else but on the toilet paper holder to avoid cross-contamination and prevent infection. The DOM further stated that all walls should be intact to help the residents' rooms appear home-like. On 1/22/26 at 4:26 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated staff were expected to report concerns to maintenance and housekeeping to ensure toilet paper holders were replaced and toilet paper was properly maintained in the holder. The LNHA also stated that chipped paint and water-damaged walls should be repaired or replaced to ensure resident safety, comfort, and a home-like environment. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 1/23/2026 at 1:30 PM, the surveyor in the presence of Certified Nurse Aide #8 (CNA #8) inspected the fifth-floor south shower room and there was a chipped and cracked plastic shelf in the shower, a dark colored caked on substance in the shower drain and black colored substance on the walls of the shower, missing, chipped and cracked floor tiles and chipped white paint on the wooden shelf. There was also a black substance that was dotted along the grout and the shower drain. There was chipped white paint on a wooden shelf. At that time the surveyor interviewed CNA #8 and asked if the shower should have broken or damaged equipment, he stated it should not. When asked if he would want to shower in either of the fifth floor showers he responded definitely not. On 1/23/2026 at 2:38 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated she was aware of the condition of the showers in the facility and that the facility was in the process of updating all the shower rooms. The LNHA acknowledged the showers were not homelike. A review of the facility's Homelike Environment policy, revised 02/2021, included that residents are to be provided with a safe, clean, comfortable homelike environment . NJAC 8:39-31.4 (a)(f)		

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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, interviews, record review and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards of practice to ensure: a.) accountability of controlled substance medications were consistently conducted for prompt identification of loss or potential narcotic diversion, and develop a policy and procedure for the use of an emergency electronic backup machine (electronic backup machine; EBM, b.) emergency medications were always available for administration, c.) consistent reconciliation of dispensed and administered controlled dangerous substances (narcotic medications) were accurately documented and discrepancies were immediately investigated. This deficient practice was identified for one (1) of one (1) EBMs and was evidenced as follows: On 1/16/26 at 9:00 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that the facility had one (1) EBM, and the inventory auditing procedure (cycle counts) were completed daily, during the day shift and were conducted by two nurses, a nurse unit manager with the Assistant Director of Nursing (ADON). The DON also stated that they had a written logbook where the nurses documented the cycle count, with the date, the time, the nurses' signatures and the residents' name for whom the narcotic medication was dispensed. On 1/16/26 at 9:09 AM, the surveyor observed the cycle count process which was conducted by the Registered Nurse/Infection Preventionist (RN/IP) and the DON. At that time, the surveyor did not observe a cycle count documentation for the daily cycle count. On 1/21/26 at 9:32 AM, in the presence of the survey team and the Licensed Nursing Home Administrator (LNHA), the DON confirmed and acknowledged that the facility did not have a process to audit the narcotic medication reconciliation process. On 1/23/26 at 9:28 AM, the surveyor, RN/IP and DON together reviewed the 12/1/25 to 1/21/26 electronic Transaction by Item log from the pharmacy. At that time, the RN/IP and the DON acknowledged and confirmed the cycle counts had not been conducted daily. A review of the 2016 facility policy titled; [brand redacted] Implementation Guide reflected the guide should be used . to serve as a starting point for developing, documenting and enforcing best practices . b.) On 1/16/26 at 9:13 AM, during the observation of the EBM cycle count, conducted by the RN/IP and the DON, the surveyor observed two house stock declining inventory sheets (DIS) for morphine sulfate 20 milligrams (mg)/1 milliliter (ml) solution with a quantity of 15 ml per bottle that was delivered, and signed received, on 12/17/25 by the LPN/UM. A review of the corresponding EBM inventory list did not contain a listing for morphine sulfate 20 mg/ml, 15ml. Further observation of the cycle count revealed two empty morphine 20 mg/ml boxes which were being stored in the non-narcotic portion of the EBM. The RN/IP and the DON acknowledged the empty boxes of morphine but were unable to explain where the two bottles of morphine were. At that time, the DON called the LPN/UM who stated she was present when the pharmacy provider removed the two bottles of morphine from the boxes and placed the morphine bottles in one of the top drawers but she could not identify exactly where it was placed. The surveyor observed the RN/IP and the DON again reviewed the inventory list and again could not locate a compartment for the morphine 20 mg/ml, 15 ml. On 1/16/26 at 10:07 AM, the surveyor discussed the concern with the DON that in the event a resident needed morphine solution medication the staff would not be able to administer the medication. The DON informed the surveyor that she would contact the pharmacy provider to locate the two bottles of Morphine that were missing. On 1/16/26 at 1:20 PM, during a follow-up meeting with the surveyor, the DON stated that she had spoken with the pharmacy representative who confirmed he had placed the bottles in the top drawer. At that time, the DON could not explain why morphine 20 mg/ml was not included in the medication drug list of the EBM. The DON stated she could not show the Morphine bottles to the surveyor because she had no access to the top drawer. At that time, the DON was asked in the event of a power outage or an electrical failure, how would she access EBM to provide emergency medications to the resident(s) (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who needed the medication. The DON informed the surveyor that she could not locate her keys for the EBM, and she did not know which key it was and even if she found the keys, that she did not know how to use them. On 1/21/26 at 9:32 AM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the DON acknowledged that the facility had no process to audit the cycle count which contributed to the improper placement and storage of the morphine and the DON further stated that there was a software problem that caused the morphine to not be included in the drug listing inventory of the EBM and that the pharmacy provider was researching the problem. On 1/21/26 at 11:01 AM, during a re-inspection of the EBM, in the presence of the surveyor, the Assistant Director of Nursing (ADON), the DON showed the surveyor two bottles of morphine and stated that it was fixed by the pharmacy to be included in the drug listing of the EBM. On 1/22/26 at 11:38 AM, during an interview with the surveyor, the pharmacy provider representative (PPR) stated that he was in the facility sometime in December, assigned a drawer for the morphine and it should have populated in the drug list inventory of the EBM; the provider pharmacy was researching the software issue as to why it did not populate during inspection. The PPR further stated that he went into the facility sometime on 1/19/26 to locate the missing Morphine that was pointed out to him by the staff who knew exactly where the two bottles of Morphine were. At that time, the PPR stated that there was a way to force open and access the medication during a power outage or an electrical failure and the staff should have been oriented to the process. A review of the provided cycle count from 12/1/25 to 1/21/26, did not reveal morphine 20 mg/ml was part of the cycle count that required two nurses to physically count the inventory of medications. A review of the 2016 facility provided policy titled; [brand redacted] Implementation Guide, under Manual Override Access reflected that manual override keys must be assigned to at least one responsible person, per shift, per cabinet area and that keys must be kept in a secured area. c.) On 1/16/26 at 9:13 AM, during the observation of the EBM cycle count, conducted by the RN/IP and the DON, the surveyor observed a House Stock declining inventory sheet (DIS) for oxycodone 5 mg and noted the following: Line #30 of the DIS did not include the date and time for when the Oxycodone was removed for Unsampled Resident #149. Line #29 had the date, time of inventory removal, the nurses' signature and the resident's name. Line #28 reflected the date of 12/31/25, with no indication of the time of removal from inventory, and did not include the nurses' signatures and the resident's name. Line #27, #26, and #25 reflected on 12/31/25 at 6:00 PM, three tablets were removed for Resident #149. The inventory count matched the DIS that demonstrated a quantity of 24 tablets remained. At that time, the DON stated that she would investigate the dispensed oxycodone for Resident #149. On 1/21/26 at 9:32 AM, in the presence of the survey team, and the LNHA, the DON stated that the nurses who had filled out the oxycodone Controlled DIS were in-serviced to ensure all lines were filled out. At that time, the surveyor and the DON reviewed the investigation provided. The facility failed to provide the previously requested packing slips for Unsampled Resident #149 and the transaction by item report. On 1/22/26 at 11:21 AM, during an interview with the surveyor, the Regional Director (RD) of the pharmacy provider stated that they had a way to track who, when, and how many medications were removed from the EBM. At that time, the surveyor requested the report. A review of the provided transaction by item report reflected multiple discrepancies that were older than the date range requested from 12/1/25 to 1/21/26 and continued to be unresolved by the facility. On 1/23/26 at 9:28 AM, in the presence of the surveyor, and the RN/IP, the DON provided the investigation related to the oxycodone then stated that the medications removed were all for Unsampled Resident #149 and the nurses involved provided a statement. The surveyor, the RN/IP and the DON reviewed the investigation together and revealed the following discrepancies: Line #30 of the oxycodone was removed on 12/23/25 at 10:10 AM and was flagged discrepancy. The DON acknowledged that the medication was removed. Line #29 reflected one tablet was removed on 12/24/25 and the eMAR (electronic medication administration record) did not reveal an administration of the as needed (PRN) Oxycodone 5 mg to Unsampled Resident #149. An investigation of the discrepancy was not provided. Line #28 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected one tablet was removed on 12/31/25 at 6:16 PM, and was flagged discrepancy, followed by Line #27, #26, and #25 reflected one tablet was removed each time per line on 12/31/25 from 6:16 PM and 6:17 PM. A review of the statements made by the two nurses who signed lines 27, 26 and #25 reflected that they removed three tablets of Oxycodone and skipped line #28 because of the discrepancy found on the EBM. The nurses also documented that Resident #149 had no remaining pills for their physician's ordered oxycodone 15 mg in the medication cart. A review of Unsampled Resident #149's eMAR for December 2025 did not reflect a physician's order for oxycodone 5 mg, to be given 3 tablets at one time to correspond to the dispensed medication by the nurses for lines #27, #26 and #25. Further review of Unsampled Resident #149's electronic Medication Administration Record (eMAR) included active medication orders for:-Oxycodone 15 mg, 1 tablet every 6 hours for pain, with a start date of 12/4/25.-Oxycodone 5 mg, 1 tablet every 8 hours as needed for severe breakthrough pain, with a start date of 12/4/25. A review of the packing slip (delivery invoice from the pharmacy) for Resident #149's physician ordered Oxycodone 15 mg reflected that a quantity of 90 was delivered and signed for on 12/10/25 [a supply for 22.5 days]. A review of the corresponding DIS for Resident #149's physician prescribed oxycodone 15 mg revealed that when the medication was received a recording was not made on the DIS, the initial pill was removed and was not recorded and the discrepancy remained unresolved. A review of the packing slip for Resident #149's physician ordered oxycodone 5mg reflected a quantity of 30 was delivered on 12/31/25. At that time, the DON stated that there were no prior orders for Oxycodone 5 mg and that was the reason the nurses utilized the EBM for Resident #149. On 1/16/26 at 9:13 AM, the during the observation of the EBM cycle count, conducted by the RN/IP and the DON, the surveyor also observed the following: A review of a House stock DIS for alprazolam (medications used to treat anxiety) 0.25 mgLine 30 reflected appropriate documentation of the date, time of inventory removal, the nurses' signature and the resident's name. Line 29 reflected a removal of a dose on 12/28/25 at 11:45 AM, by two nurses but did not reveal the resident's name. Line 26 reflected a removal of a dose on 12/22/25 at 4:30 PM, by two nurses but did not reveal the resident's name. A review of a House stock DIS for lorazepam (a medication used to treat anxiety) 0.5 mg Line 29 reflected a removal of a dose on 1/15/26 at 7:30 PM, by two nurses but did not reveal the resident's name. At that time, the surveyor discussed the concern with the process for the reconciliation of controlled medications that were dispensed and administered from the EBM. On 1/21/26 at 9:32 AM, in the presence of the survey team, and the LNHA, the DON confirmed and acknowledged that the facility did not have a process in place to audit the narcotic medication reconciliation process and that contributed to the undetected discrepancies. A review of the 2016 facility policy titled; [brand redacted] Implementation Guide included Discrepancy Handling included that discrepancy resolution should be clearly stated in the facility's policies and procedures. The department director should be notified of unresolved discrepancies. Unexplained losses should be reported to security, the Drug Enforcement Agency (DEA). NJAC 8:39-29.4(k), 29.7(c)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, medical record review and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices a.) during medication pass observation b.) during wound care observation and c.) during dining observation specifically, performing appropriate hand hygiene during the meal service to prevent the spread of potential infection This deficient practice was identified for 1 of 3 nurses observed administering medications to 1 of 4 residents (Resident #88) during the medication pass observation task, and for 1 of 1 resident (Resident #2) observed for wound care and for 1 of 5 dining rooms (6th floor). This deficient practice was evidenced by the following: 1.) On 1/16/26 at 9:22AM, the surveyor observed Registered Nurse (RN #1) prepare medications for Resident #88. RN #1 prepared five medications for the resident. One of the medications was Vitamin D3 50 mcg (microgram); give one tablet by mouth daily. The surveyor observed RN #1 open the bottle and pour the medication directly into her open palm and then proceeded to add the tablet into the prepared medicine cup. When the surveyor asked RN #1 if medication should be dispensed directly into the nurse's ungloved hand before placing the medication into the medicine cup? RN #1 stated she had cleaned her hands with alcohol-based hand rub prior to starting the medication pass, so she thought that it was okay. Then RN #1 stated, I guess there's a potential to contaminate the pills if your hands are dirty. RN #1 then donned a glove and removed the tablet from the medicine cup and discarded the pill in the designated medication eliminator solution and then re-poured all the oral medications. On 1/22/2026 at 4:42 PM, the survey team met with the facility Administration team to discuss concerns and Director of Nursing (DON) stated the nurse should not have poured any medications into their ungloved hands and acknowledged this would be an infection control issue. 2.) A review of the admission Record, an admission summary, indicated that Resident #2 was admitted to the facility with the diagnoses which included but were not limited to metabolic encephalopathy (broad term for brain dysfunction caused by systemic illness, such as diabetes, liver/renal failure, or infection, rather than a direct brain injury), acute respiratory failure, and schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia (psychosis) and a mood disorder, like bipolar disorder or depression). A review of the quarterly Minimum Data Set (MDS), an assessment that facilitates a resident's care dated 10/22/25, indicated that Resident #2 had short- and long-term memory deficits with severe impairment in decision making. The MDS further indicated that the resident was dependent on staff for all aspects of activities of daily living (ADLs) and was at risk for pressure ulcers; however, the resident did not have a pressure injury at that time. The MDS also indicated that the resident was receiving Hospice services. On 1/15/2026 at 11:36 AM, the surveyor observed Resident #2 sitting in a reclining chair in the dayroom. The surveyor did not observe the resident sitting on an anti-pressure device. The Certified Nursing Assistant (CNA) present in the dayroom stated that the resident had an excoriation on the buttocks area. The surveyor further observed that the resident's mattress was not an anti-pressure mattress. The surveyor reviewed Resident #2's Electronic Medical record (EMR) which revealed the following: Review of the Interdisciplinary Care Plan (ICP) contained a focus area dated 5/12/25, which indicated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident had the potential for alteration in skin integrity related to scratching and picking the right temporal area and wound to sacrum measuring 10 x 7 x 5 (no date of initial development of wound). The goal documented indicated that the skin would heal by next review of 4/14/26. Interventions included: Dietician consult, keep nails short and clean, keep skin clean and dry, use skin barrier with each change and skin checks two times a week per policy. A review of the Treatment Administration Record (TAR) reflected a treatment dated 1/16/26, to cleanse the sacrum with normal saline solution (NSS) and apply medi-honey, calcium alginate and silicone foam dressing daily on the day shift for wound care. On 1/22/26 At 8:50 AM, the surveyor observed the Licensed Practical Nurse Unit Manager (LPN/UM #1) perform Resident #2's sacral wound care. The sequence was as follows: -The LPN/UM reviewed the treatment order with the surveyor which included cleansing the wound with NSS, application of Medi-honey and calcium alginate and cover silicone dressing. -The LPN/UM #1 then applied personal protective equipment (PPE) for enhanced barrier precautions (EBP), an infection control intervention in nursing homes and skilled nursing facilities that mandate the use of gowns and gloves during high-contact resident care to reduce the spread of multi-drug-resistant organisms (MDROs). -The LPN/UM #1 gathered the treatment supplies which included one small bottle of NSS, one covered calcium alginate dressing, one covered silicone dressing and one tube of medi-honey and put them on top of the resident's bedside table. The LPN/UM put all treatment supplies directly on the resident's bedside table without disinfecting the table or applying a protective barrier -The LPN/UM #1 then washed her hands according to Center for Disease Control (CDC) guidelines and applied gloves. -The LPN/UM #1 removed undated soiled dressing from the resident's sacral area and then washed her hands and applied clean gloves. -The LPN/UM #1 then proceeded to pour NSS on a clean 4x4 gauze dressing and cleansed the resident's wound. The wound was large, with light brown drainage, covered with yellow/black/brown eschar (dry, dark colored skin). -The LPN/UM #1 did not wash her hands or change her gloves after cleaning the wound and then proceeded to apply the medi-honey and calcium alginate and then covered the wound with the silicone dressing. -The LPN/UM did not date the new dressing that she applied to the resident's sacral area. -After the dressing change was complete and she washed her hands, LPN/UM #1, then attempted to put the contaminated wound supplies back into the treatment cart. The surveyor stopped the nurse before she did so, in an effort to avoid contaminated equipment. -The LPN/UM then signed the treatment out in the TAR. The surveyor interviewed the LPN/UM #1 at this time, and the LPN did not have a response as to why (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did not decontaminate the bedside table or put down a clean barrier on the table before putting the treatment supplies down on the table. LPN/UM #1 did not have any response regarding breeches in infection control. She also stated that she did not think that dressings needed to be dated, because they signed them out in treatment Kardex. She stated that she would have to review the policy to see if dressings needed to be dated. On 1/22/2026 at 9:29 AM, the surveyor interviewed the Infection Preventionist (IP) who explained the process of dressing changes for residents with wounds. She stated that the nurse was responsible for checking physician treatment orders, ensuring it was the correct resident, wash hands, and apply gown, gloves and mask. The IP stated that when preparing for the treatment, the nurse should not bring the treatment equipment in the original containers into the resident's room. The nurse should put the NSS and ointments into a disposable medication cup, so that it could be disposed of after completing the treatment. She stated that this prevented any contaminated supplies from going back into the treatment cart. The nurse should disinfect the surface area they are working on and put a protective barrier down. Treatment supplies are then placed onto the protective barrier. She further stated that cleaning the table with a disinfectant and putting a clean barrier prevents contamination. She then added that the nurse should remove the soiled dressing, wash hands, change gloves, then proceed with wound cleansing. She stated that after cleaning the wound the nurse was to wash hands and change gloves, then proceed with the dressing change. She stated that she was not sure if dating dressings were within the dressing policy, however dating dressing ensured continuity of care and that dressing changes were being done. She continued to explain that after dressing change was completed, the nurse was to make sure the area was clean and the table they were working on was disinfected. The nurse should remove PPE and wash hands and sign the treatment out in the TAR. 3.) On 1/16/2026 at 12:39 PM, the surveyor observed staff on the 6th floor distributing lunch trays to the residents in the dining room. The surveyor observed three Certified Nursing Assistants (CNAs) retrieving trays from the lunch cart providing the trays to the resident. The aides delivered the tray to the resident and set the resident up, then went back to the food truck and retrieved another tray without first performing hand hygiene in between residents. On 1/16/2026 at 12:41 PM, the surveyor interviewed CNA #6 who stated that the process for passing food trays included looking at the resident's name on the tray ticket to verify that correct meal was provided. The surveyor asked the CNA what the staff should be performing before and after tray distribution to the residents and he did not know that he should be performing hand hygiene between the residents during tray pass to prevent the spread of infection. On 1/16/2026 at 12:46 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager for the 6th floor (LPN/UM #1) who confirmed that between residents and during food tray distribution, the CNA was supposed to perform hand hygiene to prevent the spread of infection. On 1/16/2026 12:57 PM, the surveyor interviewed an Activities Monitor (AM) who was observed assisting the CNAs distribute lunch trays to the residents on the 6th floor. The surveyor questioned the AM regarding hand hygiene in between tray distribution to the residents and the AM seemed to be unaware that she had to perform hand hygiene in between residents. She stated that she could not recall if she had received education regarding hand hygiene during meal tray distribution. On 1/22/26 at 8:12 AM, the surveyor interviewed the Infection Preventionist Registered Nurse (IP) who explained that when the CNAs passed out meal trays to the residents, they must perform hand hygiene in between residents. She stated that they must perform hand hygiene for standard (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions to prevent the spread of infection because they are in close contact with residents and touched objects while setting up resident trays. A review of the facility's Administering Medications policy updated 1/26 included. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. A review of the facility policy dated 1/2026 and titled, Wound Care indicated the following steps: -Use disposable cloth or paper towel to establish a clean field on the resident's overbed table. Place all items to be used during the procedure on the clean field. -After removing soiled dressing, remove the dressing, discard and wash hands. -Use a no-touch technique and use sterile tongue blades and applicators to remove ointments and creams from their containers. A review of the facility policy dated August 2019 and titled, Handwashing/Hand Hygiene indicated that hand hygiene should be done before and after handling clean and soiled dressing or gauze, before moving from a contaminated body site to a clean body site during resident care, after handling contaminated equipment and used dressings, and before and after assisting residents during meals. NJAC 8:39-19.4 (a)(m)		

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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. Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to revise a resident's care plan with related goals and interventions each time the resident sustained a fall. This deficient practice was identified for 1 of 11 residents (Resident #135) reviewed for accidents and was evidenced by the following: On 1/16/26 at 12:52 PM, the surveyor observed Resident #135 ambulating independently in the hallway without an assistive device. At that time, the surveyor attempted to interview the resident who appeared to be confused and was unable to answer the surveyor's questions appropriately. On 1/20/26 at 11:54 AM, the surveyor reviewed the medical record for Resident #135. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: morbid (severe) obesity due to excess calories, schizophrenia, unspecified (a serious mental health condition), anxiety disorder, unspecified, depression, unspecified, and primary open-angle glaucoma, bilateral, mild stage (increased intraocular (eye) pressure). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 1/2/26, included the resident had both a short-term and a long-term memory problem and the resident's cognitive skills for daily decision-making ability was described as severely impaired. Further review of the MDS revealed that the resident had one fall since admission, entry, reentry, or prior assessment without injury. A review of the resident's facility provided individual comprehensive care plan (ICCP) included a focus area, dated 1/7/21, that the resident was at risk for falls or injury related to: Psychotropic Drug Use, Behaviors, Poor Safety Awareness (sits on floor) Hx (history): Decreased mobility r/t (related to) poor endurance associated with Dx (diagnosis) COPD (chronic obstructive pulmonary disease) and morbid obesity. Further review of the Focus Area included an Actual Fall on 11/15/25, with no documented evidence that any interventions were implemented to prevent the recurrence of resident falls. A review of the Order Summary Report (OSR), dated as of 1/28/26, included the following physician order (PO): A PO, dated 11/12/25, for DC (discharge) from skilled PT (physical therapy) services this last date of service due to patient met goals. Continue ambulation with rollator walker (a rolling walker with three or four wheels, a frame with handlebars, and a seat). A review of the facility provided fall investigation included a nursing progress note, dated 11/15/25, created at 4:03 PM by Registered Nurse (RN #2), included, At approximately 2:30 pm while passing resident's room in the hallway with other staff. Observed resident trying to get out of bed while doing so seen resident lost his/her balance and landed on his/her right shoulder and right upper arm against the dresser but did not hit his/her head on any object. Skin assessment done noted redness to right upper arm applied ice pack to affected area. This writer was not able to get to the resident in time to assist. MD (medical doctor) made aware no new order and POA (Power of Attorney). On 1/21/26 at 11:40 AM, the surveyor interviewed RN #2 who stated that when a resident fall occurred, either the supervisor or he was responsible for updating the resident's care plan. RN #2 further stated that if he updated the care plan, he only documented the date that the resident had fallen. RN #2 further stated the unit manager then reviewed the care plan and implemented interventions. On 1/21/26 at 12:09 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated that she had worked at the facility for one week. LPN/UM #1 stated that new interventions were required to be put into place after each fall so that they know what they have done to help the resident and to determine the effectiveness of the interventions. LPN/UM #1 further stated they were supposed to update the interventions on the care plan with every fall. On 1/23/26 at 1:18 PM, the surveyor interviewed the Director of Nursing (DON) who stated that every new fall or event gets a new intervention on the resident's care plan. The DON further stated that the resident's care plan should have been updated immediately with new interventions after the resident fell. On 1/27/26 at 3:39 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) of the facility's failure to update the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Lakeside Blvd Bayville, NJ 08721	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's care plan with new interventions after each resident fall.A review of the facility's Care Plans, Comprehensive Person-Centered policy, dated revised March 2022, included: .Care Plan interventions are chosen only after data gathering, proper sequence of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.When possible, interventions address the underlying source (s) of the problem area (s), not just symptoms or triggers.the interdisciplinary team reviews and updates the care plan.when the desired outcome is not met.A review of the facility's Safety and Supervision of Residents policy, dated revised July 2017, included: .Monitoring the effectiveness of interventions shall include the following: .Ensuring that interventions are implemented correctly and consistently; Evaluating the effectiveness of interventions; and documenting interventions.NJAC 8:39-11.2 (e) 2		

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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. Based on observation, interview and review of medical records, it was determined that the facility failed to provide necessary treatment services, consistent with professional standards of clinical practice by not performing treatments as ordered by the physician. This deficient practice was identified for 1 (one) of 1 resident (Resident #194) reviewed for skin alterations and was evidenced by the following:Reference: New Jersey Statutes, 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 or 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 well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist:Reference New Jersey Statutes, 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 task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist.A review of the admission Record (admission summary) reflected that Resident #194 was admitted to the facility with the diagnoses which included but was not limited to dementia, bipolar disorder and heart failure. A review of the quarterly Minimum Data Set, an assessment that facilitates a resident's care dated 3/5/26 indicated that Resident #194 scored a 3 out of 15 on the Basic Interview for Mental Status (BIMS). This score indicated that Resident #194 had severe impairment with cognition. The MDS also indicated that the resident was dependent on all aspects of activities of daily living (ADLs) and was at risk for developing pressure ulcers. On 3/16/26 at 12:14 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who indicated that he was caring for Resident #194. The LPN stated that the only treatment that was being performed for the resident was for a skin tear of the right forearm. On 3/16/26 at 12:17 PM, the surveyor interviewed the primary care Certified Nursing Assistant (CNA) who stated that Resident #194 required complete care with ADLs and was incontinent with bladder and bowel. She stated that the resident had a patch on the right side of the butt and has had the wound for a couple of weeks and had a dressing on the right forearm.On 3/16/26 at 12:25 PM, the surveyor accompanied the LPN and the CNA to Resident #194's room. The surveyor observed the LPN and CNA mechanical lift the resident back to bed. The surveyor observed an anti-pressure cushion on the resident's chair, an air mattress on the resident's bed and observed that the resident had a dressing on the right forearm dated 3/12/26. The LPN and CNA acknowledged that the dressing on the right forearm was dated 3/12/26.A review of the Treatment Administration Record (TAR) dated contained a physician's order dated 3/6/26 to cleanse the right forearm with normal saline solution (NSS) apply honey gel and a clean dry dressing (CCD) every day for wound healing. The TAR reflected nursing signatures dated 3/13/26 and 3/14/26 that the treatment was administered. The TAR dated 3/15/26 was blank.On 3/16/26 at 1:20 PM, the surveyor interviewed the LPN who reviewed the TAR in the presence of the surveyor and stated that he signed the TAR on 3/14/26 that he administered the right forearm wound treatment. The surveyor asked him if he completed the wound care as ordered that day, because the dressing was dated 3/12/26. He stated that he did not remember and that the treatment was probably overlooked. He stated that it was important to follow physician's orders to ensure that the residents got the care that they needed. He also stated that when the signature plot on the TAR was blank on 3/15/26, it meant that the treatment was not done as ordered.On 3/16/26 at 2:01 PM, the surveyor interviewed the Assistant Director of Nursing (ADON), the Director of Nursing (DON) and the Licensed Nursing Home Administrator simultaneously and informed them of the surveyors findings and they did not have a response as to why Resident #194's treatment dressing of the right forearm was dated 3/12/26 and (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nursing staff were signing or not signing the TAR from 3/13/26 until 3/15/26 that a treatment was being performed.A review of the facility policy with a revised date of 1/2026 and titled, Wound Care indicated that the policy provided guidelines for the care of wounds to promote healing. The policy indicated that the staff were to verify that there was a physician order, review the care plan for any specific needs of the resident, mark date of dressing change with time, date and initials. The following documentation should be recorded in the resident's medical records: type of wound care given, date and time the wound care was given, position in which the resident was placed, the name and title of the individual performing the wound care and all assessment data obtained when inspecting the wound.NJAC 8:39-29.2(d)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide urinary catheter (a tube used to drain urine), treatment and care, based upon current standards of practice specifically : a.) not documenting urinary outputs, and b.) failing to ensure the urinary catheter drainage bag was positioned off the floor and was not visible from the doorway, for 2 of 2 (two) residents (Resident #5 and Resident #8) reviewed for urinary catheter care. The deficient practice was evidenced by the following: On 1/15/26 at 12:22 PM, the surveyor observed Resident #5 lying in bed with the head of the bed elevated while being fed by staff. The surveyor observed the urinary catheter drainage bag contained within a privacy bag and positioned on the floor, visible from the hallway. On 1/16/26 at 9:31 AM, the surveyor observed Resident #5 lying in bed. The surveyor observed the urinary catheter drainage bag positioned on the floor and visible from the hallway. On 1/16/26 at 11:36 AM, the surveyor reviewed the medical record for Resident #5. A review of the admission Record, an admission summary indicated that the resident had diagnoses that included, but were not limited to, uninhibited neuropathic bladder (impaired bladder control resulting in involuntary, sudden urges to void, frequent urination, and urinary leakage). A review of the Resident's most recent quarterly Minimum Data Set (MDS), an assessment tool, dated 12/30/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, reflecting severely impaired cognition. Further review of the MDS revealed that Resident #5 had an indwelling urinary catheter. A review of the Resident's Individual Comprehensive Care Plan (ICCP) included a focus area dated 8/20/25 that the Resident had an indwelling urinary catheter. Interventions included, but were not limited to, positioning the catheter bag and tubing below the level of the bladder and away from the room entrance. However, the Foley catheter drainage bag was observed positioned on the floor and visible from the resident's doorway. A review of the Order Summary Report (OSR) revealed an active order for foley catheter care every shift as of 8/19/25. On 1/16/26 at 1:51 PM, the surveyor interviewed Certified Nurse Assistant (CNA #7) and requested that she accompany the surveyor to Resident #5's room. When asked about the positioning of the Resident's Foley catheter drainage bag, CNA #7 acknowledged that the drainage bag should be kept off the floor and positioned away from the doorway for infection prevention and resident privacy. On 1/16/26 at 1:59 PM, the surveyor requested Licensed Practical Nurse (LPN #4) to accompany her to the Resident's room during an interview. LPN #4 stated that the Foley catheter drainage bag was on the floor and acknowledged that the drainage bag should not be placed on the floor to prevent infection. LPN #4 further stated that the drainage bag should be positioned away from the doorway to ensure resident privacy. On 1/21/26 at 11:28 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1), who confirmed that the privacy bag should be positioned below waist level, not on the floor. RN/UM (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 further stated that staff should follow the resident's care plan for proper positioning of the catheter drainage bag to prevent infection and maintain resident privacy. On 1/21/26 at 12:49 PM, the surveyor interviewed the Director of Nursing (DON), who confirmed that the catheter drainage bag should be positioned for gravity drainage, placed in a privacy bag, and kept out of view to prevent infection and maintain resident privacy. A review of the facility policy titled, Catheter Care, Urinary updated 1/26 indicated that the purpose of this procedure is to prevent catheter-associated urinary tract infections, and under Infection Control included . 2. b.) be sure the catheter tubing and draining bag are kept off the floor . On 1/22/26 at 10:41 AM, the surveyor observed Resident #8 sitting in a wheelchair in the dayroom. The surveyor and Resident #8 went to the resident's room for an interview. Resident #8 stated they had been in the facility for a few months, confirmed they used a urinary catheter, had urinary tract infections in the past and that the Certified Nurse Aides (CNAs) would collect and measure the urine output from the urinary collection bag every shift. The surveyor reviewed the medical record for Resident #8. A review of the admission Record face sheet reflected that the resident was admitted to the facility in September of 2025 with diagnoses which included urinary tract infection, urinary retention, and neuropathic bladder (a dysfunction of the bladder, caused by nerve damage prevents the bladder from properly storing or emptying urine). A review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 12/20/25, reflected that the resident had a brief interview for mental status (BIMS) score of 12 out of 15, which indicated a moderately impaired cognition. It further included that the resident had an indwelling catheter. A review of the resident's individualized person-centered Care Plan (CP) included a focus area initiated on 9/22/25 for utilizing an indwelling catheter related to a diagnosis of neuropathic bladder. Interventions included to: position catheter bag and tubing below the level of the bladder; check tubing for kinks and patency every shift, every day; monitor and document intake and output as per facility policy; monitor/document for pain/discomfort due to catheter. A review of Resident # 8's Order Summary located in the Electronic Medical Record (EMR) revealed an order to, empty and measure foley catheter urine output every shift for health monitoring, initiated 9/19/25. A review of the December 2025 Treatment Administration Record (TAR) located in the EMR revealed blanks in the documentation portion for the following dates: 12/3/25-night-blank 12/14/25-day-blank 12/18/25-day-blank 12/19/25-day-blank (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/21/25-day-blank 12/23/25-day-blank 12/28/25-evening-blank 12/29/25-evening-blank A review of the January 2026 TAR located in the EMR revealed blanks in the documentation portion for the following dates: 1/2/26-evening-blank 1/3/26-day-blank 1/5/26-day-blank 1/8/26-day-blank On 1/22/26 at 11:31 AM, the surveyor interviewed the resident's Licensed Practical Nurse #1 (LPN/#1) who stated the CNAs (Certified Nursing Aides) were responsible for emptying the catheter bags and then reporting the amount of urine to the nurses who would record the urinary output amount in the EMR. At that time the surveyor reviewed with the LPN Resident #8's December 2025 TAR and January 2026 TAR. When asked what the blanks in the TAR meant she stated there should not be any boxes left blank, the empty box meant the nurse did not record the amount of urine output. On 1/22/26 at 4:26 PM, the survey team met with the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the facility's Nursing Consultant (NC). The DON stated there should be no blanks left on the TAR, if there were blanks then the work was not done. A review of the facility policy titled, Catheter Care, Urinary updated 1/26 indicated that the purpose of this procedure is to prevent catheter-associated urinary tract infections, and under Infection Control included . 2. b.) be sure the catheter tubing and draining bag are kept off the floor . .the purpose of this procedure is to prevent catheter-associated urinary tract infections and included under Input/Output to observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor. Maintain an accurate record of the resident's daily output, per facility policy and procedure. NJAC: 8:39-27.1 (a)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to: a.) assess a resident's oxygen setting to ensure that the resident was receiving the correct amount of oxygen as ordered by the physician and b.) properly store a Bi-level positive airway pressure (BiPAP), machine [helps breathing by delivering air through a face mask], in a bag when not in use, in accordance with professional standards of practice. This deficient practice was identified for 1 of 1 (one of one) resident (Resident #191) reviewed for respiratory care and was evidenced by the following: On 1/15/26 at 12:35 PM, during the initial facility tour, the surveyor observed Resident #191 lying in bed and the resident received three liters (3L) of humidified oxygen (O²) via an oxygen concentrator (a medical device that filters and delivers oxygen from the air). The surveyor also observed that the Resident's BiPAP machine was not stored in a plastic bag as ordered when not in use. On 1/16/26 at 9:29 AM, the surveyor observed Resident #191 lying in bed and the resident received 3.5 liters (3.5L) of humidified oxygen (O²) via an oxygen concentrator. The surveyor also observed several dated plastic bags in the room; however, the resident's BiPAP machine was not placed in a bag as ordered. On 1/16/26 at 11:42 AM, the surveyor reviewed the medical record for Resident #191. A review of the admission Record, an admission summary, indicated that Resident #191 was admitted to the facility with diagnoses that included, but were not limited to chronic obstructive pulmonary disease (COPD), [a chronic lung condition that makes breathing difficult]. A review of the quarterly Minimum Data Set (MDS), an assessment that guides a resident's care, dated 12/26/25, indicated that Resident #191 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which reflected severe cognitive impairment. A review of the Order Summary Report (OSR) dated as of 1/22/26, included the following physician orders (PO) for Resident #191: A PO dated 1/13/26, for O² at 2L per minute (2L/min), as needed (PRN) every shift. A PO dated 1/13/26, to remove BiPAP machine and place it in a plastic bag, one time a day. A review of the Resident's Individual Comprehensive Care Plan (ICCP) included a focus area, dated 1/4/21, that Resident #191 had the potential for ineffective breathing related to COPD and a history of smoking. Interventions included: Administer oxygen therapy per medical doctor (MD) orders, Document respiratory status every shift as needed when not within resident baseline, and Notify the MD promptly as needed (PRN). However, the PO for O² at 2L/min was not followed, and the MD was not notified for adjustments based on the Resident's respiratory status and care plan interventions. A review of Resident #191's O² levels from 7/25/25 to 1/20/26, revealed that the resident received oxygen on multiple occasions despite O² levels being greater than 94%. (Normal oxygen saturation levels in adults range from 95% to 100%). A review of Resident #191's Progress Notes (PN) from 12/28/25 to 1/2/26 revealed there were no nurse's notes indicating communication with the MD regarding the resident's oxygen (O²) levels and O² settings, despite the ICCP specifying that the MD should be notified promptly. On 1/16/26 at 1:48 PM, the surveyor requested Certified Nursing Assistant (CNA #7) to accompany her to Resident #191's room. The surveyor asked CNA #7 to verify the resident's O² setting. CNA #7 confirmed that the resident was receiving 3L of O². CNA #7 further stated that the BiPAP machine should be stored in a bag when not in use to prevent contamination. On 1/16/26 at 1:54 PM, the surveyor interviewed Licensed Practical Nurse (LPN #4) during a tour of Resident #191's room. LPN #4 confirmed that the resident's O² concentrator was set to 3L of O². LPN #4 stated that the O² level was set by the nurse and that nurses were responsible for carrying out the MD's orders. When asked to verify the physician's order for O², LPN #4 accessed the Resident's OSR and confirmed that O² at 2L/min was ordered. The LPN further stated that it is important to follow the MD's orders and that staff should monitor the O² setting to avoid the dangers of over-oxygenation. On 1/21/26 at 11:26 AM, the surveyor interviewed LPN #2, who stated the BiPAP machine should be stored in a labeled bag when not in use for infection control purposes. On 1/21/26 at 12:43 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed that nurses are responsible for (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notifying the MD and resident's family of any changes in O ² settings and the resident's O ² levels, educating the Resident and the Resident's responsible party regarding O ² use. The DON emphasized that excess O ² can lead to negative health consequences. The DON also stated that the BiPAP machine should be cleaned and stored in a dated plastic bag to prevent contamination. The facility policy Oxygen Administration, updated 1/2026, indicated that the purpose of this procedure was to provide guidelines for safe oxygen administration. A review of the facility's CPAP/BiPAP Support policy, revised 3/2015, included that the purpose was . to promote resident comfort and safety. NJAC 8:39-27.1(a)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interviews, record review, and review of facility documents, it was determined that the facility failed to act upon the recommendations made by the Consultant Pharmacist in a timely manner. This deficient practice was identified for 1 of 35 residents (Resident #135) reviewed for medications and was evidenced by the following: On 1/16/26 at 12:52 PM, the surveyor observed Resident #135 ambulating independently in the hallway without an assistive device. At that time, the surveyor attempted to interview the resident who appeared to be confused and was unable to answer the surveyor's questions appropriately. On 1/20/26 at 11:54 AM, the surveyor reviewed the medical record for Resident #135. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: morbid (severe) obesity due to excess calories, schizophrenia, unspecified (a serious mental health condition), anxiety disorder, unspecified, depression, Acute and Chronic Respiratory Failure, Unspecified whether with Hypoxia (deficiency in the amount of oxygen in the tissues) or Hypercapnia (an excess of carbon dioxide in the blood), and Chronic Obstructive Pulmonary Disease (a progressive, inflammatory lung disease that makes it difficult to breathe) (acute) exacerbation. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 1/2/26, included the resident had both a short-term and a long-term memory problem and the resident's cognitive skills for daily decision-making ability was described as severely impaired. A review of the resident's facility provided individual comprehensive care plan (ICCP) included a focus area, dated 1/7/21, for Respiratory, resident has the potential for ineffective breathing related to: DX (diagnosis) COPD, morbid obesity, respiratory failure, smoker. Interventions included: .Observe respiratory status for: rate, depth, and ease, Presence of dyspnea (difficulty breathing), A review of the Order Summary Report (OSR), dated as of 1/27/26, included the following physician orders (PO): A PO, dated 10/20/25, for Fluticasone Furoate-Vilanterol. Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT (micrograms per actuation) 1 (one) puff inhaled orally one time a day for nasal congestion. On 1/21/26 at 10:09 AM, the surveyor reviewed the Consultant Pharmacist Comments Report (CR) for Resident #135, which revealed that on 11/29/25, the Consultant Pharmacist (CP) made a recommendation to clarify and update the diagnosis for the Fluticasone-Vilanterol inhaler (used to treat chronic obstructive pulmonary disease (COPD) to improve breathing problems). Further review of the CR revealed that on 12/31/25, the CP recommended that Resident #135 should rinse their mouth after using Fluticasone-Vilanterol to decrease the risk of oral fungus infections. Please clarify and update the diagnosis. On 1/21/26 at 10:09 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1), who stated she had worked at the facility for one week. LPN/UM #1 stated the CP came into the facility and performed a Monthly Medication Review (MMR) and then sent their recommendations to the Director of Nursing (DON), who then provided the recommendations to the unit managers for review and implementation within a couple of days of receipt. At that time, LPN/UM #1 reviewed the order for Fluticasone Furoate-Vilanterol and stated they should have changed the diagnosis and updated the instructions for the resident to rinse their mouth in accordance with the CP recommendations. On 1/23/26 at 1:04 PM, the surveyor interviewed the DON, who stated that when she received the CP recommendations, she sent them to the unit managers via email and asked them to follow up. The DON stated that there had been a lot of turnover with the management staff. At that time, the DON confirmed that the CP recommendations were not acted upon effectively. The DON further stated that the nurse should have documented that the CP recommendations were conveyed to the physician and indicated if any physician orders were received. On 1/27/26 at 3:39 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON) were informed of the concerns related to the facility's failure to implement the CP recommendations in a timely manner. A review of (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's Pharmacy Services-Role of the Consultant Pharmacist policy, revised April 2019, included: .The consultant pharmacist will provide specific activities related to medication regimen review including: a documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines;. NJAC 8:39-29.3(a)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to properly store and secure medication left at a resident's bedside (Resident #13). This deficient practice was identified on 1 of 5 nursing units (5th Floor) and was evidenced by the following: On 1/20/26 at 10:36 AM, the surveyor in the presence of another surveyor, observed Resident #13 lying in bed, with their eyes closed, fully dressed with a blanket over their legs. On the bedside table there was a clear plastic cup containing a clear liquid and a plastic medicine cup with two round pills, one pink-colored pill, and one slightly smaller light orange pill. The resident had their privacy curtain pulled to the side of their footboard on the bed, inhibiting access to the nightstand. The resident did not respond to surveyor inquiry. At that time, the surveyor did not observe any residents ambulating independently near the resident's room without staff present. On 1/20/26 at 10:37 AM, surveyor #2 went to find the nurse and the Certified Nursing Aide (CNA) assigned to Resident #13, while surveyor #1 stayed with the resident. When CNA #2 arrived at the room and was shown the pills in the medicine cup on the nightstand she stated the medication should not be left there, and that the resident was supposed to take their medication while the nurse was in the room. On 1/20/26 at 10:41 AM, the surveyor interviewed the Licensed Practical Nurse #5 (LPN #5) who acknowledged the medications found at the bedside and stated she had given Resident #13 their medications in the hallway and not in their room. LPN #5 stated that the medication in the cup was not from her morning medication pass. LPN #5 confirmed that medications should not be left at the bedside, and should be secured in a medication cart. On 1/20/26 at 11:01 AM, the surveyors interviewed the fifth floor Registered Nurse Unit Manager #2 (RN/UM #2) who acknowledged the medications on the bedside table, she was unable to identify the pills in the medicine cup. RN/UM #2 confirmed there should be no medications left unsecured at the resident's bedside. RN/UM #2 explained the medication process and stated that the nurse must observe that the resident has taken the medication, to ensure the resident was therapeutic, and must ensure that no medication was left around for another resident to take. RN/UM #2 then took the medications to secure them. On 1/20/26 at 1:14 PM, the Director of Nursing (DON), RN/UM #2 and LPN #5 went to the medication cart to review the orders and identify the pills left in the medication cup. Upon review the DON determined the medications were Aspirin 81 mg (milligram) chewable tablet (a medication used to prevent blood clots) and Vitamin B12 100mcg (micrograms) tablet (a supplement used for vitamin deficiency). The DON confirmed medications should not be left at the bedside because they must be secured for the safety of all the residents. A review of the facility's undated Storage of Medications policy included. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. The nursing staff is responsible for maintaining medications storage and preparation areas in a clean, safe and sanitary manner. NJAC 8:39-29.4(h)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Lakeside Blvd Bayville, NJ 08721	
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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to properly dispose of garbage and refuse in one of one garbage disposal areas. This deficient practice was evidenced by: On 1/15/26 at 10:25 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the facility's garbage disposal area. The surveyor observed container tops, food waste, plastic utensils, pieces of wood and cardboard boxes, as well as used gloves and face masks discarded on the ground adjacent to the garbage disposal containers. The surveyor also observed low-lying black tubing and additional black tubing running along the ground in the garbage disposal area. During the tour, the surveyor interviewed the FSD regarding the facility's garbage disposal practices and the presence of black tubing in the garbage disposal area. The FSD stated that maintenance of the facility's garbage disposal areas was a shared responsibility between the dietary and maintenance departments. The FSD confirmed that all trash and discarded items were expected to be placed inside the disposal containers and not discarded on the ground to maintain a safe and sanitary environment. The FSD further stated that the black tubing should not be located on the ground or hanging in a low position due to safety concerns. On 01/21/26 at 2:00 PM, the surveyor interviewed the Director of Maintenance (DOM), who stated that trash should be properly disposed of by placing it inside the disposal containers and not on the ground. The DOM further stated that the black tubing should always be maintained in a safe manner. The DOM explained that proper disposal and maintenance were important to prevent contamination and ensure a safe, sanitary environment. On 01/22/26 at 4:28 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that it was unacceptable for the garbage disposal area to be littered with trash, used items, or have tubing located on the ground. The LNHA further stated that she expected the garbage disposal area to be maintained in a sanitary condition, free of debris, to prevent infection and contamination. The surveyor reviewed the facility's Waste Disposal policy, updated February 2025, which included that all infectious and regulated waste . disposed of in a safe, controlled, and compliant manner to prevent exposure, environmental contamination and regulatory violations NJAC 8:39-19.7(c)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Crystal Lake Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Lakeside Blvd Bayville, NJ 08721	
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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the required members were present during the quarterly Quality Assurance and Performance Improvement (QAPI) Committee Meetings. This deficient practice occurred during 2 of 4 meetings reviewed and was evidenced by the following: On 1/15/26 at 11:39 AM, the surveyor requested to view the last four quarters of the QAPI meeting sign-in sheets. On 1/20/26 at 10:13 AM, the surveyor was provided with the QAPI Committee Quarterly Meeting Sign-In Sheets that were dated 1/23/25, 4/24/25, July 2025, and October 2025. A review of the 4/24/25 Sign-In Sheet revealed that LOA (Leave of Absence) was documented in the signature panel of a mandatory participant, the Infection Control Preventionist (ICP). Further review of the July 2025 QAPI Meeting Sign-In Sheet revealed that the signature panel that was allotted for the ICP's signature was not filled in with any data to indicate the status of the ICP's attendance at the quarterly QAPI Meeting. On 1/23/2026 at 3:04 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. At that time, the surveyor asked the LNHA if the ICP was on leave of absence during two of the four quarterly QAPI Meetings reviewed that were dated 4/24/25 and July 2025? The LNHA stated that the QAPI Meetings were held before both she and the current Director of Nursing (DON) were hired. A Further review of the July 2025 QAPI Committee Meeting Sign-In sheet revealed that both the LNHA and the current DON had signed their names in the signature panel to indicate their attendance at the meeting. On 1/23/2026 at 3:39 PM, the surveyor interviewed the Director of Human Resources and Staffing who stated that the ICP was out on a leave of absence for two quarters, both April 24, 2025, and July 2025 and was not in attendance at the meetings. On 1/23/2026 at 3:50 PM, in a later interview with the LNHA, she stated the Medical Director, LNHA, DON, and the ICP were all required to be in attendance during the quarterly QAPI Committee Meetings. The LNHA stated that the ICP was required to be there, but she maintained that it was prior to her term as the LNHA. A review of the facility's Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership policy, updated 1/2026, included: .the following individuals serve on the committee: Administrator, or a designee who is in a leadership role; Director of nursing services; Medical director; Infection preventionist; and Representatives of the following departments, as requested by the administrator: 1. Pharmacy; 2. Social services; 3. Activity services; 4. Environmental services; 5. Human resources; and 6. Medical records. The committee meets at least quarterly (or more often as necessary). Committee members are reminded of meeting day, time and location via e-mail at least two business days prior to the meeting. NJAC 8:39-33.1 (b)		