STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Rehabilitation Hospital	2381 Lawrenceville Road Lawrenceville, NJ 08648

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to have a system in place to inform and offer written information regarding the option to formulate an Advance Directive. This deficient practice was identified for 2 of 2 residents (Resident #9 and Resident #69) reviewed for AD, and affected all residents who resided in the facility. The evidence was as follows:a. On 1/28/26 at 10:43 AM, Resident #9 was observed in bed, and they were unable to participate in an interview with the surveyor due to confusion. On 1/28/26 at 10:31 AM, the surveyor reviewed the medical record for Resident #9 which revealed the following: A review of the admission Record (an admission summary) reflected that the resident was admitted with diagnoses which included but were not limited to; malignant neoplasm of the prostate (prostate cancer), dementia (loss of intellectual functioning) and peripheral vascular disease (blood vessels usually in the legs become blocked). A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated 1/20/26, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 4/15, indicating that the resident was severely cognitively impaired. The admission Record indicated the resident was listed as a Do Not Resuscitate (DNR- not provided with cardiopulmonary resuscitation if heart stops beating). There was a POLST document (Practitioner Orders for Life Sustaining Treatment form that enabled patients to indicate their preferences regarding life-sustaining treatment) located in the medical record, that indicated DNR and intubate (emergently inserting a tube to assist with breathing) and use artificial airway as needed. The POLST was signed by the Resident Representative (RR) on 11/12/25. There was no documented evidence in the medical record, Progress Notes (PN), including Social Service PN regarding whether the resident had an AD, and if not, determined whether the resident/RR was offered to formulate an AD. A physician's order (PO) dated 1/13/26, revealed: Do Not Resuscitate (DNR), Order Type: Advanced Directive (there was no AD located in the medical record). Review of the resident's individualized Care Plan contained a Focus area that indicated [Resident #9] has the following AD on record: Copy of POLST. A review of the Social Service assessment dated [DATE] revealed: (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#3. Advanced Directs have been reviewed b. No. b. On 1/28/26 at 10:00 AM, the surveyor reviewed the closed electronic medical record (EMR) for Resident #71 which revealed the following: The admission Record revealed the resident had diagnoses including but were not limited to; hemiplegia and hemiparesis (body weakness and paralysis). There was no Health Care Proxy (a legal document, also known as a medical power of attorney, that designates a specific person, the agent or proxy, to make medical decisions on your behalf if you become unable to communicate or make decisions for yourself due to illness or injury. A component of advance care planning, ensuring your treatment preferences are honored.) The admission Minimum Data Set, dated [DATE] revealed that the resident scored 15/15 on the Brief Interview for Mental Status and was cognitively intact. A Nursing Progress Note (PN) dated 12/4/25 at 15:46 (3:46 PM) revealed Resident #71 was transferred to another facility. A review of the A Late Entry, Social Service Note, Effective Date: 12/4/25 at 12:46 revealed Note Text: Discharge Note: The resident has been approved to transition into long-term care at [Name redacted] Care & Rehabilitation Center and the resident will be picked up in a wheelchair-accessible van on Thursday, 12/04/25, at 3:45 PM . There was no documentation in the medical record regarding an AD. Resident was a Full Code (all life sustaining measures would apply during a medical emergency. Review of the resident's individualized Care Plan contained a Focus area that indicated [Resident #71] has the following AD on record: Copy of POLST located in the medical record (Full Code). The Goal revealed Resident's AD are in effect and their wishes will be carried out through the next review; Date Initiated: 10/27/25. Interventions included and Date Initiated 10/27/25 The resident is capable of making informed consent regarding their health care decisions; Discuss advanced directives with the resident and/or appointed health care representative on admission and as needed; The appointed health care representative will make all decisions if the resident is incapacitated; Notify HCP (Health Care Proxy) of any change in patient condition or POC (Plan of Care); I am a Full Code. On 1/28/2026 at 11:24 AM, the surveyor interviewed Social Worker #1 (SW #1) who was assigned to the fifth floor. The surveyor inquired about the process/procedure for Advanced Directives (AD). SW #1 stated that they asked the residents and families if they had an AD, if they had an AD, SW #1 would put the AD in their Electronic Medical Record (EMR). SW #1 stated that the facility also completed a Practitioner Orders for Life-Sustaining Treatment (POLST- is not an AD and is used as a portable medical order in an emergency) with residents. The Medical Doctor (MD) reviewed them and obtained final signatures. She further explained that a POLST form was completed if they did not have an AD. SW#1 stated she did not inform or provide residents or resident representatives with educational material regarding AD. SW #1 stated that she told residents and resident representatives that there were sites online they could review. The SW could not recall the name of the sites that she provided. On 1/28/26 at 12:25 PM, the surveyor interviewed the Unit Manager (UM) regarding AD. The UM stated that she was unsure if educational material regarding Advance Directives (AD) was provided to residents and/or legal representatives. The UM stated that the Medical Doctor (MD) spoke with the patient and/or loved one and had them sign the POLST form. The POLST form was uploaded into the EMR and the nurse updated the code status if needed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/28/26 at 1:48 PM, a second surveyor interviewed two Social Workers (SW #1 and SW #2) in the presence of the survey team. SW #1 stated she was responsible for the 2nd floor and Social Worker #2 stated she was responsible for the 5th floor. When asked about their roles, SW #2 stated that discharge planning was initiated on the first day, they advocated for their residents also. When asked specifically what their role was in the Advanced Directive process, SW #2 stated, Do you mean a POLST form? SW #2 then stated, we don't review Advanced Directives, we can give them a link for the computer. The surveyor again addressed both SW #1 and SW #1 to clarify if they reviewed AD with the residents, and both responded, No. On 01/29/26 at 11:35 AM, the surveyor conducted a telephone interview with Resident #71 and their spouse and currently resided in the facility that they were transferred to. When asked if the former facility informed them about formulating an AD, or provided information regarding an AD. Resident #71 stated, they never offered anything related to an AD. On 1/30/26 at 11:42 AM, the DON and LNHA confirmed that they do not have a process in place for AD. A review of the facility's policy Advanced Directives updated 6/2023, included: Policy: Residents of the facility will be informed of their right to formulate an Advanced Directive. Policy Interpretation and Implementation: Upon admission, the resident will be provided with written information concerning the right to formulate an advanced directive if he or she chooses to do so. If the resident is not competent to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. NJAC 8:39-9.6 (a)(b)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on interview and review of documents it was determined that the facility failed to ensure residents who required Medicaid were admitted to the facility per the facility SNF/NF (Skilled Nursing Facility/Nursing Facility) designation from the Centers for Medicare/Medicaid (CMS) and per the New Jersey Department of Health (DOH). The deficient practice affected all residents admitted to the facility and was evidenced by the following: On 01/27/26 at 11:04 AM, during the facility entrance conference held with the Licensed Nursing Home Administrator (LNHA), and an Executive [NAME] President (EVP) the surveyor asked what the resident population of the facility was. The LNHA confirmed the residents were all short term, and there were no long-term care residents at the facility. When asked if the facility's residents met and had an organized group meeting (Resident Council Meeting).The LNHA stated there was no resident council meeting held at the facility. When the surveyor again asked about long-term care residents at the facility, the LNHA confirmed that there was no long-term care resident at the facility, only short term. The LNHA stated when residents needed long-term care placement, the facility could transfer them next door or refer them (a separate SNF/NF facility with a different CMS provider number and was located in close proximity to the facility). When asked how long the facility had been designated only a short-term facility without having any long-term care residents, the LNHA stated she had been there for 3 years and there was no long-term care. When asked what the population was for the 2nd and 5th floor, both the LNHA and EVP confirmed there were only sub-acute residents at the facility (skilled nursing and sub-acute residents are billed at a higher rate for certain skilled services).On 1/27/26 at 11:45 AM, the surveyor accessed the facility website which revealed the facility was a physical rehabilitation hospital that offers a wide range of acute and sub-acute physical rehabilitation services .We boast .56 subacute rehab beds (licensed bed # per CMS) .On 01/27/26 at 12:13 PM, the [NAME] President of Operations (VPO) for the parent company introduced himself to the survey team. When the surveyor asked about the type of facility and the type of residents admitted to the facility. The VPO stated, the facility was a sub-acute facility. When asked about if the facility currently had any residents stay for long long-term care that had Medicaid as a payer source. The VPO stated, if residents had a need (and were on Medicaid) there were no Medicaid residents that had requested to stay at the facility for long-term care. The surveyor reiterated the facility's Medicare/Medicaid designation from CMS and the VPO stated, they (the company) have other buildings that people can go to if they (the skilled nursing/sub-acute residents) want to stay long term care.On 1/27/26 at 1:05 PM, the surveyor reviewed the facility entrance binder (a binder that contained the required recertification survey documentation per the CMS entrance conference requirements) that was provided by the LNHA. The tab for Resident Council had a document on facility letterhead that revealed This is a subacute facility and does not have a resident council president. The tab for Facility Assessment was titled, Subacute Facility Assessment. A 44 Page Welcome Packet was identified as the facility admission agreement. The page titled Medicaid revealed Medicaid is a health insurance that is federally, and state funded and is available to Virginia residents through the Department of Medical Assistance Services . Services covered under Medicaid: Room and board, Nursing Services . The How to Apply for Medicaid section identified the New Jersey Department of Human Services, Division of Medical Assistance and Health Services . On 1/28/26 at 8:00 AM, the LNHA provided the Long-Term Care Facility Application for Medicare and Medicaid, which indicated 0 for Medicaid under F8b.On 01/28/26 at 8:56 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPNUM). The surveyor asked what her responsibilities included and the LPNUM stated, she oversaw the 2nd and 5th floor (contained all 56 licensed Medicare/Medicaid beds). When asked if any residents stayed long-term care? The LPN/UM stated, no, they need to go, this is strictly sub-acute. When asked if she had ever attended a (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	care conference for long-term care residents? The LPN/UM stated, it never happened (that a resident stayed at the facility for long- term care) and stated the facility was rehab only and the facility had acute (required a higher level of care and was under a different license designation and was located on the third floor) and sub-acute.On 01/28/6 at 1:48 PM, the surveyor interviewed two Social Workers (SW #1 and SW #2) in the presence of the survey team. SW #1 stated she was responsible for the 2nd floor and Social Worker #2 stated she was responsible for the 5th floor. When asked about the facility, both SW #1 and SW #2 stated it was dually certified (accepted Medicare and Medicaid). When asked if there were any residents that currently had Medicaid as a payor source, they both confirmed there were none. When asked if they could provide the name of one resident that was discussed staying long-term at the facility, they both confirmed that they had none to offer. When asked if the SWs would assist a resident who required a transfer to Medicaid for payment, they both confirmed that they would not assist with helping someone transfer to Medicaid.On 01/30/26 at 11:41 AM, the survey team met with the LNHA and Director of Nursing and again discussed the concern regarding the facility as being self-designated as only a Sub-Acute facility and not following the CMS designation. No additional information was provided.NJAC 8:39-2.1(c)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, it was determined that the facility failed to implement a comprehensive, effective data driven Quality Assurance Program (QAPI) that included self-identifying areas for improvement and maintaining documentation of QAPI initiatives. The deficient practice affected all residents who resided at the facility and was evidenced by the following:Refer to F620, F627, F881 On 01/30/26 at 9:12 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding how the facility determines what was reviewed by the QAPI team and how QAPI plans were developed. The LNHA stated skin issues, and fall concerns were reviewed. The LNHA stated trends were reviewed, including the dates and the trends were analyzed. The surveyor asked what all the current facility QAPI initiatives were. The LNHA stated the facility currently had the following QAPI plans which included:A resident who had an incorrect name band. When asked about the data collected. The LNHA stated it was related to one resident and now the facility was 100% compliant. No additional information or data was provided.Therapy was changing leg bags for the urinary catheters too frequently. Again, the LNHA stated this was related to one resident requesting a leg urinary catheter bag and no additional information was provided.Psychotropic medication consent forms. When asked to show and speak to the specific data related to the concern including the goals. The LNHA stated it was related to the nurses and unit managers. The surveyor asked where the data was presented at the QAPI meeting and there was no additional information to provide.The LNHA stated the last QAPI in effect was related to employee education not completed. When asked how the data was related to the failure of the employees to complete the education, including the root cause of the identified problem, the LNHA could not locate the information. On 01/30/26 at 10:19 AM, the surveyor asked the LNHA if the facility self-identified any concerns related to the admission or discharge process, or any concerns related to social services, the LNHA stated there were no QAPIS for those areas. When asked about any specific QAPI plans for infection control, the LNHA stated there were no QAPIs related to infection control. The surveyor reiterated that the facility was cited for issues with Antibiotic Stewardship during the 9/6/24 survey and concerns regarding the Antibiotic Stewardship process were relayed again during the survey. On 1/30/26 at 11:41 AM, the survey team met with the LNHA and Director of Nursing and reviewed the above conerns. On 1/30/26 at 2:00 PM, during the exit conference, the facility LNHA, Director of Nursing, Executive [NAME] President and Corporate Nurse met with the survey team and confirmed that there was no additional information to provide. The Quality Assurance Performance Improvement Plan, undated and unsigned was provided to the survey team which revealed: Our QAPI plan includes the policies and procedures used to: Identify and use data to monitor our performance. Establish goals and thresholds for our performance measurement. Identify and prioritize problems and opportunities for improvement. Systematically analyze underlying causes of systemic problems and adverse events. Develop corrective action or performance improvement activities. NJAC 8:39-33.1(a)(c); 33.2(a)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review it was determined that the facility failed to investigate, analyze and monitor adverse events and utilize data to develop activities to prevent further adverse events. This deficient practice had the potential to affect all residents who resided at the facility and was evidenced by the following: On 01/30/26 at 9:12 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding how the facility determines what was reviewed by the QAPI team and how QAPI plans were developed. The surveyor asked if incidents were reviewed, including grievances. The LNHA stated skin issues, and fall concerns were reviewed at QAPI. The LNHA stated trends were reviewed, including the dates and the trends were then analyzed. The surveyor asked for the data and information related to the Falls QAPI and the LNHA provided the following information on falls and stated that was the QAPI plan for falls dated March 2025. The Performance Improvement Project (PIP) for Falls revealed that the Problem or Opportunity for Improvement was identified as Falls were trending up in the facility. The Document Root Cause Analysis (Probable causes and scope of the problem) section revealed: 27.3% Falls occurred on Tuesday, 54.5% Falls occurred on Second floor, 36% Falls occurred on 3-11 shift mainly between 8:00 PM and 11:00 PM, 46 (%) occurred on 11:00 PM to 7:00 AM shift mainly between 1:00 AM to 7:00 AM. The Monthly trend for March 2025 revealed 9 Total Falls, 3 falls with injury and 1 person sent to the hospital. The surveyor requested the specific corrective actions related to the causes of falls and any adverse events. The surveyor asked about the time of the falls and what were the root causes? Were the falls tracked and trended and plans to prevent recurrence implemented? The LNHA stated that would have been done independently for each fall and had no information to provide. When asked about the hospitalization related to the fall, she stated that would be an internal risk meeting and none of the internal risk management information would be discussed at QAPI. The LNHA had no information to provide regarding systematically analyzing the root cause of the falls or significant events. When asked if grievances were reviewed at QAPI, or tracked and trended, the LNHA stated that grievances were not reviewed at QAPI. When asked if Reportable Events were reviewed at QAPI, the LNHA stated, that was not part of the QAPI process and the LNHA had no further information to provide. The Quality Assurance Performance Improvement Plan, undated and unsigned was provided to the survey team which revealed: Our QAPI plan includes the policies and procedures used to: Identify and use data to monitor our performance. Establish goals and thresholds for our performance measurement. Identify and prioritize problems and opportunities for improvement. Systematically analyze underlying causes of systemic problems and adverse events. Develop corrective action or performance improvement activities. NJAC 8:39-33.1(a)(c); 33.2(a)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on observation, interview, and record review of pertinent facility documentation, it was determined that the facility failed to ensure a system was in place to utilize an infection assessment tool prior to prescribing antibiotics and ensure the Antibiotic Stewardship program was implemented consistently. This deficient practice was identified for (2) of two (2) residents reviewed for antibiotic stewardship, (Resident #84 and Resident # 69) and was evidenced by the following: a. On 1/28/26 at 12:00 PM, the surveyor reviewed Resident #69's electronic medical record which revealed the following: The admission Record revealed the resident had diagnoses which included, but were not limited to: dementia, retention of urine and benign prostatic hyperplasia (enlargement of the prostate gland). A Nurse Practitioner Note dated 12/5/25 at 10:42 PM revealed reports discomfort to foley catheter insertion area . UA (urinalysis) results discussed, Macrobid started, cultures pending . A Health Status Note, nurse progress note dated 12/5/25 at 11:10 PM, revealed patient stated, started on Macrobid 100 mg today for UTI X 10 days . A review of the Order Summary report revealed a Physician Order, dated 12/5/25 for Nitrofurantoin (Macrobid an antibiotic (ABX) typically used to treat urinary tract infections) Macrocrystal Capsule 100 MG (milligram), Give 1 Capsule by mouth every 6 hours for UTI for 10 days. The Medication Administration Record (MAR) for December 2025 revealed the Nitrofurantoin was administered on 12/5/25 at 6:00 PM, and on 12/6/25, 12/7/25, 12/8/25 at 6:00 AM, 12:00 PM and 6:00 PM, and on 12/9/25 at 6:00 AM, 12:00 PM and 6:00 PM. The Nitrofurantoin was administered for 4 days and not 10 days per physician order. On 01/28/26 at 2:23 PM, the surveyor interviewed the Infection Preventionist (IP) in the presence of the survey team. The surveyor asked about the ABX stewardship process. The IP stated it was to optimize and appropriately use ABX. The surveyor asked if a nationally recognized tool was used, and did the IP track and trend usage of antibiotics. The IP stated the tool was Mcgeer and it was embedded into the electronic medical record system. The IP stated that typically she would complete the form within 24 hours of when an antibiotic was ordered. When asked if this was completed for Resident #69's antibiotic order that was not completed, the IP stated, I did not do it for Resident #69, it should have been filled out. The IP continued and stated she attended weekly risk meetings to discuss the ABX usage with the Director of Nursing and physician. When asked if the ABX usage was tracked and trended and documented. The IP was unable to provide documentation regarding the antibiotic stewardship process at that time. On 1/28/26 at 3:00 PM, the surveyor interviewed the physician (MD) regarding the ABX order that was not completed for Resident #69. The MD stated the NP may have put the ABX order in presumptively, pending urinary cultures. On 1/29/26 at 9:35 AM, the surveyor interviewed the IP again regarding the antibiotic stewardship process in the presence of the survey team. The IP stated when an ABX is ordered for a resident that it is reviewed in a clinical meeting, and the Director of Nursing (DON) would also tell her to review and after the surveyor inquired about the antibiotic stewardship yesterday, the IP created a binder. The IP (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated that any resident that was admitted on ABX was also supposed to be checked to ensure the ABX was appropriate. The IP started that once she became aware of what residents were on antibiotics by getting a weekly report, she would also initiate a care plan. The IP confirmed that she would not complete the tool prior to an ABX being initiated as she was not always made aware. The surveyor asked how the facility ensured the process for reviewing the ABX was completed timely. The IP stated that the review of the ABX should be completed prior to the initiation of the ABX. When asked about a policy for completing the tool prior to initiation of ABX, the IP stated, there is no policy regarding who is supposed to complete the form for the infection screening for the ABX usage. The IP stated after surveyor inquiry, the facility now had implemented an ABX tracking form. b. On 2/5/26 at 10:11 AM, the surveyor observed the resident in bed watching television. The resident had a PICC (peripheral intravenous catheter) line visible on the left upper arm. The resident informed the surveyor that they were admitted post-surgery for rehabilitation. The resident reported also that the line was difficult to flush, and it took a long time over an hour for the medication to infuse, and they discussed the concern with the nurse. The surveyor reviewed the medical records of Resident #84. The admission Record (an admission summary) revealed the resident was re-admitted to the facility with diagnoses which included but were not limited to: type, type 2 diabetes, pain in left foot, difficulty in walking. The Progress notes (PN) dated 1/28/26 revealed that the resident was found to have a wound infection and was started on antibiotic. The culture completed at the hospital was positive for MSSA (Methicillin Susceptible Staphylococcus Aureus) a common staph bacteria that causes infections, and Pseudomonas (a common opportunistic bacterium that causes infections particularly in healthcare settings) The resident was receiving cefepime Hydrochloride (a powerful, fourth-generationcephalosporin antibiotic that treat severe bacterial infections), 2 grams intravenously every 12 hours for infection. The January 2026, electronic Medication Administration Record (eMAR) revealed a Physician Order dated 1/20/26 for Cefepine 2 gm intravenously twice daily for 2 weeks. On 1/26/26 at 9:20 AM, the surveyor met with the Infection Preventionist (IP) and requested all the policies on Infection control. During an interview with the IP the surveyor inquired regarding the tool used to monitor and track infection at the facility. The IP stated that the facility used the McGeer Criteria. The IP further stated that she conducted Risk meeting for antibiotic weekly, reviewed and discussed the criteria, monitor response, discussed with primary physician to help determine if the antibiotic is needed. The surveyor required the data collected for the residents currently on antibiotic included Resident #84 A review of the Revised McGeer criteria for antibiotic use in Long Term Care facility revealed the following: Key Aspects of McGeer Criteria: Purpose: Surveillance and tracking infection rates in nursing homes. UTI (Non-catheterized): Requires at least one symptom (e.g., acute dysuria, fever, new incontinence) (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	plus a positive urine culture (≥105is greater than or equal to 10 to the fifth power ≥105 CFU/mL). UTI (Catheterized): Requires one or more signs (e.g., fever, suprapubic pain, delirium, rigors) plus a positive culture (≥105is greater than or equal to 10 to the fifth power ≥105 CFU/mL). Infection Types: Includes, but is not limited to, UTI, respiratory tract infections, skin/soft tissue infections, and gastrointestinal infections. Differentiation: Focuses on new or changing symptoms compared to the resident's baseline. These criteria are essential for antibiotic stewardship in LTC settings to distinguish true infections from colonization. The IP could not provide documentation that the McGeer criteria was being used. The IP stated that the facility had a computer-generated tool and all she had to do is to enter the data on the computer. Th IP could not comment on how the data was being analyzed and how the trending and tracking was done. A review of the facility's policy titled, Antibiotic Stewardship -Review and surveillance of Antibiotic se and outcomes dated December 2016 revealed the following: Antibiotic Usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decision making for improvement of individual resident prescribing practices and facility-wide antibiotic stewardship. Policy interpretation and implementation. The IP or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. Therapy may require further review and possible change changes if: The organism is not susceptible to antibiotic chosen. The organism is suspected to narrower spectrum antibiotic. Therapy was ordered for prolonged surgical prophylaxis; or therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. (continued on next page)

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	315127	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Rehabilitation Hospital	2381 Lawrenceville Road Lawrenceville, NJ 08648

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At the conclusion of the review, the provider will be notified of the review findings. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The Antibiotic Stewardship Program dated 12/23, was provided by the Infection Preventionist (IP) indicated the following: Policy statement. Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. NJAC 8:39-19.4 (a) (d)(e)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of pertinent documents, it was determined that the facility failed to honor the right to self-determination related to resident choices for mealtimes for a resident who attended dialysis treatments three times per week. This deficient practice was identified for 1 of 1 resident (Resident # 4) reviewed for dialysis care and was evidenced by the following:On 01/27/26 at 11:49 AM, the surveyor observed Resident #4 in their room and they informed the surveyor that they just returned from dialysis (a treatment that removes impurities from the blood when the kidneys do not function). The surveyor observed an opened breakfast tray on the bedside table and the resident stated that the food was cold. Resident #4 stated that they want to have their breakfast upon return from dialysis and the staff were aware of their preference. Resident #4 stated that staff would leave the tray in the room, and they had to eat the cold breakfast meal after their dialysis treatment.The surveyor exited the room and reviewed the dialysis communication log at the nurses' station which identified Resident #4 left the facility at 5:00 AM on 1/27/26 and returned at 11:30 AM. The staff informed the surveyor that the breakfast cart arrived on the floor at 7:45 AM which confirmed that the breakfast tray was left in the room for almost 4 hours. The surveyor interviewed Resident #4, who stated that they would eat the food and staff never offered to warm the food. The Licensed Practical Nurse (LPN) was at the bedside and informed Resident #4 that it was lunch time, and she would order their lunch tray. Resident #4 stated, I do not want lunch, I want my breakfast tray! On 1/27/26 at 12: 10 PM. the surveyor interviewed the LPN who confirmed that she was caring for Resident #4 but was not familiar with Resident #4's routine. She informed Resident #4 that it was lunch time and would call the kitchen for their lunch tray. The LPN stated the resident was very upset and stated that they did not want a lunch tray, they wanted the breakfast tray. The LPN informed the surveyor that she would call the kitchen and request a breakfast tray for Resident #4.On 1/27/26 at 1:00 PM, during a second interview with the LPN, the LPN stated that if Resident #4 preferred to eat breakfast upon return from dialysis that staff should be aware and honor the resident choice. The LPN stated that it was her first day on the 7:00 AM- 3:00 PM shift and she could not comment on the resident's routine. On 1/27/26 at 1:30 PM, the surveyor conducted an interview with a random CNA assigned to the unit. The CNA revealed that Resident #4 preferred to eat breakfast post dialysis, regardless of the time they arrived back to the unit. She could not comment on whether the food was reheated post dialysis or if dietary department was aware of the resident's preference. On 1/27/26 at 2:15 PM, the surveyor reviewed Resident #4's medical record. The admission Face Sheet (an admission summary) reflected that Resident # 4 was admitted to the facility with diagnoses that included but were not limited to; hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness or reduced motor function of one side of the body) peripheral vascular disease multiple fracture of ribs and diabetes mellitus. The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident # 4 was cognitively intact. Resident #4 scored 13 out of 15 on the Brief Interview for mental status (BIMS). Resident #4 required extensive total assistance with activities of daily living including transfers. Resident #4 also required assistance with all meals. Review of the comprehensive Care Plan revealed a Focus for Dialysis; I need dialysis resulting to End Stage Renal Disease: The Goal: I will have no signs or symptoms of complications from dialysis through next review date; Interventions included Resident received Dialysis Tuesday/ Thursday and Saturday, chair time 6:00 AM. Resident #4's meal preferences related to having the breakfast meal served after the dialysis treatment three times per week was not reflected in the Care Plan. On 1/28/26 at 9:15 AM, the surveyor interviewed the resident again regarding the meal delivery. Resident #4 confirmed that staff were aware of their wish to have their breakfast tray post dialysis. Upon return from dialysis the tray would be left on the table, and they would consume as much as they could. On (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/28/26 at 2:30 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that she was made aware of the issue with Resident #4's breakfast tray, after the surveyor inquiry, and she discussed it with the Unit Manager. The DON stated the Unit Manager informed her that Resident #4 would have a fit if they could not have their breakfast tray upon return from dialysis. The breakfast tray was left in the room for the resident. This DON stated that information was never communicated to dietary services, and the resident was provided with the same breakfast tray that was served in the morning and was left in the room. The DON added that her expectations would be that this information will be documented, shared with all staff and measures would be implemented to honor the resident's preferences.A review of the facility admission agreement included the following: Resident Rights: The resident has a right to a dignified existence, self-determination, and communication with and access to person and services inside and outside the facility, including those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. Respect and dignity: The resident has the right to be treated with respect and dignity including:3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.f. Self Determination: The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) through (11) of this section. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. These rights include the resident's right to: self-determination.NJAC 8:39-4.1(a)22-24

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and document review, it was determined that the facility failed to consistently follow a system to ensure a) prior to hire, all employees were pre-screened to ensure that they had not been found guilty in a court of law of abuse, neglect, or misappropriation, or had findings entered into the state nurse aide registry or against a professional license, and b) a process was in place to maintain documentation to confirm an appropriate pre-screening had occurred for all contracted facility employees which including dietary and housekeeping. The deficient practice was identified for 2 of 39 employee files reviewed that were provided by the facility.The evidence was as follows:On 1/27/26 at 11:04 AM, during entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a list of all employees that were hired since last survey, including name, date of hire, title, and including contracted employees and their files including medical information. On 1/28/26 at 10:38 AM, the LNHA provided the list of employees, status, position, department, and date hired and their human resource and medical files. On 1/28/26 the surveyors reviewed thirty-four employee files provided by the facility and provided a list of concerns/missing items to the LNHA. Employee #1, with date of hire 10/1/25, was noted to have a background check ordered and completed 10/3/25. Employee #1's timecard shows that the employee worked 10/1/25, 10/2/25, and 10/3/25.On 1/30/26 at 9:43 AM, the facility provided an additional four files of dietary employees and informed the survey team that dietary (the kitchen) is outsourced through an outside vendor with a service contract dated 10/30/25. The surveyor reviewed the additional files. Employee #28 with date of hire 1/3/26, an employee of the dietary vendor, was noted with positive findings on his background check including:Possession controlled dangerous substance/analog, 3rd degree, with an offense date of 3/24/23 and a sentence date of 7/12/24. Disposition was guilty and sentenced to jail 476 days credit, prison 5 years, total fines $2175.Manufacture/distribute controlled dangerous substance or intent to manufacture/distribute controlled dangerous substance, 3rd degree, with an offense date of 3/24/23 and a sentence date of 7/12/24. Disposition was guilty.Possession controlled dangerous substance/analog, with an offense date of 10/3/22. Disposition was guilty and sentenced on 7/12/24.Aggravated assault with firearm, 4th degree, with an offense date of 4/11/21. Disposition was guilty and sentenced on 7/19/21 to jail 99 days credit, prison 18 months.Possession controlled dangerous substance/analog, 3rd degree, with an offense date of 3/2/21. Disposition was guilty and sentenced to a fine of $1175. Possession controlled dangerous substance/analog, 3rd degree, with an offense date of 2/5/21. Charge was downgraded to possession controlled dangerous substance - fails to give controlled dangerous substance to police - disorderly persons offense on 6/3/21 with a fine of $447Obstruct the Administration of Law-Obstruct criminal investigation, 4th degree, with an offense date of 1/22/19. Disposition was guilty and sentenced to jail 104 days credit, prison 104 days.Possession controlled dangerous substance/analog- 3rd degree and Manufacture/distribute controlled dangerous substance or intent to manufacture/distribute controlled dangerous substance, offense date 10/10/18, downgraded to possession controlled dangerous substance, charge amended to any menace- disorderly person. Disposition was guilty.The surveyor did not find any reference checks or other documentation regarding this employee, his work ethics, or circumstances since last arrest in Employee #28's file. On 1/30/2026 at 10:36 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) what the processes were for hiring someone with a positive background, she stated she will get back to the survey team. She further stated she was not familiar with an employee with the above background. On 1/30/2026 11:35 at AM, the LNHA stated she spoke to the regional manager of dietary vendor who stated he had the candidate for an interview and made a judgement to hire him. On 1/30/2026 at 12:37 PM, the LNHA provided the policy, Background Review and Hiring Decision Authority, dated 1/1/2025, which included:Policy Statement:It is the policy of [Name Redacted] (dietary vendor) to consider employment candidates with a background history on a case-by-case basis provided the background does not include findings or substantiated cases (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	involving resident abuse, neglect, exploitation, or other disqualifying offenses as defined by applicable federal, state, and local regulations. Procedure:1. All candidates undergoing the hiring process shall be subject to a background review in accordance with [Name Redacted] policy and regulatory requirements.2. Candidates with background findings that do not involve resident abuse or disqualifying offenses may be considered for employment on an individual basis. 3. Following completion of the interview process, the Regional Manager shall review the candidate's background information, professional conduct, work history, and overall character.Decision Authority:The authority for the final hiring decision rests solely with the Regional Manager. Based on comprehensive evaluation, the Regional Manager may approve or decline the candidate for employment at their discretion.Guiding Principles:All hiring decisions shall be made with consideration for:Resident and patient safetyProfessional conduct and integrityCompliance with regulatory requirementsAlignment with [Name Redacted] standards, mission, and values.Compliance:This policy is applied consistently to ensure fair hiring practices while maintaining [Name Redacted] commitment to safety, quality care, and regulatory compliance.On 1/30/2026 at 1:07 PM, the LNHA provided the policy, Background Screening Investigations, revised March 2019, which included:Policy Statement:Our facility conducts employment background screening checks, reference checks, and criminal conviction investigation checks on all applicants for positions with direct access to residents (direct access employees)Policy Interpretation and Implementation:1. For the purpose of this policy direct access employee means any individual who has access to a resident or patient of a long term care (LTC) facility or provider through employment or through a contract and has duties that involve(or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the state for purposes of the national background check program. 2. The director of personnel, or designee, conducts background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreement and completed prior to employment. 6. Any information (e.g., court actions) discovered through the course of the background investigation that indicates that the applicant is unfit for employment in a nursing home (for example, convictions involving child abuse, sexual assault, theft, assault with a deadly weapon, etc) is reported to the individual's appropriate licensing boards. The LNHA was asked to provide her reference for the regulations referenced in above policy.01/30/2026 1:08 PM LNHA brought another policy Disqualifying Criminal Events for Employment dated 1/1/2025, which included:Policy Statement:[Name Redacted] (dietary vendor) is committed to maintaining a safe, ethical, and compliant environment for residents, patients, staff, and visitors. Certain criminal offenses are deemed incompatible with employment at [Name Redacted] due to the risk posed to vulnerable populations, organizational integrity, and regulatory compliance. Individuals with confirmed findings of disqualifying criminal events are not eligible for employment. Scope:The policy applies to all:Employment candidatesEmployees under reviewContractors, agency personnel, and volunteers, where applicableDisqualifying Criminal Events:The following criminal offenses are considered automatic disqualifiers for employment with [Name Redacted], subject to applicable federal, state, and local law.Crimes Against Persons:Murder or attempted murderManslaughterHomicideKidnappingHuman TraffickingAbuse-related OffensesResident or patient abuse, neglect, or exploitationElder abuseChild abuseSexual OffensesSexual assaultRapeSexual batteryAny offense requiring registration as a sex offenderReview and Determination:All candidates shall undergo background screening in accordance with [Name Redacted] policy and applicable regulatory requirementsAny confirmed finding of a disqualifying criminal event shall result in automatic disqualification from employment considerationOn 1/30/2026 at 1:09 PM, the surveyor interviewed the Human Resources (HR) Manager, who stated she was unaware of the kitchen vendor employees' background checks. [Name Redacted] is separate, I don't check on them. When asked what the process was for in-house employee candidates, she stated corporate runs the background (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checks and sends any that are flagged, then a checklist is completed including charges, outcomes, is it harmful to hire, comments, supply good references, and statements. The application and information are then submitted to LNHA, who reviews and chooses yes or no, then to regional who signs off, then back to HR.When asked if she would expect the dietary vendor to have a similar process, she answered They should.On 1/30/2026 at 1:25 PM, the HR manager provided the facility policy for background investigations and checklist for positive findings. The surveyor reviewed facility provided policy, Process for the Positive Background Check, revised January 2021, which included:When a facility receives a positive background check result from a criminal background check, they will complete this form.The facility will contact the candidate, provide a copy for them, review the results of the background check with them and request a statement regarding the conviction.The facility will complete page 2, reviewing the candidates' full history, unless the conviction disqualifies them, by regulation, for employment in a nursing home. After assessing the candidate's suitability for the position, the Administrator will render a decision whether to continue with the employment process with the candidate.The form and backup documentation, i.e. statement and background check, is reviewed for completeness by [Name Redacted] Consulting Services. The surveyor reviewed the form Positive Background Check list, revised January 2021, which included:Applicant's name, date of background check, and requested position. Criminal record and referral history summary included in a table format: referral, criminal charge or conviction; date of incident; number of years since concerning behavior; age at time of criminal history; could the conviction be a concern to resident/patient safety or security, and need for additional information. There is also a box for any other pertinent information and the administrator's signature and title and date.A review of second page included whether the positive background was provided to and reviewed with the employee and whether the employee provided a statement of the details surrounding the positive finding. Second page also included area for the administrator to review employment history, references and determination for employment.The surveyor reviewed the contract for the dietary department with [Name Redacted] dated 10/30/25, which included:Service provider's fixed responsibilities:With respect to the fixed dining service, Service Provider shall provide:All staffing responsibility including:Background checks for Company employees, in compliance with applicable federal and state lawNo further information was provided by the facility.N.J.A.C. 8:39-9.3(b)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure a thorough investigation was completed to determine abuse or neglect had not occurred after a resident sustained a fall while attempting to transfer self to the bathroom. Resident #55 reported rough handling by the Licensed Practical Nurse (LPN) who assisted them from the floor to the wheelchair. This deficient practice was identified for 1 of 1 resident (Resident #55) reviewed for accidents and was evidenced by the following:On 1/27/26 at 10:58 AM, during the initial tour, the surveyor observed Resident #55 seated in a wheelchair in their room. Resident #55 stated, on 1/25/26, I had to go to the bathroom, I rang the call bell and called out for help. No one responded to the call bell for 45 minutes. The urine started to come out, so I attempted to get out of bed by myself, I fell on the floor and hit my head. Resident #55 continued and stated, the Licensed Practical Nurse (LPN) grabbed me from behind, threw me in the chair, and hurt my back. Resident #55 informed the surveyor that they reported the incident to the Unit Manager and was told that the nurse would not be assigned to care for them anymore. On 1/27/26 at 1:00 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #55 which revealed the following: admission Minimum Data Set (MDS), an assessment tool, dated 1/16/26, indicated Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognitive function. The MDS was coded that the resident had one fall since admission, and a diagnosis that included but not limited to malignant ascites (excessive fluid in the abdomen related to cancer), anxiety, depression (mental health condition), Diabetes Mellitus (DM) (difficulty regulating blood sugar), Cerebrovascular Accident (CVA) (stroke) and heart failure . A review of the individual comprehensive care plan (ICCP) included a Focus area dated 1/10/26, that the resident was at risk for falls; Goals included that the resident would remain free from fall related injury. Another focus area dated 1/10/26, identified the resident was at risk for falls, with an Intervention that the resident received diuretics and may need to void frequently and quickly. Routinely check and offer/provide assistance with toileting.A further review of the EMR revealed a progress note dated 1/25/26 at 11:26 PM, noted resident found on floor by the Certified Nursing Assistant (CNA). Call light was not on. Patient yelled from the floor. Staff nurse notified, supervisor and Director of Nursing (DON) notified. MD notified. New order for neuro checks to be started. Family notified. Continued monitoring for patient. Vital Signs Stable, no acute distress noted.A review of the facility provided one page document titled Incident Report and dated 01/27/26 at 9:55 PM, which revealed:Status: ClosedIncident Date/Time: Sunday, January 25, 2026, 10:30 PM, The second page was titled Details:Fall Type: Found on floorFall Witnessed: NoPosition when found: laying The facility was unable to provide any additional information and or statements until after survey inquiry on 1/28/26. The statements provided after surveyor inquiry were dated 1/28/26 three days after the incident occurred and revealed the following: The Certified Nursing Assistant (CNA) documented the following statement: I heard someone shouting, no call light was on. I entered the room and observed Resident #55 on the floor. The resident wanted me to pick them up. I left the room to inform the nurse, then I saw the Nursing Supervisor in the hallway, I alerted both the nurse and the nursing supervisor that Resident #55 was on the floor. The nurse transferred the resident from the floor to the wheelchair.The nurse assigned to the resident provided a verbal statement on 1/28/26. The following was documented:On 1/25/26 at 10:30 PM, the CNA came to the nursing station and reported that Resident #55 was on the floor. The resident was yelling, Help me. I found the resident on the floor and water on the floor. The resident yelled, Get me up. I informed the resident that I was waiting for the supervisor to evaluate. The resident denied hitting their head. I bent down, put my arms under their arms from the front, and lifted them into the wheelchair safely. I educated the resident to use the call bell. The resident yelled at me and asked me to get out. So, I stepped outside.A statement documented by the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN (Nursing Supervisor) dated 1/28/25 revealed the following: At about 10:30 PM on 1/25/26, I followed the nurse to Resident #55's room. I found Resident #55 on the floor with their head against the stand. The resident yelled, Get me up. After evaluating the resident, the nurse assisted Resident #55 by supporting them under their armpit as they were safely lifted into the chair. No complaints of pain or discomfort during or after transfer. The nurse then educated the resident to use the call bell. Resident #55 yelled at the nurse, used profanities and asked the nurse to get out of the room. On 1/28/26 at 12:42 PM, the surveyor interviewed the DON regarding Resident #55's fall incident that occurred on 1/25/26. The DON stated that she saw the resident the next morning on 1/26/26 and Resident #55 did not tell her that they didn't like the way the nurse put them in the chair. The DON had no documentation regarding that interaction to provide to the surveyor. The DON further stated that she was made aware of the allegation on 1/27/26 (2 days after the incident occurred), when she spoke to Resident #55 when she performed evening rounds with the Administrator. On 1/29/26 at 1:58 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the process/procedure for investigating incidents, accidents and abuse and neglect. The Administrator stated when a resident was found on the floor it should be investigated at that time, we get statements. The Administrator further added that the LPN should have documented the details of the fall to include a physical assessment in the EMR and statements regarding the fall incident should have been obtained at the time when the fall occurred. Upon inquiry, the LNHA stated, when a resident had a need and the need was not met to it could be neglect. On 1/29/26 2:43 PM, the surveyor conducted a telephone interview with the LPN, the LPN stated that he scooped them up from the arms and put them in the chair. I checked the call light, and it was working. The resident yelled at me and said, get out of the room. The LPN stated that the and the Supervisor LPN heard Resident #55 yell at him. On 1/29/26 at 3:46 PM, the surveyor conducted a telephone interview with the supervisor LPN. The Supervisor LPN stated that resident #55 was on floor by the bed and there was yellow liquid on the floor. Resident #55 stated help me get off the floor. The LPN stood in front of the resident and assisted the resident under their arms and placed them in the chair. The Supervisor LPN stated that the resident was upset and agitated with the situation and stated I don't want him taking care of me. The Supervisor LPN told the LPN to step out of the room. The Supervisor LPN stated that Resident #55 was removed from the LPN's assignment. The Supervisor LPN stated when she saw the DON that night I reported it. I believe I told the DON that Resident #55 was upset with the LPN. The Supervisor LPN stated that the DON was in the facility that night because of the snowstorm. The Supervisor LPN stated that she was not aware of any follow ups and she cannot remember if she reported this to the Unit Manager (UM) but stated the DON was aware of the incident. On 1/30/26 at 11:41 AM, the surveyor informed the DON and LNHA of the concerns related to the investigation. On 1/30/26 at 2:00 PM, the LNHA,DON Executive [NAME] President and Corporate Nurse met with the survey team for the exit conference and no additional information was provided. A review of the Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy, Version October 2022 revealed: The resident abuse, neglect and exploitation prevention program consists of a facility-[NAME] commitment and resource allocation to support the following objectives: 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; b. neglect of residents .9. Identify and investigate all possible incidents of abuse, neglect, mistreatment . A review of facility policy Accidents and Incidents- Investigating and Reporting, revised July 2017 included:Policy Statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and ImplementationThe nurse supervisor /charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data, as applicable, shall be included on the Report of Incident/Accident form:c. The circumstances surrounding the accident or incident;f. The injured person's account of the accident or incident;I. The condition of the injured person, including his/her vitals;k. Any corrective action;l. Follow up information;m. Other pertinent data as necessary or required; NJAC 8:39-9.4(f)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Rehabilitation Hospital	2381 Lawrenceville Road Lawrenceville, NJ 08648

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to a.) initiate a wound treatment order for a newly identified skin tear (Resident #9), and b.) upon admission to the facility, transcribe a resident's (Resident #7) allergy information documented on a hospital discharge summary. This deficient practice was identified for 1 of 1 resident (Resident #9) who was reviewed for skin conditions and for 1 of 2 residents (Resident #7) reviewed for choices and was evidenced by the following:a. On 1/28/26 at 10:43 AM, Resident #9 was lying in bed he was confused and unable to participate in an interview. The surveyor observed a large bloody gauze type dressing, undated and observed on their left upper arm. On 1/28/26 at 10:31 AM, the surveyor reviewed the medical record for Resident #9 which revealed the following: A review of the admission Record (an admission summary) reflected that the resident was admitted with diagnoses which included but were not limited to; malignant neoplasm of the prostate (prostate cancer), dementia (loss of intellectual functioning) and peripheral vascular disease (PVD). A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 1/20/2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 4/15, indicating that the resident was severely cognitively impaired. A review of the physician's order (PO) revealed that there was no treatment order in place for Resident #9's left upper arm. On 1/28/26 at 11:29AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #9 sustained a skin tear when they slid out of bed and fell on Monday 1/26/26. She stated that she did the dressing this morning, but she forgot to put the date on it. She further stated that the order was to clean the skin tear with Normal Saline (NS) and apply bacitracin daily. The surveyor requested to review the treatment order in the Electronic Medical record (EMR) with the LPN. In the presence of the surveyor the LPN reviewed the treatment record. She confirmed that there was no treatment order for Resident #9's left upper arm. She further stated that the order to cleanse right calf skin tear with NS, pat dry, apply xeroform, abdominal (ABD) pad, kerlix daily and prn were orders that were ordered for the right upper arm skin tear not the calf. The LPN stated this treatments is for their left upper arm they don't have a skin tear on their calf . The LPN showed the surveyor that she signed the treatment order for the calf knowingly that she applied the treatment to the right upper arm. The LPN stated I should have called the Medical Doctor and updated the order. On 1/28/26 at 12:01PM, the LPN informed the surveyor that the Nurse Practitioner (NP) was made aware that there was no treatment in place for Resident's #9's left upper arm and new treatment order was initiated. On 1/29/26 at 9:06 AM, the Director of Nursing (DON) acknowledged that every wound should have their own individual treatment order. The DON confirmed that the resident also had a skin tear on their right calf in addition to the new skin tear on Resident # 9's right upper arm. A review of the facility's policy Wound Treatment revised 4/2023, included: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Preparation Verify that there is a physician order. Review the residents' orders and care plan for special needs of the resident. b.) On 1/27/26 at 11:02 AM, observed Resident #7 seated in a wheelchair, appropriately dressed, wearing a back brace, shoes and was conversant. Resident #7 stated they were allergic to milk that caused vomiting. On 1/27/25 at 11:38 AM, during an interview with the surveyor, the Registered Dietician (RD) stated that within 72 hours of admission, she conducted a Nutritional Assessment for height, weight, food preferences, obtained history of swallowing issues, interviewed the resident for gastrointestinal issues such as nausea, vomiting, constipation, and calculated the calories the resident required. The surveyor reviewed the medical record for Resident #7. According to the admission Record, (AR; face sheet, an admission summary) reflected that Resident #7 was admitted to the facility with diagnoses which included chronic obstructive pulmonary disease and displaced fracture. Further review of the AR, under allergies reflected to be determined. A review of the comprehensive care plan (CP) reflected a focus on nutritional problems, risk of malnutrition related to therapeutic diet, medical diagnosis and non-compliance with diet. The interventions did not reflect milk allergy prior to surveyor inquiry. A review of the 12/8/25 Nutritional Assessment reflected that Resident #7 had no food preferences. Under the section of relevant conditions, food intolerance and allergies were left blank. A review Allergies Roster did not include Resident #7. A review of 1/29/26 Resident #7's preprinted breakfast, lunch and dinner selection sheet, under allergies reflected none and preferences indicated none. A review of Resident #7's hospital record under allergies revealed the following under Allergies and associated reaction: Allergen: Denosumab (other), Atorvastatin (myalgia), Bee Pollen (hives/swollen welts), Calcitonin (rash), Codeine (hives/swollen welts), Dextromethorphan (rash), Guaifenesin (rash), phenylephrine (rash), sulfa (hives/swollen welts), Sulfamethoxazole (unknown reaction), Trimethoprim (hives/swollen welts) and Verapamil (unknown). On 1/29/26 at 12:24 PM during a follow-up interview with the surveyor, the RD stated that she interviewed Resident #7 regarding their food allergy and was not informed of the milk allergy or other food associated allergy. On 1/29/26 at 12:26 PM, during an interview with the surveyor the Licensed Practical Nurse (LPN) informed the surveyor that at admission the admitting nurse spoke with the resident and family to obtain allergy information, reviewed the hospital record and informed the prescriber of any allergies. The LPN was asked why the resident's medical record did not reflect the allergies found in the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospital record. The LPN stated she would immediately inform the physician, the unit manager, and the Director of Nursing. On 1/29/26 at 12:25 PM, in the presence of the surveyor, the RD assessed the resident's nutritional status, and the resident informed the RD of their allergy to milk. On 1/30/26 at 11:41 AM, during a meeting with the survey team, the LNHA, and the DON, the surveyor discussed the concern with Resident #7's allergy information from admission that was not reflected in the resident's medical record. A review of the provided facility policy titled admission Notes, dated 9/2012, reflected under policy statement, that preliminary resident information shall be documented upon a resident's admission to the facility. Further review of the policy included that the admitting nurse must document the following information in the nurses' notes, admission form or other appropriate place, as designated by facility protocol that included any known allergies. NJAC 8:39-11.2 (a)(b), 27.1(a), 29.3(a)1

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and record review, it was determined that the facility failed to ensure a physician order was followed to ensure a resident's heels for a resident who was at risk for skin breakdown. This deficient practice was identified for 1 of 1 resident (Residents #4) reviewed for pressure ulcers and was evidenced by the following:During the initial tour of the 500 Unit on 1/27/26 at 11:30 AM, the surveyor observed Resident #4 lying in bed with the head of bed (HOB) slightly elevated. The surveyor observed that Resident #4's bilateral lower extremities were not offloaded and that Resident #4's feet were lying directly on the mattress. When interviewed, at that time, Resident #4 informed the surveyor that they just returned from dialysis and reported discomfort to the feet.The surveyor exited the room and requested the dialysis communication book from the Licensed Practical Nurse (LPN) assigned to the unit. The surveyor followed the LPN to the room and both. The surveyor continued the facility tour and returned to the resident's room at 12:30 PM. Resident #4 was eating breakfast, and the feet were still in the same position (resting on the mattress).Review of the resident's admission Record revealed that Resident #4 was admitted to the facility with diagnoses which included but were not limited to; Cerebro vascular accident, diabetes mellitus, hemiplegia and hemiparesis.Review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, completed 01/05/26, reflected that Resident #4 had intact cognition. Resident #4 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS). Resident #4 required extensive to total assist with Activities of Daily Living. The MDS further revealed that the resident was at risk for developing pressure ulcers.The assessment reflected that the resident did not exhibit behaviors of rejecting care that would interfere with treatment goals. The resident required one person assist with turning, two- persons assist with toileting. two- persons assist with bed mobility and transfers. Resident #4 was admitted with a deep tissue injury (DTI) to the right heel. The right heel DTI measured: 2 centimeters (cm) x 2. The Braden Scale Evaluation completed on 12/30/25, 7 days post admission, reflected that Resident #4 received a score of 11 and indicated that Resident #4 was at high risk for pressure ulcer. A review of the admission Nursing History and Assessment form dated 12/23/25 reflected that Resident #4 had bilateral heel abrasions, was alert and oriented to self and had no significant lower extremity edema.A review of the Assessment/ Plan for the wound dated 12/30/25 revealed the following: Physical examination findings, treatment plan, and the importance of offloading are discussed with the patient and nursing. Understanding verbalized.Continue preventive measures:Turning/ repositioning every two hours as tolerated.Pressure reduction to the heels and all bony prominences.Float heels while in bed as tolerated, with pillows.Dietitian on board monitoring nutritional status. [pressure relieving cushion brand] to wheelchair.Pressure redistribution mattress-recommending upgrade to low air mattressMinimize friction.Review of the Order Summary Report for Active Orders as of 1/29/26 reflected a physician's order (PO), dated 12/25/25, to offload bilateral heels on pillows when in bed every shift. Another order was for weekly skin assessment on Saturday during the 7:00 AM-3:00 PM shift.Review of the Medication Administration Record (MAR) revealed corresponding POs to offload bilateral heels on pillows when in bed every shift. The surveyor observed that the nurses initialed the MAR that the heels were not offloaded on the following days: 1/3/26, 1/8/26, 1/10/26, 1/13/26 and 1/27/26. Upon inquiry, the nurses informed the surveyor that the resident was out of the facility. Resident #4 left the facility at 5:00 AM and returned to the facility between 11:00 AM-11:30 AM on their dialysis days (Tuesday, Thursday and Saturday). There were no measures in place to ensure that Resident 4's heels were offloaded upon return from dialysis.A review of Resident # 4's Interdisciplinary Care Plan (CP) revealed that the facility's Interdisciplinary Team identified a Focus that resident is at risk for skin breakdown with an intervention to elevate off load/float heels while in bed. Document skin checks weekly and as needed. Report significant changes and declines to the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provider and follow-up as needed. Initiated 12/31/25.A review of the Braden Scale-for Predicting Pressure Sore Risk assessment dated [DATE] as a late entry reflected that the resident was at risk for developing a pressure ulcer. Resident #4 received a score of 11, indicating high risk. The assessment had a total score of 15. A score of 15-18 reflected mild risk for developing a pressure ulcer. The scale further revealed: Moderate risk 13-14High risk 10-12Very high risk 9 or below. On 01/27/26 at 11:30 AM, the surveyor observed Resident #4 in bed. The surveyor observed that the resident's lower extremities were not off loaded and that the resident's feet were rested directly on the mattress.On 01/28/26 at 9:15 AM, the surveyor observed Resident #4 asleep in bed. The surveyor observed that the resident's lower extremities were not off loaded and that the resident's feet were rested directly on the mattress.A physician Assistant Progress notes dated 1/28/26 timed 10:53 PM, reflected the following under impression and plan: Mobility and selfcare dysfunction status post subdural hematoma /Cerebro-vascular accident -continue physical therapy, Occupational therapy, and speech-language therapy.Heel pain with DTI's -floating heels, wound care following.Food and Nutrition: Juven supplementation to enhance wound healing.On 1/29/26 at 11:30 AM, the surveyor observed Resident #4 resting supine in bed with eyes closed, with the HOB elevated. The surveyor observed that Resident #4's lower extremities were not offloaded and that the residents' feet were rested directly on the mattress.On 1/29/26 at 12:30 PM, the surveyor interviewed the CNA assigned to care for Resident # 4. The CNA stated that the 11:00 PM-7:00 AM shift assisted the resident in the morning for dialysis, he was not aware that the resident did not have the heel protectors on, he will put them on after assisting the resident with incontinence care. The CNA was unsure about the heel DTI or any treatment that had been applied.During an interview with the surveyor on 01/29/26 at 2:30 PM, the LPN/Unit Manager (LPN/UM #1) stated that she had not been to the room and was not aware that Resident #4 heels were not offloaded. The Certified Nurse Aide, when giving care, should make sure that interventions were in place when they left the room, and the nurses should check that the resident's heels were off-loaded as ordered.During an interview with the surveyor on 01/29/26 at 2:40 PM, the Director of Nursing (DON) stated that her expectations were that staff should ensure that interventions in place to prevent pressure sores were implemented.On 1/29/26 at 2:50 PM, the above concerns were discussed with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and additional information was requested along with the policy for pressure ulcers prevention.On 1/30/26 at 9:10 AM, the surveyor observed the resident in bed, the feet were not off-loaded. The surveyor asked a Registered Nurse to measure the DTI of the right heel, The area was covered with necrotic tissue, and measured 7 centimeters (cm) x 5 cm. On 1/30/26 at 10:30 AM, the surveyor attempted to interview the UM regarding the worsening of the DTI to the right heel. The UM informed the surveyor that she was on a conference call and could not comment on the wound. On 1/30/26 at 11:16 AM the Regional Clinical Nurse provided a policy titled, Prevention of Pressure Injuries last revised April 2020.The following were documentedPurposeThe purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.PreparationReview the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.Risk AssessmentAssess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition.Use a standardized pressure injury screening tool to determine and document risk factors. MonitoringEvaluate, report and document potential changes in skin.Review the interventions and strategies for effectiveness on an ongoing basis.On 1/30/26 at 11:41 AM, the surveyor informed the Licensed Nursing Home Administrator and Director of Nursing of the above conerns.On 1/30/26 at 2:15 PM, during the facility exit conference, the facility had no additional information to provide.NJAC 8:39-25.2 (b)(c); 27.1 (a)(e)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview, record review and review of pertinent documentation it was determined that the facility failed to ensure that appropriate care and services were provided for a resident with a physician order for a bladder scan upon removal of a indwelling urinary catheter. The deficient practice occurred for 1 of 1 resident reviewed for unplanned hospitalization and urinary tract infection (Resident #69). The evidence was as follows: On 1/28/26 at 12:00 PM, the surveyor reviewed Resident #69's electronic medical record which revealed the following: The admission Record revealed the resident had diagnoses which included, but were not limited to: dementia, retention of urine and benign prostatic hyperplasia (enlargement of the prostate gland). A Progress Note (PN) documented by the Unit Manager (UM) dated 12/23/25 at 7:04 AM which revealed: Went to visit Resident #69 for wound rounds and noted that vomited green colored liquid and was lethargic . and skin extremely hot .patients temperature was 104 Farenheight -F (normal 97 to 99 F) and blood pressure was low .62/48 and 64/58 (normal 120/80 mmHg- millimeters of mercury) . sent out 911 (emergency). A Physician Order dated 12/22/25 at 12:00 AM revealed Void Trial start Remove urinary catheter in am; bladder scan for PVR (an ultrasound machine that measures amount of urine left in the bladder -post -void residual) every 6 hours after removing the catheter for 3 days; straight catheter for PVR > 350 ML (milliliters) every 6 hours for Trial voiding post Foley (catheter) removal for 3 days. The Medication Administration Record (MAR) revealed there was no PVR documented on 12/22/25 at 12:00 PM, 6:00 PM; on 12/23/25 at 12:00 AM and 6:00 AM, all areas were initialed by staff and coded 22 which indicated Treatment not Administered. On 12/23/25 at 12:00 AM, there was no PVR documented, initialed and coded 2 which indicated treatment refused. On 12/23/25 at 6:00 PM; on 12/24/25 at 12:00 AM and 6:00 AM the areas were initialed by staff and coded 3 absent from facility. A progress note signed by the Licensed Practical Nurse (LPN) on 12/22/25 at 14:15 (2:15 PM) revealed the bladder scanner not available . brief wet and voiding on toilet, patient will be monitored for retention. There was no change in the order for the PVR, or indication that the physician was notified. On 01/28/26 at 9:14 AM, the surveyor interviewed the UN who documented that on 12/23/25 at 7:04 AM, Went to visit Resident #69 for wound rounds and noted that vomited green, and asked if she had recalled Resident #69 and that encounter. The UM stated she had to leave the resident to do the wound rounds and left the Licensed Practical Nurse and the Director of Nursing to handle the situation, and then the physician was called and came to see Resident #69. The surveyor asked if the UM had been aware the bladder scan was broken when the physician ordered the machine to be used every 6 hours. The UM stated she was unaware that the bladder scan was broken and that she should have been notified. On 01/28/26 at 9:28 AM, the surveyor reviewed the MAR for Resident #69 with the UM and showed the UM the blank areas in the MAR for the PVR. The surveyor asked should the urine PVR have been listed? The UM stated, yes, she was not told that the bladder scan was not functioning, but that was a concern. On 01/28/26 at 9:32 AM, the surveyor interviewed the LPN that cared for Resident #69 on 12/22/25 at 14:15 (2:15 PM) documented that the bladder scanner not available. The LPN looked at her computer and informed the surveyor that she had received the information in the nursing shift to shift report that the bladder scan was already broken and she observed that the resident was urinating, so it was okay and stated another nurse removed the catheter prior to her shift. When asked if the LPN recalled when the resident was vomiting green and became ill, she stated she told the supervisors and then was instructed to assess the resident by the Director of Nursing. When asked if the machine was important, she stated, it was important but since the resident urinated in the bathroom, it was okay. When asked what the machine would do, the LPN stated it would read how much urine was left in the bladder and would indicate the milliliters which would be documented in the MAR. On 01/28/26 at 10:25 AM, the surveyor interviewed the Registered Nurse, staff educator (RNS). The surveyor asked what the bladder scan was used for when the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	catheter was removed, and how the staff were trained to use it. The RNS stated the bladder scan was important to see if a person was retaining urine. The RNS stated if a resident urinated in the toilet, it could not be documented as an amount, as it could not be quantified, although voiding could be documented. When asked about the bladder scanner being broken and would that be a concern, the RNS stated there would be a few hours as the body holds 30 cc's (cubic centimeter= 1 ounce fluid) every hour and the staff should have reached out to a supervisor if the machine was broken and contacted the physician. When asked about having the LPN assess the resident, the RNS stated, no, LPN's do not perform assessments (only RN's perform assessments). On 1/28/26 at 3:00 PM, the surveyor interviewed the Physician (MD) who cared for Resident #69. When asked about the purpose of the bladder scan, the MD stated it was to make sure the resident was not retaining urine after they had voided. On 1/30/26 at 11:41 AM, the surveyor reviewed the above concerns with the Director of Nursing and Licensed Nursing Home Administrator with the above concerns. On 1/30/26 at 2:00 PM, the facility administration had no further information to provide. NJAC 8:39-27(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services for a resident with a tracheostomy (trach; a device inserted into a surgically created opening in the neck into the windpipe to help with breathing) in accordance with standard of practice. This deficient practice was identified for one (1) of one (1) resident reviewed for respiratory/tracheostomy care (Resident #77) and was evidenced by the following:On 1/27/26 at 11:42 AM, during the initial tour, Resident #77 was observed asleep, in bed, the head of the bed was elevated and was receiving oxygen (O2) via tracheostomy tube. The surveyor reviewed the medical record for Resident #77. According to the admission Record, face sheet, an admission summary, reflected that Resident #77 was admitted to the facility with diagnoses which included but were not limited to: cognitive communication deficit (impairment in communication) and tracheostomy (trach; a device inserted into a surgically created opening in the neck into the windpipe to help with breathing). A review of the comprehensive care plan (CP) that included a focus on altered respiratory status related to respiratory failure, and tracheostomy placement. The interventions included: to administer medications as ordered, monitor effectiveness, side effects, report abnormal findings to the practitioner and to document findings and interventions. A review of the 01/28/26, Order Summary Report included a physician's order dated 1/21/26, for Aerosol Humidity 35% (5 liters) via trach mask (used to keep airway secretions thin to prevent mucus plugging and provide comfort) as needed, downsize trach from #8UN85 (tracheostomy tube size) to #4UN65H, speaking valve (a one-way, air-tight device attached to a trach tube hub that enables communication) 6 to 8 hours as tolerated/room air, increase to 12 hours as tolerated. A review of the electronic Medication Administration Record (eMAR) and the electronic Treatment Administration Record (eTAR) did not reflect documentation that the aerosolized humidification at 35% was checked for accuracy in accordance with the PO and monitored for effectiveness as part of the CP interventions. On 1/28/26 at 1:26 PM, the surveyor observed the resident asleep, tracheostomy mask was loose and heard a gurgling sound from the resident. At that time, the License Practical Nurse (LPN) entered the resident's room, and confirmed observing the same gurgling sound. At that time, the LPN informed the surveyor that a respiratory nurse/campus director of specialty programs, provided tracheostomy care to the resident that same morning. On 1/28/26 at 1:31 PM, the surveyor observed the LPN looked at Resident #77's oxygen indicator. The LPN stated that she made sure that the oxygen was set between 5 and 6 liters per minute (lpm) and confirmed the setting was seen between 5 lpm and 6 lpm. The LPN stated that the oxygen setting was the only thing she checked and that she did not document the humidity settings at all, in the eMAR, eTAR, or progress notes. At that time, the LPN stated, it's okay for the trach mask to be loose like that. On 1/28/26 at 1:52 PM, during an interview with the surveyor, the Campus Director of Specialty Programs (CDSP) stated that she was also the respiratory nurse who provided care to Resident #77 that morning. The CDSP stated that the pulmonologist assessed the resident at the beginning of the week, and the respiratory therapist (RT) provided care to the resident at the end of the week, while she provided the morning trach care to the resident however, she stated the remainder of the care and monitoring was completed by the nurses on the floor, assigned to the resident. The CDSP also stated that the humidity setting was set by the RT and that the nurse caring for the resident could not correct it, in the event it was at the incorrect setting; that would be outside of her scope of practice. At that time, in the presence of the surveyor and the CDSP, the LPN stated that she only looked at the oxygen saturation that was between 5 and 6 lpm, was unaware of the aerosolized humidification setting, and stated that the humidification setting was not in the PO and the CP. On 1/28/26 at 2:30 PM, during a follow-up interview with the surveyor, the CDSP stated that it was not required for the LPN to sign the eMAR or the eTAR, even if there was a physician's order but could not explain how the facility ensured the correct aerosolized (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	humidification was provided and monitored at every shift of the day for Resident #77 who had a tracheostomy. At that time, the CDSP confirmed and acknowledged that the LPN would benefit from more education. On 1/30/26 at 11:41 AM, during a meeting with the survey team, the LNHA, and the DON, the surveyor discussed the concerns with the LPN who was not aware of the aerosolized humidity order for Resident #77, the incorrect oxygen concentration per physician's order, evidence of monitoring of the physician's order for tracheostomy humidification, and the implementation of the CP intervention to document and monitor the resident's response were not found. On 1/30/26 at 2:00 PM, during the exit conference held with the facility DON, LNHA, Corporate Nurse and Executive [NAME] President, the facility informed the survey team they had no additional information to provide. A review of the facility provided policy titled Tracheostomy Care dated 6/25/25, under procedure guidelines, included to check the physician's order. NJAC 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to thoroughly review dialysis communication sheets post dialysis and informed the physician of new recommendations based on laboratory chemistry obtained at dialysis treatment, and ensure the care plan addressed the care of the dialysis access site. This deficient practice was identified for 1 of 1 residents (Resident #4) reviewed for dialysis and was evidenced by the following: a. On 1/27/26 at 11:30 AM during the initial tour of the facility, the surveyor observed Resident #4 in bed. The resident informed the surveyor they just returned from dialysis treatment.On 1/27/26 at 12:10 PM, the surveyor inquired regarding the dialysis communication book and obtained the communication book from the nurse assigned to the unit.A review of the admission Record, an admission summary, revealed the resident had diagnoses that included, but were not limited to end-stage renal (kidney) disease, dependence on renal dialysis, hemiplegia and hemiparesis, and diabetes mellitus.A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 1/5/26, included the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the residents' cognition was intact. Further review of the MDS revealed the resident received dialysis while a resident at the facility. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 12/23/25, that the resident needed dialysis related to renal disease, and that the resident was scheduled for dialysis on Tuesdays, Thursdays and Saturdays with a chair time (appointment time) of 6:00 AM. A review of the Communication book revealed that on 1/24/26 the resident went to dialysis at 5:00 AM and returned to the facility at 11:30 AM. The dialysis communication form reflected an order to discontinue Calcium Acetate 667 milligrams (2 tabs) (a phosphate binder used to treat hyperphosphatemia). Dated 1/24/26. The order indicated that the resident phosphate was 2.9. Normal value: 2.5 to 4.5 milligram per deciliter. The surveyor reviewed the Medication Administration record and noted that the Calcium Acetate was not discontinued. Resident #4 received the Calcium Acetate on 1/24/26 at 12:00 PM and 5:00 PM, on 1/25/26 at 8:00 AM, 12:00 PM and 5:00 PM, on 12/28/26 at 5:00 PM. The Calcium Acetate was discontinued on 1/29/26 after the surveyor inquiry. On 1/28/26 at 10:30 AM, the surveyor reviewed the dialysis communication sheet dated 1/24/26 with the Licensed Practical Nurse, and we both observed that the calcium acetate was not discontinued. There was no documented evidence that the physician was called and informed of the recommendations. Resident #4 received the Calcium Acetate on 1/24/26 at 12:00 PM and 5:00 PM, on 1/25/26 at 8:00 AM, 12:00 PM and 5:00 PM, on 12/28/26 at 5:00 PM. The Calcium Acetate was discontinued on 1/29/26 after the surveyor inquiry. On 1/28/26 at 11:30 AM, the surveyor interviewed the Unit Manager regarding the order. The Unit Manager stated that she was off on Saturday and was not aware of the order. The surveyor then inquired if there was a system in place to review the dialysis communication form for orders, the Unit manager could not comment. The surveyor then inquired regarding if the dialysis communication as checked every night during the 24 hours chart check, the Unit Manager stated, No.On 1/28/26 at 2:30 PM, the surveyor again interviewed the nurse who cared for the resident regarding the facility's protocol for residents on dialysis. The nurse informed the surveyor that the nurses were to assess the residents pre and post dialysis and ensure the communication log was filled out by the nurses and the dialysis center. Upon further inquiry regarding the order noted on the communication form dated 1/24/26, the nurse stated that she did not check for any order. She reviewed the communication log to ensure that the dialysis center entered the resident's weight pre and post dialysis, the vital signs and that the communication form was signed by the dialysis center. On 1/29/26 at 2:30 PM, the surveyor interviewed the Director of Nursing (DON), who stated that it was an oversight, the nurses should have reviewed the communication log and transcribed the order. The physician should have been made aware of the order.b. Resident #4 had a permcath (an access site) on the right chest wall for their hemodialysis treatment. On 1/27/25 at 11:30 AM the surveyor observed the Licensed Practical Nurse assessed the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing on the right chest wall for bleeding and ensure the catheter was intact. The Order Summary Report (OSR) with the start order date of 12/25/25, had an order to check the dialysis access site (Right chest wall) Perma Cath for signs and symptoms of infection, drainage, bruising, and bleeding every shift and as clinically indicated.The resident's comprehensive CP review for access site care revealed that Resident #4 had a CP dated 12/23/25 with a focus for hemo/peritoneal dialysis related to end stage renal disease. The intervention was to check for Bruit and Thrill (audible whooshing sound and palpable vibration felt over a functioning dialysis fistula) .On 1/28/26 at 2:30 PM, the surveyor reviewed the care plan with the Director of Nursing (DON). The DON stated that the care plan should reflect the appropriate site and revise the care plan. On 1/29/26 at 2:15 PM, the above concerns were discussed with the Director of Nursing. The Director of Nursing revised the care plan to reflect the right access site. The DON stated that staff will be educated.On 1/30/26 at 11:41 AM ,during the pre-exit conference held with the DON and Licensed Nursing Home Administrator (LHNA), the above concerns were discussed. On 1/30/26 at 2:00 PM, during the exit conference held with the facility DON, LNHA, Corporate Nurse and Executive [NAME] President, the facility informed the survey team they had no additional information to provide.A review of the facility's policy titled, Care Plans, comprehensive Person-Centered revealed the following: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 care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.A review of the facility's undated Dialysis Communication policy revealed the following: The facility and dialysis center will establish a communication and reporting mechanism to promote situational awareness between both facilities.Routine communication of relevant information will be provided by the facility to the dialysis center on treatment days, and more frequently as necessary.Examples of information that may be communicated between the facilities include, Hemodialysis communication Form.Medication Administration records laboratory results.The dialysis center will communicate relevant information to the facility upon the resident's return to the facility.Inquiries concerning dialysis communication should be directed to the Director of Nursing. policy, updated April 2024, did not include accommodating the resident's medication administration times.A review of the facility's Medication and Treatment Orders revealed that medication and treatment orders must be recorded on the physician's order sheet in the resident's chart.All orders shall be written, dated and signed by the person lawfully authorized to give such an order.NJAC 8:39-27.1 (a)NJAC 8:39- 11.2(d),(e) 1,2

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview, record review, and review of facility documents, it was determined that the facility failed to evaluate the performance of all Certified Nursing Aides (CNAs) on an annual basis. This deficient practice was identified for 3 of 5 CNAs whose personnel records were reviewed and was evidenced by the following:On 1/29/26 at 1:33 PM, the surveyor reviewed the Annual Staff Performance Appraisals for five randomly selected CNAs.CNA#1, with a date of hire of 5/24/23, had their most recent Annual Staff Performance Appraisal signed as completed on 3/20/24.CNA#2, with a hire date of 9/8/20, had their most recent Annual Staff Performance Appraisal signed as completed on 4/8/24.CNA#3, with a hire date of 3/27/23, had their most recent Annual Staff Performance Appraisal signed as completed on 8/24/24.On 1/30/26 at 11:41 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) regarding concerns with the annual performance appraisals. The LNHA stated that the 2025 evaluations would not be completed until 2026. She further stated she would check on this. On 1/30/26 at 2:00 PM, the survey team met with the LNHA, DON, and a corporate nurse and no further information was provided by facility. NJAC 8:39-43.17 (b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) Lokelma (sodium zirconium cyclosilicate, a potassium binder for those with high potassium) a medication was administered in accordance with manufacturer's specifications for one (1) of four (4) nurses observed b.) Questran (cholestyramine used to lower cholesterol), a medication was labeled with cautionary instructions for proper administration, for one (1) of four (4) residents observed during the medication pass, c.) quality control testing (calibration) was conducted for the blood glucose (bg) monitors, both used for residents as per manufacturer's specifications, for two (2) of two (2) medication carts inspected, d.) consistent disposition (destruction), reconciliation, and accountability of the controlled dangerous substance (narcotic; medications, with high potential for abuse, were tracked with detail) for one (1) of one (1) medication carts inspected, and e.) consistent maintenance of the system of record keeping of the Drug Enforcement Agency (DEA) order Form-222 (a federal narcotic requisition form), that enabled accurate reconciliation of distributed and received narcotics, identified 31were missing of 28 DEA Form-222 reviewed. The deficient practice was evidenced by the following: Refer to F756. Reference: According to the manufacturer's specifications for Lokelma section 2.3 Reconstitution and Administration: In general, Lokelma should be administered at least 2 hours before and 2 hours after Lokelma. Reference: According to the manufacturer's specifications for Questran under Drug Interaction; since Questran may bind other drugs given concurrently, it is recommended that patients take other drugs at least one hour before or four (4) to 6 hours after Questran (or at as great an interval as possible) to avoid impeding their absorption. On 1/29/26 at 9:19 AM, during the medication pass observation, the surveyor observed Licensed Practical Nurse (LPN #1) prepare 14 medications for Resident #55 that included Lokelma and Questran. On 1/29/26 at 9:33 AM, LPN #1 confirmed she was ready to administer 14 medications to Resident #55 and entered the resident's room. On 1/29/26 at 9:58 AM, the surveyor observed the completion of administration of Resident #55's oral medications and the refusal of their patch and injectable. On 1/29/26 at 10:01 AM, the surveyor observed the LPN #1 disposed of the patch, returned the injectable to the resident's inventory and signed the electronic Medication Administration Record (eMAR) a.) Review of the physician order (PO) dated 1/9/26, revealed an order to administer Lokelma 10 grams (gm) 1 packet by mouth one time a day for hyperkalemia (high potassium). A review of the physician's progress notes from admission, did not reveal that the physician was aware of the drug interaction and the manufacturer's specifications for Lokelma. On 1/30/26 at 8:20 AM, during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) stated that the medication scheduling for the residents was reviewed by the Consultant Pharmacist. On 1/30/26 at 8:38 AM, the surveyor and LPN #1 reviewed the box for Lokelma together and observed a cautionary that indicated Take this product at least 2 hours before or 2 hours after your other medications.The surveyor and LPN #1 reviewed the eMAR together that did not reveal a cautionary was added to the PO. At that time, LPN #1 confirmed and acknowledged that she did not review the cautionary affixed to the label of Lokelma. b.) Further review of Resident #55's PO dated 1/9/26, revealed an order to administer Questran 4 gm, 1 packet by mouth and at bedtime for hyperlipidemia (high cholesterol and/or triglycerides). A review of the physician's progress notes from admission, did not reveal that the physician was aware of the drug interaction and the manufacturer's specifications for Questran. On 1/30/26 at 8:40 AM, the surveyor and LPN #1 reviewed the box for Questran together and the box did not reveal a cautionary. The surveyor and LPN #1 reviewed the eMAR together that did not reveal a cautionary was added to the PO. At that time, the surveyor discussed concerns with the administration of Lokelma and Questran against manufacturer's specifications. The LPN informed the surveyor that she would reach out to the pharmacy and inform her supervisors. On 1/30/26 at 9:59 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM, in the presence of the Director of Nursing (DON), the surveyor conducted a telephone interview with the CP who stated that the pharmacy should have affixed the cautionary label for Questran. On 1/30/26 at 10:18 AM, the surveyor discussed the above concern with the DON. On 1/30/26 at 11:41 AM, in the presence of the survey team, the LNHA, and the DON, the surveyor discussed the concerns during the medication pass wherein LPN #1 did not read the cautionary for Lokelma and the concern with the Questran label that did not include the cautionary that lead to administration of both medications against manufacturer's specification, and without notification to the physician of the drug interactions. A review of the facility provided policy titled; Administering Medications, included that medication administration times are determined by resident need and benefit.preventing potential medication or food interaction. c.) On 1/29/25 at 10:03 AM, in the presence of LPN #2, the surveyor began the inspection of medication cart #1 located on the fifth floor and observed two (2) unlabeled bg monitors (glucometers). A review of the [brand redacted] quality and control reflected one (1) of two (2) glucometers was calibrated from 12/16/26 to 1/29/26. At that time, LPN #2 confirmed and acknowledged that both glucometers should have been calibrated, checked for functionality and accuracy. LPN #2 could not identify which glucometer was calibrated that morning. On 1/29/26 at 11:24 AM, in the presence of LPN #3, the surveyor began the inspection of medication cart #2 located on the second floor and observed two (2) unlabeled glucometers. A review of the [brand redacted] quality and control reflected only one (1) of two (2) glucometer was calibrated from 12/16/26 to 1/29/26. At that time, LPN #3 confirmed and acknowledged that both glucometers should have been calibrated, checked for functionality and accuracy. On 1/29/26 at 1:41 PM, the surveyor discussed the concerns with the inconsistent calibration of the unlabeled glucometers, wherein the nurses could not identify which machine was calibrated, checked for functionality and accuracy prior to use. A review of the facility provided policy titled, Blood Sampling, dated 9/14, did not reflect procedures to ensure calibration, functionality and accuracy were executed for all glucometers. d.) On 1/29/25 at 10:05 AM, in the presence of LPN #2, the surveyor began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart (narcotic box) on the high side of the fifth floor. At that time, the surveyor and LPN #1 reviewed the declining inventory book ([NAME]) page number 169 for Resident #1 that reflected Oxycodone 10 mg had 1 tablet remaining and the last dose removed was on 1/12/26 at 5:22 PM. LPN #2 stated that she did not have a corresponding bingo card (a multidose card containing individually packaged medications). At that time, the surveyor discussed the concern regarding the missing bingo card that had one (1) remaining tablet. At that time, LPN #2 stated she would inform the unit manager (UM). On 1/29/25 at 11:26 AM, during an interview with the surveyor, the UM stated that she spoke with the nurse on duty who forgot to sign the removal and administration of the pill. The UM was unable to provide any documented evidence regarding that conversation. The surveyor discussed the concern with the absence of the narcotic reconciliation and accountability for Resident #1's Oxycodone to identify loss or potential diversion and that the facility failed to identify the discrepancy prior to surveyor inquiry. A review of the provided facility policy, titled, Discarding and Destroying Medications dated 11/22, included that controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that maximizes the time between loss/diversion and detection/follow-up. e.) On 1/29/26 at 1:55 PM, the surveyor and the DON reviewed the DEA Form-222 together and revealed the following DEA Form-222 were missing: -240413617-240413618 -240413621-240413622 -241647035 -241647036 -250315607 -251315608-251476182 -251476183-251476184-251476186 -241647028-241647029-241647032-241647033-241647038-241647039-250315601-250315604-250597157-2 At that time, the surveyor discussed the concern of the missing DEA Form-222 with the DON. The DON stated that she would re-organize the DEA Form-222, to locate the missing forms. On 1/30/26 at 11:41 AM, during a meeting with the survey team, the LNHA and the DON, the surveyor discussed the concern with the missing DEA Form-222. On 1/30/26 at 2:00 PM, during the exit conference held with the facility DON, LNHA, Corporate Nurse and Executive [NAME] President, the facility informed the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	survey team they had no additional information to provide. A review of the facility provided policy titled Drug Enforcement Administration (DEA) Form 222, dated June 2024 included that retaining copies of completed forms and corresponding invoices, readily available for inspection by authorized agencies. Procedures included: Complete part 1, and 2, double checking for accuracy, making a copy, part 5 to be filled out once the order is received. No further information was provided. NJAC 8:39-11.2(b), 27.1(a), 29.2(d) 29.4(a)10, (b)3

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, and record review, it was determined that the facility failed to ensure the Consultant Pharmacist identified irregularities during the drug regimen review of a newly admitted resident. The deficient practice was identified for one (1) of four (4) residents observed during the medication pass (Resident #55). Refer to 755. Reference:According to the manufacturer's specifications for Lokelma section 2.3 Reconstitution and Administration: In general, Lokelma should be administered at least 2 hours before and 2 hours after Lokelma. According to the manufacturer's specifications for Questran under Drug Interaction; since Questran may bind other drugs given concurrently, it is recommended that patients take other drugs at least one hour before or four (4) to 6 hours after Questran (or at as great an interval as possible) to avoid impeding their absorption. On 1/29/26 at 9:19 AM, during the medication pass observation, the surveyor observed Licensed Practical Nurse (LPN #1) prepare 14 medications for Resident #55 that included Lokelma and Questran. A review of the physician order (PO) dated 1/9/26, revealed an order to administer Lokelma 10 grams (gm) 1 packet by mouth one time a day for hyperkalemia (high potassium). Further review of the PO dated 1/9/26 revealed an order to administer Questran 4 gm, 1 packet by mouth and at bedtime for hyperlipidemia (high cholesterol and/or triglycerides). A review of the 1/12/26, CP medication regimen review (MRR; drug regimen review) did not reveal a recommendation was made by the CP for Lokelma and Questran. On 1/30/26 at 8:20 AM, during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) stated that the medication administration schedule for the residents was reviewed by the Consultant Pharmacist (CP). On 1/30/26 at 9:49 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that all newly admitted residents' drug regimen were reviewed by the CP. The DON also stated the medication list was sent to the CP upon admission to the facility and the expectation was that the review would occur on the same day the list was uploaded into the system which was the same day of admission. On 1/30/26 at 9:59 AM, in the presence of the DON, the surveyor conducted a telephone interview with the CP who stated that she had access to the electronic Medical Record (eMR) of the facility, was able to review the resident's medication list the same day of admission. At that time, the CP confirmed and acknowledged that she did not identify the irregularities and did not make recommendations to change the administration times in accordance with the manufacturer's specifications for Lokelma and Questran. On 1/30/26 at 10:18 AM, the surveyor made the DON aware of the concern regarding the CP who did not identify the irregularities during the MRR. On 1/30/26 at 11:41 AM, during a meeting with the survey team, the LNHA, and the DON, the surveyor discussed the concerns with irregularities that were not identified during the MRR by the CP. On 1/30/26 at 2:00 PM, during the exit conference held with the facility DON, LNHA, Corporate Nurse and Executive [NAME] President, the facility informed the survey team they had no additional information to provide. A review of the Consultant Pharmacist Provider Agreement dated 2/1/23, included that the Consultant shall identify any irregularities as defined in the State Operations Manual. NJAC 8:39-29.3

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	315127	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Rehabilitation Hospital	2381 Lawrenceville Road Lawrenceville, NJ 08648

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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, interview, and record review, it was determined that the facility failed to perform appropriate hand hygiene for 2 of 2 staff observed and disinfect shared medical equipment prior to and after use, in accordance with facility infection control policy. This deficient practice was evidenced by the following:On 1/27/26 at 11:30 AM, the surveyor observed a signage posted at the entrance door of Resident #4's room. The signage indicated Enhanced Barrier Precaution. There was a Personal Protective Equipment box hung outside the door that included gowns and gloves. The surveyor then observed the LPN approached the room with the medication cart and a blood pressure machine. The LPN placed the medication cart next to the entrance door. The LPN, donned (put on) gloves and a gown and entered the room without first performing hand hygiene. The LPN then used the gloved hands to remove the resident's blanket, located the dialysis access site on the resident chest, palpated the dressing, returned the blanket on top of the resident, then used the blood pressure machine to monitor the vital signs. The LPN removed their gloves and gown and exited the room without performing hand hygiene. The LPN left the blood pressure machine in the hallway, and did not disinfect the blood pressure machine after use.On 1/27/26 at 12:45 PM, the surveyor interviewed the LPN regarding the above observations. The LPN confirmed that she did not wash her hands or perform any hand hygiene prior to, and after exiting the room. The LPN stated she did not disinfect the blood pressure machine either. The LPN stated that she should have washed her hands and disinfected the blood pressure machine to prevent cross contamination.On 1/29/26 at 2:30 PM, the Licensed Practical Nurse/ Unit Manager (LPN/UM) was called to Resident #4's room for a wound evaluation. The surveyor then observed the LPNUM reached for a gown at the entrance door and, donned gloves without first performing hand hygiene and then entered the room . The LPNUM proceeded to the room removed the sheet from the resident, and then assessed the resident's Deep Tissue Injury (DTI) wound without first performing hand hygiene.The above concerns were discussed with the IP on 1/30/26 at 10:30 AM. The IP acknowledged the infection control breaches and stated that she would have to in-service the staff.On 1/30/26 at 11:41 AM, the surveyor discussed the above concerns with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON).On 1/30/26 at 2:00 PM, the DON, LNHA, Executive [NAME] President and Corporate Nurse met with the survey team, no additional information was provided. A review of the facility policy, A review of the facility policy titled, Handwashing/Hand Hygiene, revealed the following:Policy StatementThe facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections.All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.Indications for hand hygiene.Immediately before touching a resident. After touching a resident.After touching the residents' environment.Before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal. The use of gloves does not replace hand washing/ hand hygiene.The policy for cleaning and disinfection of Resident-Care Items and Equipment indicated the following:Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to CDC recommendations for disinfection and the OSHA(Occupational Safety and Health Administration) Bloodborne Pathogens Standard.Non-critical resident-care items blood pressure cuffs, items that come in contact with intact skin but not mucus membranes, disinfection is performed with a EPA-)(Environmental Protection Agency) registered disinfectant labeled for use in healthcare setting.NJAC 8:39-19.4(a)n,

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and review of facility documentation, it was determined that the facility failed to ensure that a) Certified Nursing Aides (CNAs) received 12 hours of mandatory annual in-service training for 2 of 5 CNAs reviewed and b) CNA education included abuse training for 3 of 5 CNA education files reviewed. The deficient practice was evidenced by the following:On 1/29/2026 at 1:33 PM, the surveyor reviewed the in-service education hours for five randomly selected CNAs, which were provided by the facility.The [Name Redacted] Transcripts provided showed the following: CNA#1, with a hire date of 5/24/23, had 3.4 hours of education from 5/24/24 - 5/24/25, which did not include training on abuse. The last abuse training documented was 7/3/24. CNA#2, with a hire date of 9/8/20, had 4.98 hours of education from 9/8/24 - 9/8/25. CNA#4, with a hire date of 5/8/24, had a most recent abuse training dated 5/8/24. CNA#5, with a hire date of 5/6/24, had a most recent abuse training dated 8/1/24. On 1/30/26 at 11:28 AM, the facility provided an education calendar listing all education topics and what month they are given in. Elder Abuse: The Elder Justice Act self paced is given in September according to this calendar. On 1/30/26 at 11:41 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). When asked about timing of abuse training, the LNHA stated that it should be completed annually. The surveyor reviewed the facility provided policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated October 2022 which included:Policy Statement:Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.7. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. N.J.A.C. 8:39-43.17 (b)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, it was determined that the facility failed to ensure the admission Agreement did not required residents to waive their right to receive 30-day written notice of discharge. This deficient practice was identified for 1 of 1 residents reviewed for appropriate discharge (Resident # 71) and was evidenced by the following: On 1/27/26 at 1:05 PM, the surveyor reviewed the facility entrance binder (a binder that contained the required recertification survey documentation per the Centers for Medicare and Medicaid-CMS- entrance conference requirements) that was provided by the LNHA. A 44 Page Welcome Packet was identified as the facility admission Agreement. The Notice of Resident's Rights Regarding Transfer or discharge: You may be transferred or discharged for one of the following reasons: 1. The move is necessary for your own welfare, and your needs cannot be met withing the facility. 2. Your health has improved sufficiently so that you no longer need the services provided by the facility. 3. The safety of individuals in the facility is endangered. 4. The health of individuals in the facility is endangered. 5. You have failed after reasonable and appropriate notice, to pay for (or failed to have Medicaid or Medicare pay for) a stay in the facility. 6. The facility is closed. In general, you cannot be transferred or discharged until 30 days after you receive the facility notice unless you agree to an earlier date . The page titled Medicaid revealed Medicaid is a health insurance that is federally, and state funded and is available to Virginia residents through the Department of Medial Assistance Services . Services covered under Medicaid: Room and board, Nursing Services . The How to Apply for Medicaid section identified the New Jersey Department of Human Services, Division of Medical Assistance and Health Services . On 1/28/26 at 10:00 AM, the surveyor reviewed the closed electronic medical record (EMR) for Resident #71 which revealed the following: The admission Record revealed the resident had diagnoses including but not limited to; hemiplegia and hemiparesis (body weakness and paralysis). The admission Minimum Data Set, dated [DATE] revealed that the resident scored 15/15 on the Brief Interview for Mental Status and was cognitively intact. A review of the primary payer source revealed that the resident was admitted with Medicare A (covered skilled nursing facilities) and payment ended on 12/4/25. A Nursing Progress Note (PN) dated 12/4/25 at 15:46 revealed Resident #71 was transferred to another facility. A Late Entry, Social Service Note, Effective Date: 12/4/25 at 12:46 revealed the resident was transferred . to sister facility .On 01/28/6 at 1:48 PM, the surveyor interviewed two Social Workers (SW #1 and SW #2) in the presence of the survey team. SW #1 stated she was responsible for the 2nd floor and Social Worker #2 stated she was responsible for the 5th floor. When asked about the facility, both SW #1 and SW #2 stated it was dually certified (accepted Medicare and Medicaid). When asked if there were any residents that currently had Medicaid as a payor source, they both confirmed there were none. When asked if they could provide the name of one resident that was discussed staying long-term at the facility, they both confirmed that they had none to offer. When asked if the SWs would assist a resident who required a payment change to Medicaid for services, they both confirmed that they would not assist with helping someone who required Medicaid. When asked about Resident #71, SW #1 stated they were never offered to stay at the present facility, as they needed Medicaid and she confirmed that she did not document this in Resident #71's medical record. On 01/29/26 at 11:35 AM, the surveyor conducted a telephone interview with Resident #71 and their spouse as the resident currently resided in the facility that they were transferred to. When asked why they had been transferred to another facility, Resident #71 stated they had to be transferred because their payment source was ending on 12/4/25. Resident #71 stated that 12/4/25 was their day 99 and the facility they were transferred to was the only facility that they could go to that accepted pending Medicaid. When asked if they were offered to transfer to the facility that was located next door, they were informed that they could only be transferred next door if they currently had Medicaid as a payment (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	source, and the Medicaid status could not be pending. Resident #71 stated they would have absolutely stayed at the previous facility if it had been offered to as they loved the therapy and missed one of the staff members who provided them care. The spouse reiterated that they had been told that since they needed Medicaid and were considered Medicaid Pending that they only had one option as other facilities were not offered. Resident #71 again stated they would have preferred to stay at the prior facility instead of being transferred to another facility. On 1/29/26 at 2:00 PM, the surveyor again reviewed the EMR for Resident #71 which revealed an admission Packet dated as electronically signed on 10/22/25 and indicated the Primary Payor Source Medicare A. The admission Agreement was not the same agreement provided to the survey team upon entrance, and included an Attachment P- Addendum for Short Term Post-Acute Rehabilitation Care which revealed: The Sub-Acute Rehabilitation Unit is Designated for the Sole Purpose of Providing Short-Term Rehabilitation Services to Individuals Being discharged from a Hospital or Needing Rehabilitative Services to Individuals Being discharged From a Hospital or Needing Rehabilitative and/or Nursing Care at a Level Above that Provided in a Skilled Nursing Unit. 1. Resident and/or Resident Representative specifically understand and acknowledge that the Facility admits and retains residents with sub-acute care service needs only for that period of time needed to provide such services. Therefore, Resident and/or Resident Representative and the facility is that the Resident returns to his/her home or a less restrictive setting, if appropriate. The resident and his/her Resident Representative agree to facility discharge from post-acute care as soon as medically appropriate and hereby represent and agree that they will work with the Facility staff to secure and appropriate and timely discharge. Facility reserves the right to discharge and transfer a Resident who needs medical care or other services that are not available at the Facility in accordance with the terms and conditions of the Agreement and Applicable Law. 2. Because it is anticipated that Resident's post-acute care needs will be met in less than 30 days, Resident and/or Resident's Representative specifically waives the right to a 30-day written notice of discharge when admitted for post-acute services. Resident and/or Resident Representative agree that this provision supplements and amends Section 3v. related to Transfers and Discharges within the Agreement and serves as a formal statement of the Facility's intent to discharge Resident at the time post-acute services are concluded. 3. Residents admitted for post-acute care are responsible for any charges that may accrue after termination of their third-party coverage if they remain in the Facility for any reason, as further set forth in Section 4. of the agreement, Financial Matters. Residents covered by Medicare Part A are responsible for any Medicare deductibles and/or coinsurance and agree to pay such amount to the Facility. 4. Resident/Resident Representative acknowledge the above . and was initialed by Resident #71. Section 3v Transfers and Discharges as referenced above were reviewed and revealed that #1, # 2, #3 and #5 were similar to the above information under Transfer and Discharges as was provided to the survey team. However, 4 revealed the Resident/Resident Representative has failed, after reasonable and appropriate notice, to pay for (or have a third party/payor pay for) the facility services. NJAC 8:39-5.1(a)(b)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of pertinent documents it was determined that the facility failed to ensure an appropriate discharge process was in place for residents who had a change in payor source. This deficient practice occurred for 1 of 1 resident reviewed for appropriate discharge (Resident #71) and was evidenced by the following: On 01/27/26 at 11:04 AM, during the facility entrance conference held with the Licensed Nursing Home Administrator (LNHA), and an Executive [NAME] President (EVP) the surveyor asked what the resident population of the facility was. The LNHA stated the residents were all short term, and there were no long-term care residents at the facility. When asked if the facility held resident council meetings, the LNHA stated there was no resident council meeting held at the facility. When the surveyor again asked about long-term care residents at the facility, the LNHA confirmed that there was no long-term care residents at the facility, only short term. The LNHA then stated when residents needed long-term care placement, the facility could tour them next door or refer them (a separate SNF/NF facility with a different CMS provider number and was located in close proximity to the facility). When asked how long the facility had been designated only a short-term facility without having any long-term care residents, the LNHA stated she had been there for 3 years and there was no long-term care. When asked what the population of residents resided on the 2nd and 5th floors, both the LNHA and EVP confirmed there were only sub-acute residents at the facility (skilled nursing and sub-acute residents are billed at a higher rate for certain skilled services).On 01/27/26 at 12:13 PM, the [NAME] President of Operations (VPO) for the parent company introduced himself to the survey team. When the surveyor asked about the type of facility and the type of residents admitted to the facility. The VPO stated, the facility was a sub-acute facility. When asked about if the facility currently had any residents stay for long long-term care that had Medicaid as a payer source. The VPO stated, if residents had a need (and were on Medicaid) and there were no Medicaid residents that had requested to stay at the facility for long-term care. The surveyor reiterated the facility's Medicare/Medicaid designation from CMS and The VPO stated, they (the company) have other buildings that people can go to if they (the skilled nursing/sub-acute residents) want to stay long term care.On 01/28/26 at 8:56 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPNUM). The surveyor asked what her responsibilities included. The LPNUM stated she oversaw the 2nd and 5th floor (contained all 56 licensed Medicare/Medicaid beds). When asked if any residents stayed long-term care? The LPN/UM stated, No, they need to go, this is strictly sub-acute. When asked if she had ever attended a care conference for long-term care residents? The LPN/UM stated, it never happened (that a resident stayed at the facility for long- term care) and stated the facility was rehab only. On 1/28/26 at 10:00 AM, the surveyor reviewed the closed electronic medical record (EMR) for Resident #71 which revealed the following: The admission Record revealed the resident had diagnoses including but not limited to; hemiplegia and hemiparesis (body weakness and paralysis). The admission Minimum Data Set, dated [DATE] revealed that the resident scored 15/15 on the Brief Interview for Mental Status and was cognitively intact. A review of the primary payer source revealed that the resident was admitted with Medicare A (covered skilled nursing services such as rehabilitation) and the payment ended on 12/4/25. A Nursing Progress Note (PN) dated 12/4/25 at 15:46 (3:46 PM) revealed Resident #71 was transferred to another facility. A Late Entry, Social Service Note, Effective Date: 12/4/25 at 12:46 revealed Note Text: Discharge Note: The resident has been approved to transition into long-term care at [Name redacted] Care & Rehabilitation Center and the resident will be picked up in a wheelchair-accessible van on Thursday, 12/04/25, at 3:45 PM . Social Services will continue to provide support to the resident and family throughout her transition to our sister facility. On 01/28/26 at 1:48 PM, the surveyor interviewed two Social Workers (SW #1 and SW #2) in the presence of the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey team. SW #1 stated she was responsible for the 2nd floor and Social Worker #2 stated she was responsible for the 5th floor. When asked about the facility, both SW #1 and SW #2 stated it was dually certified (accepted Medicare and Medicaid). When asked if there were any residents that currently had Medicaid as a payor source, they both confirmed there were none. When asked if they could provide the name of one resident that was discussed staying long-term at the facility, they both confirmed that they had none to offer. When asked if the SWs would assist a resident who required a transfer to Medicaid for payment, they both confirmed that they would not assist with helping someone transfer to Medicaid. When asked about Resident #71, SW #1 stated they were never offered to stay at the present facility, as they needed Medicaid for payment. When asked if this was documented regarding discharge to the other facility, she confirmed there was no specific documentation regarding a discharge plan. On 01/29/26 at 9:19 AM, the surveyor interviewed the staff educator Registered Nurse (RN). When asked about any long- term care residents that resided at the facility. The RN stated, in the presence of the survey team, that the long-term care facility was located next door. On 01/29/26 at 11:35 AM, the surveyor conducted a telephone interview with Resident #71 and their spouse as currently resided in the facility that they were transferred to. When asked why they had been transferred out, Resident #71 stated they had to be transferred because their payment source was ending on 12/4/25. Resident #71 stated that 12/4/25 was their day 99 and the facility they were transferred to was the only facility that they could go to that accepted pending Medicaid, when other facilities did not. When asked if they were offered to transfer to the facility that was located next door, they were informed that they could only be transferred next door if they had already had Medicaid as a payment source, and could not be pending. Resident #71 stated they would have absolutely stayed at the facility if it had been offered as they loved the therapy and missed one of the staff members who provided them care. The spouse reiterated that they had been told that since they needed Medicaid and were considered Medicaid Pending that they only had one option as other facilities were not offered. Resident #71 stated they would have preferred to stay at the facility instead of being transferred to another facility.On 01/29/26 11:51 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and asked about the transferring residents out of the facility who required Medicaid and she stated we try to put people in areas that suit their needs, it should be documented in the patients chart, and the social workers should documenting the meetings.On 1/29/26 at 2:00 PM, the surveyor again reviewed the EMR for Resident #71 which revealed an admission Packet dated as electronically signed on 10/22/25 and indicated the Primary Payor Source Medicare A. The signed admission Agreement for Resident #71 was not the same agreement provided to the survey team upon entrance and included an Attachment P- Addendum for Short Term Post-Acute Rehabilitation Care which revealed: The Sub-Acute Rehabilitation Unit is Designated for the Sole Purpose of Providing Short-Term Rehabilitation Services to Individuals Being discharged from a Hospital or Needing Rehabilitative Services to Individuals Being discharged From a Hospital or Needing Rehabilitative and/or Nursing Care at a Level Above that Provided in a Skilled Nursing Unit. 1. Resident and/or Resident Representative specifically understand and acknowledge that the Facility admits and retains residents with sub-acute care service needs only for that period of time needed to provide such services. Therefore, Resident and/or Resident Representative and the facility is that the Resident returns to his/her home or a less restrictive setting, if appropriate. The resident and his/her Resident Representative agree to facility discharge from post-acute care as soon as medically appropriate and hereby represent and agree that they will work with the Facility staff to secure and appropriate and timely discharge. Facility reserves the right to discharge and transfer a Resident who needs medical care or other services that are not available at the Facility in accordance with the terms and conditions of the Agreement and Applicable Law. 2. Because it is anticipated that Resident's post-acute care needs will be met in less than 30 days, Resident and/or Resident's Representative specifically waives the right to a 30-day written notice of discharge when admitted for post-acute services. Resident and/or Resident Representative agree that this provision supplements (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and amends Section 3v. related to Transfers and Discharges within the Agreement and serves as a formal statement of the Facility's intent to discharge Resident at the time post-acute services are concluded. 3. Residents admitted for post-acute care are responsible for any charges that may accrue after termination of their third-party coverage if they remain in the Facility for any reason, as further set forth in Section 4. of the agreement, Financial Matters. Residents covered by Medicare Part A are responsible for any Medicare deductibles and/or coinsurance and agree to pay such amount to the Facility. 4. Resident/Resident Representative acknowledge the above . and was initialed by Resident #71. Section 3v Transfers and Discharges as referenced above were reviewed and revealed that #1, # 2, #3 and #5 were similar to the above information under Transfer and Discharges as was provided to the survey team. However, # 4 revealed the Resident/Resident Representative has failed, after reasonable and appropriate notice, to pay for (or have a third party/payor pay for) the facility services. The language to have Medicaid or Medicare pay for a stay in the facility was not in the agreement. Additionally, the agreement included an Attachment N which was initialed by Resident #71 on 10/22/26 and was a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN -A notice when Medicare Part A skilled services benefit days/payment would be exhausted). Option 3 was checked off and the dates of services ending and the estimated cost was left blank.On 01/29/26 at 1:07 PM, the surveyor interviewed the Registered Nurse Minimum Data Set (MDS) Coordinator who worked at the facility for over fifteen years and asked about any long-term care residents who had resided at the facility. The MDS stated it is all skilled now. The surveyor asked if the facility conducted care conferences for long term care, and the MDS stated if a resident needed long term care they could go to other facilities [named facilities] that were owned by the same company. On 01/30/26 at 11:44 PM, the surveyor reviewed the Physical Therapy Documentation from the Rehabilitation Department and Physical Therapist that provided care. The Physical Therapy Discharge Reason was documented as exhausted benefits . Patient Progress was documented as Patient has made consistent progress throughout plan of treatment. Payer was identified as Medicare Part A. Resident #71 was discharged from Occupational Therapy, Physical Therapy and Speech Therapy on 12/3/25, the day before they were transferred to another facility. NJAC 8:39-2.1(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Rehabilitation Hospital	2381 Lawrenceville Road Lawrenceville, NJ 08648

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of medical records, other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 3 of 19 residents reviewed (Resident #71, Resident # 72, and Resident #74). This deficient practice was evidenced by the following:On 1/28/2026 at 9:25 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #71 which revealed an admission record (face sheet) with diagnoses that included but not limited to hemiplegia and hemiparesis (weakness) following CVA (stroke) affecting the right dominant side and dysphagia (difficulty swallowing).The individual comprehensive care plan (ICCP) included a focus area initiated 10/27/25 of discharge potential with interventions which included referrals to other community agencies as deemed appropriate. A social service late entry note dated 12/4/25 indicated Resident #71 had been approved to transition into long-term care at [Name Redacted]. Transportation has been arranged through [Name Redacted], and the resident will be picked up in a wheelchair-accessible van on Thursday, 12/04/25, at 3:45 p.m Social Services will continue to provide support to the resident and their family throughout the transition to our sister facility.The DCRNA (discharge return not anticipated) Minimum Data Set (MDS), an assessment tool, dated 12/4/25, was coded to indicate the discharge was unplanned to a nursing home.On 1/28/2026 at 10:56 AM, the surveyor reviewed the EMR for Resident #72 which revealed an admission record (face sheet) with diagnoses that included but not limited to benign prostatic hypertrophy (enlarged prostate) and obstructive uropathy (obstruction of the flow of urine).The ICCP included a focus area initiated 12/9/25 of discharge potential with interventions which included discussing any special equipment needs and notifying MD of discharge plans, ensure all required discharge documentation is complete including orders, and precipitations available at time of discharge.A social service note dated 12/26/26 indicated the social worker spoke with Resident #72's family member to inform that insurance has issued last covered day (LCD) of 12/29/2025 with anticipated discharge on [DATE]. The family member stated the resident will be discharged on 12/30/2025 and they do not plan to appeal the date. When asked about homecare services, the family member stated they have services in place and did not feel additional services were needed at this time.A Discharge summary dated [DATE] indicated that Resident #72 would be transported via [Name Redacted], homecare referral was made, and a wheelchair and commode were ordered.The DCRNA MDS dated [DATE], was coded to indicate the discharge was unplanned to home. On 1/30/2026 at 12:05 PM, the surveyor reviewed the EMR for Resident #74 which revealed an admission record (face sheet) with diagnoses that included but not limited to adult failure to thrive. The ICCP included a focus area initiated 7/18/25 of discharge potential with interventions which included discussing any special equipment needs and facilitate obtaining prior to discharge and make referrals to other community agencies as deemed appropriate.A social service noted dated 9/18/25, indicated the social worker spoke with Resident #74 to inform of insurance has issued LCD 9/20/2025 with anticipated discharge on [DATE]. Resident stated preference to go home sooner.Call placed to Meals on Wheels to arrange for home delivered meals. This writer and resident went over some food items that they would like so this writer can place a food order with Walmart until [NAME] (meals on wheels) is able to begin service. Transport scheduled for 9/20/25 at noon. Email and call placed to Meals on Wheels informing of LCD.A Social Service Note dated 9/19/25 indicated that the social worker resident called Meals on Wheels to see if the intake assessment can be sooner due to the resident not having a phone. Spoke with [NAME] who completed the intake and approved resident for [NAME] free of charge; will receive a hot and cold meal daily beginning 9/22/25. Resident was reminded that a department store order would be placed for delivery on Saturday 9/20/25.Call placed to [Name Redacted] Pharmacy to discuss resident's medications being pre-packaged and delivered. The rep stated the scripts, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insurance information and request for delivery and pre-packaging can be faxed to the pharmacy.This writer faxed in medications and dropped off prescriptions for Narcotics to [Name Redacted] Pharmacy. All medications were picked up except for Liothyronine and Benztropine that will be delivered to resident's home on 9/22/25 by the pharmacy. The medications that were picked up from the pharmacy were given to the nurse and placed in the nursing cart for discharge.A later Social Service Note dated 9/19/25 indicated that a call was placed to resident's family member informing that resident's medications have been picked up from the pharmacy and will go home with resident tomorrow at discharge, Verizon bill has been paid, department store food delivery was scheduled for 9/20/2025 and Meals on Wheels scheduled to begin 9/22/25.The DCRNA dated 9/20/25 was coded to indicated discharge was unplanned to home under the care of a home health service organization. On 1/29/2026 at 12:11 PM, the surveyor interviewed the MDS Coordinator (MDSC) who indicated the unplanned discharge MDS question was based on functional status and if the resident did not meet their goals, they coded unplanned. When asked if that was how the RAI (Resident Assessment Instrument) instructs, she stated that's the way we do it. Requested policy on MDS completion. On 1/29/2026 at 1:11 PM, the MDSC brought page 2-41 of October 2025 RAI manual with definition of unplanned discharge Resident unexpectedly deciding to go home or to another setting (e.g. due to the resident deciding to complete treatment in an alternate setting). When asked how this related to Resident #71, MDSC stated that the resident was given choices, picked [Name Redacted], and that they didn't meet their goals.When asked how this relates to Resident #72, MDSC stated that the resident did not meet their goals.On 1/30/2026 at 11:41 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to discuss concerns. Regarding the above MDS assessments and questions of planned or unplanned discharge, the DON stated she would not consider them unplanned.N.J.A.C 8:39-11.1

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to develop or initiate a comprehensive, person-centered care plan to address a.) the care of a Foley catheter. This deficient practice was identified for 1 of 27 residents (Resident #80) reviewed for a comprehensive Care Plan (CP) and was evidenced by the following:On 1/27/2 at 11:45 AM, the surveyor observed Resident #80 in the room sitting in a wheelchair by the bed. Resident #80 was awake and alert and able to answer the surveyor's inquiry. The resident informed the surveyor that they were in Physical therapy this morning and they were admitted to the facility for rehabilitation. The surveyor observed that Resident #80 wore a urinary catheter leg bag. The surveyor reviewed the Electronic Health Record (EHR) of Resident #80. The admission Record documented that Resident # 80 was admitted with diagnoses that included but were not limited to diabetes mellitus, hypertension and atherosclerotic heart disease of native coronary artery without angina pectoris, encounter for surgical aftercare following surgery on the circulatory system. The admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care with an assessment reference date of 1/23/26, indicated that the resident had intact cognition. Resident #80 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) Section H0100 of the MDS was coded as yes reflecting the presence of an indwelling catheter (tube inserted into the urethra to allow the bladder drainage). The Order Summary Report (OSR) with the start order date of 1/16/26, did not include an order for Foley catheter. The resident's comprehensive CP review for catheter care revealed that no CP was initiated on admission. The resident was admitted on [DATE]. The care plan initiated on 01/16/26 had a focus for urinary incontinence related to weakness and impaired mobility. The goal was to provide incontinence care and apply moisture barriers as needed. There was no care plan for urinary catheter or use of the leg bag. On 1/28/26 at 1:47 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) regarding the care plan for Resident #80's Foley catheter. The LPN/UM stated that there should be a CP for the Foley catheter. The Infection Control Preventionist was responsible for generating the care plan as the resident was on Enhanced Barrier Precautions.On 1/28/29 at 2:00 PM, the surveyor reviewed the Care Plan with the IP. She agreed that the resident should have had a care plan in place.A review of the facility's policy titled, Care Plans, comprehensive Person-Centered revealed the following: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 care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. NJAC 8:39-11.2(d),(e) 1,2

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to post the nursing staffing report daily. This deficient practice was evidenced by the following: On 1/27/26, on entrance and initial tour, the survey team did not observe the nursing staffing report to be posted in the facility.On 1/28/26 at 12:56 PM, the surveyor did not observe the nursing staffing posted in the lobby, on the second floor, or on the fifth floor.On 1/28/2026 at 1:06 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) about the posted staffing. She stated it is posted on floors two and five by the time clock. LNHA walked with surveyor to the second-floor time clock, staffing was not observed to be posted there. The LNHA stated she observed it posted there yesterday. admitted that it should be posted there.On 1/29/2026 at 9:56 AM, the surveyor interviewed the staffing coordinator who stated the supervisors are responsible for posting the staffing. She further stated they had a new supervisor, who was educated yesterday when it was noted by the surveyor to not be posted. She stated it is usually posted on the second-floor medication room door and on the fifth floor on a pole by the nursing station. On 1/29/2026 at 10:11 AM, after surveyor inquiry, the surveyor observed on the fifth floor the staffing for yesterday posted on a pole behind the nurse's station, with a print date and time of 1/28/26 at 1:14 PM. The surveyor also observed the staffing posted for 1/29/26 on the medication room door, which was located behind the nurse's station, not readily visible to residents and visitors. The second-floor staffing was also posted on the medication room door, which was located behind the nurse's station, not readily visible to residents and visitors.No further information was provided by the facility.NJAC 8:39-41.2 (a)(b)(c)