STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315128	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 27193 Complaint #NJ 165805 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure the call bell was accessible and within reach for all residents. This deficient practice was identified for 2 of 2 residents (Resident #22 and #29) reviewed for falls and was evidenced by the following: a) On 1/30/25 at 10:00 AM, the surveyor observed Resident #29 lying in bed, and the call bell on top of the the bedside table out of Resident #29. On 1/31/28 9:10 AM, the surveyor observed Resident #29 in bed, and the call bell was again observed on top of the bedside table. On 2/5/25 at 9:00 AM, the surveyor observed Resident #29 lying in bed and the call bell was hanging over the side rail, tucked underneath the mattress, and out of the resident's reach. The resident stated they knew how to use the call bell, but that they could not find it to demonstrate the process for the surveyor. On 2/5/25 at 9:20 AM, the surveyor escorted the Unit Manager (UM) to the resident's room and the UM confirmed that the call bell was not accessible. On 2/5/25 at 10:30 AM, the surveyor reviewed Resident #29's medical record. The Admission Face Sheet reflected that Resident #29 was admitted to the facility with diagnoses which included but were not limited to; other lack of coordination, unspecified dementia, with other behavioral disturbances, muscle wasting and atrophy. The Annual Minimum Data Set (MDS), an assessment tool, dated 02/25/24, revealed a Brief Interview of Mental Status (BIMS) of 03 out of 15, which indicated the Resident's cognition was severely impaired. A review of the Care Plan (CP), Initiated 5/4/23, included a Focus for falls related to deconditioning, weakness, other lack of coordination. Interventions included but were not limited to, be sure call light is within reach, and provide reminders to use call bell for assistance as needed. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 02/05/25 at 9:00 AM, the Certified Nurse Aide (CNA) stated that the resident used the call bell sometimes when they needed assistance. The CNA further stated that she placed the call bell on the side of the resident's bed prior to leaving the room. During an interview with the surveyor on 2/5/25 at 9:20 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) confirmed that the resident was able to use the call bell to ask for assistance. The surveyor then escorted the LPN/UM to the room where we both observed the call bell was tucked underneath the mattress and not accessible to the resident. The UM stated that she expected staff to secure the call bell to prevent the call bell from falling out of reach of the resident. During an interview with the surveyor on 2/5/25 at 12:55 PM, the Director of Nursing (DON) stated that staff should have ensured Resident's call bell was secured and placed within reach of the resident. 48423 b) On 1/29/25 at 9:57 AM, during an initial tour the surveyor observed Resident #22 reading a book in the bed. The resident stated, I need to be changed, when the surveyor approached the resident. The surveyor observed the resident's call bell hanging from the left corner of the bed frame. Resident #22 was not able to reach the call bell. On 1/30/25 at 8:19 AM, the surveyor observed Resident #22 sitting in bed with their head of bead elevated. Resident #22's call light was hanging down from left corner of the bed frame. Resident #22 was not able to reach the call bell. On 2/4/25 at 12:45 PM, the surveyor reviewed the electronic medical record for Resident #22 which revealed: According to the Admission Record (AR; admission summary), Resident #22 was admitted to the facility with diagnoses which included but were not limited to; Hypertension (high blood pressure), anxiety disorder, and difficulty in walking. A review of the Quarterly Minimum Data Set Assessment, (an assessment tool), dated 12/28/24, revealed that the Resident #22 scored 06 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated that the resident had a severely impaired cognition. Further review of the MDS revealed that Resident #22 required maximal assistance with toileting hygiene. Section H of the MDS revealed that Resident #22 was frequently incontinent of bowel and bladder. A review of Resident #22's Care Plan (CP) Initiated on 10/6/23, reflected that Resident #22 had an ADL (Activities of Daily Living) self-care performance deficit. Interventions included: Encourage me to use call bell for assistance. On 2/5/25 at 1:53 PM, the survey team met with Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS). The surveyor informed them of the above-mentioned concerns for all the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided document titled: Certified Nursing Assistant (CNA) /Geriatric Nursing Assistant (GNA) under section Personal Nursing Care Functions included: Ensure that residents who are unable to call for help are checked frequently. Under Safety and Sanitation: Keep the nurses' call system within easy reach of the resident. On 2/7/25 at 12:34 PM, the survey team met with DON, RDCS and the Regional Director of Operations for an Exit Conference. NJAC 8:39-31.8 (c)(9)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 48423 Based on interview and record review, it was determined that the facility failed to ensure a process was followed to ensure that all concerns presented by the residents during the monthly resident council meetings (RCM) were consistently addressed. This deficient practice was identified for 5 of 5 residents who attended a resident council meeting, for 1 of 1 monthly resident council minutes reviewed (October 2024) and was evidenced by the following: This deficient practice was evidenced by the following: On 1/31/25 at 10:30 AM, the surveyor conducted RCM with 5 of the 5 residents who stated they were unaware of any follow up to their expressed concerns and were not provided with documented follow up at subsequent resident council meetings. A review of the RCM minutes that were provided by the Licensed Nursing Home Administrator (LNHA) revealed: 1.RCM dated October 2024 at 2:00 PM Staff in attendance: Director of Life Enrichment (DLE), LNHA, Director of Nursing (DON), and Assistant Director of Nursing (ADON). Residents in attendance: 17 A review of the RCM minutes dated October 2024 included the following under Nursing: Residents asked if staff could refrain from wearing earbuds while giving care, Director of Nursing (DON) stated she will reeducate the staff of phone usage. On 2/7/25 at 11:43 AM, in the presence of the survey team, the DON acknowledged that she was unable to find any resolutions from RCM. The DON stated the process should be that during RCM all residents' concerns should be addressed and brought up at the next meeting as an old business resolution and new concerns should be added as a new business. The review of the facility's Resident Council, policy dated revised February 2021 included under Policy Interpretation and Implementations: 6. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the items(s) of concerns. On 2/7/25 at 12:34 PM, the survey team met with DON, RDCS and the Regional Director of Operations for an Exit Conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-4.1 (a)(29), 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 27193 Complaint # NJ 165805 Based on interview, record review, and other facility documentation, it was determined that the facility failed to ensure that Resident #29 was free from neglect and received adequate supervision when a Certified Nurse Aide (CNA #1) neglected to supervise the resident. Resident #29 was found lying on the floor complaining of severe pain and CNA #1 who refused to supervise Resident #29 was found sleeping at the nurses' desk on 5/17/23 at 3:35 AM. The resident required emergent transfer to the hospital and was diagnosed with a closed fracture of the left hip that required surgical repair (open reduction external fixation). This deficient practice was identified for 1 of 1 resident (Resident #29) reviewed for neglect. The evidence was as follows: On 2/5/25 at 10:30 AM, the surveyor reviewed Resident #29's electronic medical record. The Admission Face Sheet reflected that Resident #29 was admitted to the facility with diagnoses which included but was not limited to; other lack of coordination, unspecified dementia with other behavioral disturbances, muscle wasting and atrophy. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 2/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15, which indicated Resident #29 was severely cognitively impaired. The MDS further revealed that the resident needed extensive assistance with all activities of daily living (ADL; toileting, bathing, washing, etc.). A review of the Care Plan (CP), initiated on 5/4/23, included a focus area for falls related to deconditioning, weakness, and other lack of coordination. The interventions included but were not limited to; call light within reach and to provide reminders to use call bell for assistance as needed. There was also a focus area for ADL self-care performance deficit related to deconditioning and status post hospitalization , initiated on 5/4/23. One of the interventions documented was Resident #29 required a one-person physical assist with toileting. A focus area for incontinence initiated on 5/4/23, indicated I have urinary incontinence; I will not have skin breakdown due to incontinence through the review date. Interventions included to: provide incontinence care and apply moisture barrier as needed; offer/encourage toileting prior to bedtime; check resident approximately every two hours and provide incontinence care as needed. A review of a Progress Note (PN) documented by the Licensed Practical Nurse (LPN #1), dated 5/17/23 at 4:18 AM, revealed that around 3:35 AM, a thud was heard. Staff went to check where the noise came from and found Resident #29 lying on their left side by their room door. [Resident #29] stated they had to go to the bathroom. Upon assessment, the resident could be seen with their hand over their left leg complaining of pain. [Resident #29] would not let staff turn them to assess the site where they reported the pain. The on-call Medical Doctor (MD) assessed the resident via video chat and ordered to send the resident to ER [emergency room]. The supervisor and Director of Nursing (DON) and unit manager were notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0600

Level of Harm - Actual harm

Residents Affected - Few

A review of the nurse's note from the Registered Nurse/Supervisor of Nursing (RN/SON) dated 5/17/23 at 4:44 AM, included the writer was called to assess the resident who had an unwitnessed fall. Upon arrival, the resident was lying on the floor on their left side complaining of severe pain to left thigh. A complete body assessment was not completed as the resident complained of severe pain when we tried to move them. The resident denied hitting their head; no bleeding noted at this time. The MD was made aware, and paramedics were called per MD order. The resident was transferred to the ER at 4:20 AM. The Resident Representative, Licensed Nursing Home Administrator (LNHA), and DON were notified.

A review of Resident #29's hospital medical record (HMR) dated 5/17/23 at 4:22 AM, included the reason for visit: fall; comments: . coming from [facility name redacted]- staff found [resident] on floor- unwitnessed fall. Hip pain: resident complaining of left hip pain . Primary diagnoses: closed fracture of left hip .

On 2/5/25 at 9:40 AM, the surveyor requested the facility's investigation for review, and the DON submitted the Facility's Reportable Event record (FRE) that was forwarded to the New Jersey Department of Health (NJDOH) on 5/17/23. The FRE included no statements, and the summary provided dated 5/2023, included under investigation revealed the following:

Per the Certified Nurse Aide [CNA #1], resident was last seen at 2:37 AM, and was in bed. At 3:30 AM, CNA (#2) heard a loud bang, and [Resident #29] was observed on the floor. The resident was noted in pain; new order received to be sent to hospital .

Conclusion: Per hospital records, [Resident #29] sustained a fracture of the left hip. [Resident #29] will be evaluated by therapy upon return and will follow their recommendations. No abuse or neglect could be substantiated. The document was not signed. The incident occurred on 5/17/23. The surveyor reviewed the document with the DON and requested any statements from staff who were involved with Resident #29's care during the 11:00 PM-7:00 AM shift (during the time the unwitnessed fall occurred).

A review of the Fall Witness Statement signed by CNA #1 revealed that the last time they saw the resident was at 2:37 AM. The resident was last toileted at 1:00 AM. CNA #1 heard a loud bang and rushed to resident room.

A review of LPN #1's statement included that around 3:35 AM, she heard a thud, and staff went to check where the noise came from. Staff found [Resident #29] on the floor lying on their left side by their door, and [Resident #29] stated that they had to go to the bathroom. Upon assessment, the resident was seen with their hands over the left leg, complaining of pain. [Resident #29] would not allow staff to turn and assess the site where they were complaining of pain. The on-call MD assessed the resident via video chat and said to send resident to the ER.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of LPN #2's statement dated 5/24/23, indicated that [Resident #29] was sleeping in bed when [CNA #1] was assigned to sit by the room side. (CNA was assigned to sit outside the resident's door and supervise them.) LPN #2 documented that both her and LPN #1 informed CNA #1 of their assignment to sit by Resident #29's door and supervise. LPN #2 documented that CNA #1 refused the assignment. LPN #1 and LPN #2 were making rounds on the unit when they heard a loud sound coming towards Resident #29's room, and they observed Resident #29 on the floor. They asked [Resident #29] if they had pain and the resident stated, yes. LPN #2 documented that CNA #1, who was assigned to supervise Resident #29, was sleeping at the nurse's desk until the nurse screamed. CNA #1 then got up and came to the scene. The paramedics were called, and the resident was taken to the hospital. On 2/5/25 at 11:15 AM, the surveyor reviewed LPN #2's statement with the DON. The DON stated that she did not review the statements, and she had not been aware that the CNA assigned to provide supervision for Resident #29 was found sleeping instead of watching the resident she was assigned to supervise. The surveyor then asked the DON what the facility protocol was if a CNA refused an assignment, and the DON stated that the nurse covered the assignment with someone else and notified the nursing supervisor immediately. The surveyor reviewed the facility provided Quality Assessment Report (incident type report) provided by the DON. The Quality Assessment Report revealed the following: Problem Statement: The resident had to go the bathroom and fell . Why 1: The resident had been toileted four hours prior. Why 2: The resident did not have to go and was asleep during next round. Root Cause: The resident was dry and asleep during last round. Awoken, self-transferred from bed and fell attempting to go the bathroom. The surveyor requested CNA #1, CNA #2, LPN #1, and LPN #2's phone numbers for interviews. The DON informed the surveyor that all four staff involved in the incident were no longer employed by the facility, and no contact information was provided. The surveyor reviewed all four staff's files (CNA #1, CNA #2, LPN #1, and LPN #2) and the incident was not documented in their employee files. A review of the facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy dated last revised 9/2022, included: Policy Statement: All reports of resident abuse (including injuries of unknown origin) neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings off all investigations are documented and reported. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator . NJAC 8:39-4.1(a)5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423 Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to a) ensure that physician orders were being consistently followed for a medication with hold parameters for 3 of 18 residents (Residents #82, #23 and #89), b) follow the physician orders for bilateral floor mats for a resident who was a fall risk for 1 of the 1 resident (Resident #19), c) administer medications according to the physician's orders for 1 of 6 residents (Resident #44) reviewed for medication administration. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 1/30/25 at 1:00 PM, Surveyor #1 reviewed Resident # 82's electric medical records (EMR) that revealed the following: The Admission Record (an admission summary) revealed that Resident #82 had diagnoses that included but were not limited to; Chronic Kidney Disease, Stage 3 (when kidneys are damaged and can't filter blood the way they should), hypertension (high blood pressure), anxiety disorder and difficulty in walking. A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate management of care, dated 1/10/25 reflected that Resident #82 had Short-term and Long-term memory problems. A review of the Order Summary Report (OSR) reflected that Resident #82 had an active Physician Order (PO) dated 5/11/22 for a medication: Hydralazine Tablet 25 MG (milligram). Give 1 tablet by mouth every 8 hours for Elevated BP (blood pressure) related to hypertensive heart and chronic (continuing for a long time) kidney disease without heart failure. Additional directions included: Hold for SBP (systolic blood pressure -a measurement of the pressure in the arteries during a heart beat) < (less than) 120, HR (heart rate) <55. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The corresponding PO was transcribed into the electronic Medication Administration Record (eMAR). Further review of the December 2024 - January 2025 eMARs for Resident #82 revealed that nurses signed and reflected a checkmark which indicated that the medication was administered when the med should have been held for a SBP that was less than 120 according to the PO, for the following dates and times: Date: Time: SBP: 12/3/24 6 AM 110/48 12/12/24 10 PM 98/51 12/16/24 2 PM 112/64 12/19/24 2 PM 107/68 12/21/24 10 PM 118/53 12/23/24 2 PM 119/63 12/25/24 2 PM 119/57 12/26/24 6 AM 118/52 12/27/24 6 AM 101/54 12/29/24 6 AM 108/59 1/1/25 2 PM 115/62 1/4/25 6 AM 106/45 1/4/25 2 PM 116/61 1/4/25 10 PM 118/61 1/10/25 2 PM 115/60 1/13/25 2 PM 112/58 1/14/25 2 PM 118/48 1/19/25 2 PM 112/58 1/22/25 2 PM 118/62 1/24/25 6 AM 110/58 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/24/25 10 PM 118/70 1/25/25 6 AM 112/62 1/25/25 10 PM 118/65 1/26/25 6 AM 109/58 1/28/25 2 PM 110/51 1/29/25 2 PM 112/62 On 2/4/25 at 12:10 PM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN #1) stated that the Hydralazine was for high blood pressure. The LPN #1 stated she would check resident's BP before administering the medication. The LPN #1 further stated Hydralazine was ordered with holding parameters and explained if the BP was less than 100, and HR was less than 60 then the medication would be held as per holding parameters ordered by physician. The LPN #1 further stated if Hydralazine was administered with BP less than 100 then it would lower the BP more. The LPN #1 stated if the medication was administered for BP less than 100 or HR less than 60, then she would contact and notify the physician, and the Unit Manager (UM). The LPN #1 stated that the UM was responsible to check and make sure that everything was right in the eMARs. During an interview with Surveyor #1 on 2/4/25 at 12:29 PM, the LPN/UM stated Hydralazine was for the blood pressure. The LPN/UM stated she would check the resident's BP, HR and physician's additional orders to see if there were any holding parameters. The LPN/UM further stated the medication would be held as per holding parameters. The LPN/UM stated it was important to hold medication with holding parameters because if medication was administered with low blood pressure, the resident could pass out with low BP and low HR. The LPN/UM stated she was responsible to check eMARs to make sure there were no mistakes. The LPN/UM reviewed the December 2024 and January 2025 eMARs in the presence of Surveyor #1, the LPN/UM acknowledged that the nurses should have held the medication and written a progress note that they held the medication. On 2/5/25 at 1:53 PM, the survey team met with the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS). Surveyor #1 notified them of the above-mentioned concerns for Resident #82. A review of the facility policy titled Administering Medications revised 4/19 included under Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Under section Policy Interpretation and Implementations: - 4.) Medications are administered in accordance with prescriber orders, including any required time frame. On 2/7/25 at 12:34 PM, the survey team met with DON, RDCS and the Regional Director of Operations for an Exit Conference. The facility management did not refuse the findings. 2. On 1/29/25 at 10:31 AM, Surveyor #1 observed Resident #19 sitting up in the bed. Resident was watching television (TV). Surveyor #1 observed a floor mat on the left side of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 8:52 AM, the surrey #1 observed Resident #19 eating breakfast in the bed, with their head of bed elevated. The surveyor observed a floor mat on the left side of the bed. On 1/31/25 at 10:50 AM, Surveyor #1 reviewed the electronic medical record for Resident #19 which revealed: According to the Admission Record, Resident #19 was admitted to the facility with diagnoses which included but were not limited to; Repeated Falls, Hypertension and anxiety disorder. A review of the comprehensive MDS dated [DATE], revealed that the Resident #19 scored 01 out of 15 on their BIMS, which indicated that the resident had a severely impaired cognition. A review of Resident #19's Care Plan (CP) Initiated on 12/17/24, reflected that Resident #19 was at risk for falls related to Parkinson's (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) with lack of coordination and difficulty walking history of falls prior to admission, dementia . muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue). The interventions initiated on 7/5/23 included: Fall mat(s) to both sides of the bed at all times when the resident is in bed. A review of the February 2025 Order Summary Report (OSR) reflected that Resident #19 had an active PO dated 8/12/24 for floor mats to both sides of the bed when resident in bed every shift. The corresponding PO was transcribed into the eMAR. Further review of the January 2025-February 2025 Medication Administration Record for Resident #19 revealed that nurses signed and reflected a checkmark which indicated that there were floor mats to both sides of the bed when resident was in bed all three shifts. On 2/5/25 at 9:23 AM, during an interview with Surveyor #1, the LPN #2 stated the POs were to have floor mats for the residents. The LPN #2 reviewed the eMAR for POs in the presence of Surveyor #1 and stated Resident #19 had PO for bilateral floor mats on the floor and the nurses check off the orders for floor mats in the eMARs each shift. The LPN #2 further stated that Resident #19 had bilateral floor mats available in the room. On 2/5/25 at 9:37 AM, during an interview with Surveyor #1, the Certified Nursing Aide (CNA #2) stated Resident #19 was at fall risk and the resident had one floor mat when the resident was in bed. The CNA #2 further stated the floor mat was placed on resident's left side, towards the window because Resident #19 liked facing towards the window. The CNA #2 further stated that the CNAs would check the floor mat placement, and the nurses would document it. Surveyor #1 accompanied the CNA #2 to Resident #19's room and observed only one floor mat to resident's left side of the bed. There was no floor mat observed to resident's right side of the bed. Surveyor #1 notified the LPN #2 about the observation of left sided floor mat. The LPN #2 acknowledged that Resident #19 should have had a floor mat on each side of their bed. On 2/5/25 at 9:49 AM, Surveyor #1 met with the LPN/UM and notified of the above-mentioned concern. The LPN/UM stated, I don't even have an answer for you. The LPN/UM further stated that the nurses should be more vigilant before signing off the orders. The LPN/UM stated the nurses should check to confirm that there were floor mats on bilateral sides before signing it off because it's a doctor's order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 1:53 PM, the survey team met with the DON and the RDCS. Surveyor #1 informed them of the above-mentioned concerns. The facility had no policy or procedure to provide regarding the use of floor mats. On 2/7/25 at 12:34 PM, the survey team met with DON, RDCS and the Regional Director of Operations for an Exit Conference. The facility management did not provide additional information and did not refute the findings. 3. On 1/29/25 at 12:15 PM, Surveyor #3 observed Resident #23 in the dining room awaiting the meal delivery. On 2/5/25 at 1:54 PM, the surveyor reviewed the medical record for Resident #23 which revealed the following: Resident #23 was admitted to the facility with diagnoses which included but were not limited to; diabetes mellitus and hypertension. The Order Summary Report dated 02/2025 reflected an order for Olmesartan Medoxomil-Hydochloride Oral Tablet 20-12.5 milligrams (medication used to treat hypertension) give 1 tablet orally one time a day for hypertension (HTN). The order specified to hold for systolic blood pressure less than 100 and Heart Rate less that 60. Initial order date 12/27/24. A review of the electronic Medication Administration Record (eMAR) for December 2024, January 2025 and February 2025, revealed that the eMAR was signed to reflect the administration of the Olmesartan. Further review of the eMAR reflected that the blood pressure and Heart Rate had not been entered into the eMAR in accordance with the physician order [the area was left blank]. The nurses initialed the eMAR which indicated that the medication had been administered. There was no documented evidence that the physician orders for blood pressure monitoring prior to administered the anti hypertensive medication was followed. On 2/7/25 at 8:57 AM, Surveyor discussed the above concerns with the DON, and reviewed the physician orders and the eMAR's together. The DON acknowledged that the staff failed to follow the order. During the exit conference at 12:55 PM no additional information was provided. A review of the facility policy titled Administering Medications revised 4/19 included under Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Under section Policy Interpretation and Implementations: - 4.) Medications are administered in accordance with prescriber orders, including any required time frame. 38079 4. On 1/31/25 at 7:47 AM, Surveyor #4 observed LPN #3 prepare to administer medications on the secure memory unit. At 8:07 AM, as LPN #3 was preparing medications for Resident #44, the breakfast meal was delivered to the resident, and they began to eat the meal. On 1/31/25 at 8:11 AM, LPN #3 administered a cup filled with unidentified medications and Surveyor #4 observed Resident #44 swallowed the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record revealed Resident #44 had diagnoses which included but were not limited to; gastro-esophageal reflux disease (GERD - a backflow of stomach acid into the esophagus). A review of the Admission MDS dated [DATE], documented a BIMS of 07 out of 15 indicating severely impaired cognition. A review of the Order Summary Report, active orders as of 1/31/25, included a physician's order dated 1/31/25, Esomeprazole Magnesium Delayed Release (gastric acid secretion reducer) 40 mg, give 1 capsule by mouth in the morning for GERD. Give at least 1/2 hour prior to meals. A review of the Care Plan Focus area dated 12/20/24, revealed a nutritional problem . related to GERD. A review of the eMAR dated 1/1/25 - 1/31/25, documented Esomeprazole Magnesium Delayed Release 40 mg, give 1 capsule by mouth one time a day for GERD. Give at least 1/2 hour prior to meals and was plotted to be administered at 8:00 AM. The MAR indicated LPN #3 signed as administered on 1/31/25. On 1/31/25 at 9:01 AM, LPN #3 acknowledged the physician's order was to administer the Esomeprazole half an hour prior to the meal. She further stated, I am aware. I have many medications to give but I am aware. I don't think she/he ate all their breakfast when I gave it (the Esomeprazole). On 1/31/25 at 9:42 AM, the Assistant Director of Nursing (ADON) stated an order that indicated to be administered half hour before a meal should be administered half hour before the meal. She stated that it could be because of the action of the medication or just because the physician ordered it that way. A review of the facility provided policy, Administering Medication revised 4/2019, included but was not limited to; 4. Medications are administered in accordance with prescriber orders . 7. Medications are administered within 1 hour of their prescribed time . 10. check the label 3 times to verify . right time before giving the medication. On 2/5/25 at 1:54 PM, the DON and the RDCS were made aware of the above concerns. The facility had no additional information to provide. 27193 5. On 1/31/24 at 8:04 AM, Surveyor #2 observed the LPN #4 administered the following medications to Resident #89: Primidone (an anticonvulsant) 50 mg 1 tablet Methimazole (to treat an overactive thyroid) 5 mg Naglimere (to treat Type 2 Diabetes) 100 mg Eliquis (a blood thinner) 5 mg Oxycontin ER (pain medication) 15 mg Pyridostigmine (a muscle stimulant) 30 mg 1 tablet LPN #4 checked the blood pressure prior to administering the medications. The blood pressure was 95/50. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #89, had an order for Midodrine 5 milligrams, give 1 tablet by mouth three times a day for hypotension. The Midodrine was not administered. The LPN informed the surveyor that the Midodrine was not available and she would follow up with the physician at 8:04 AM. The physician order dated 1/29/25 revealed the following: Midodrine HCl Tablet 5 MG, give 1 tablet three times a day. DO NOT GIVE AFTER EVENING MEAL OR WITHIN 4 HOURS OF BEDTIME TO AVOID SUPINE HYPERTENSION -HOLD SBP greater than 140. On 1/31/25 at 11:17 AM, Surveyor #2 followed up with LPN #4 regarding the Midodrine. The LPN stated that she was busy and did not follow up. Resident #89 did not receive the Midodrine as prescribed by the physician. The surveyor asked the LPN if she addressed the issue with the Unit Manager, she stated, No. At 11:30 AM, the surveyor interviewed the Unit Manager (UM) regarding the protocol for ordering and addressing missing medication. The UM informed the surveyor that staff were to order any medication prior to reaching the blue line noted on the Bingo Cart (tablet #8). The UM further added that some medications can be retrieved from the facility back up supply. The surveyor then inquired about Midodrine. The UM stated that Midodrine was included in the medication box. The UM added that she was not aware that Resident #89 missed the 8:00 AM dose of Midodrine that morning. The UM added that if the medication was not in the back up supply then the pharmacy would need to be called and the physician notified. The UM then stated that there should be documentation in the electronic records which indicated the reason why a medication was not administered. On 1/31/25 at 12:30 PM, Surveyor #2 reviewed the electronic medical record for Resident #89 who was admitted to the facility with diagnoses which included but were to limited to; Parkinsonism, cerebral infraction, adult failure to thrive. According to the Minimum Data Set, dated dated dated [DATE], Resident #89 had a Brief Interview for Mental Status score of 14 out of 15 indicative of intact cognition. The MDS also indicated that Resident # 89 required extensive assistance for Activities of Daily Living (ADL). Resident #89 had an ADL Self Care Performance Deficit related to weakness and deconditioning due to recent hospital stay. Review of the Physician Order Summary Sheet Dated February 2025, revealed an order for Midodrine (medication used to treat low blood pressure that causes severe dizziness and fainting) 5 mg to be administer x 3 daily for hypotension. A nurse's notes created 1/31/25 timed 11:56 AM reflected the following: Created Date :1/31/2025 11:56:04 Note Text: Midodrine HCl Tablet 5 MG Give 1 tablet by mouth three times a day for hypotension. Medication unavailable; reordered from pharmacy; Will call Medical Doctor (MD) to make aware. The LPN did not call the physician nor attempted to get the medication from the facility back up box until 11:38 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/25 at 12:30 PM, the above concerns was discussed with the Regional Director of Clinical Services (RDCS), the DON provided in-services education which addressed medication administration. No additional information was provided. NJAC 8:39-11.2(b), 27.1(a), 29.2(a), 29.3(a)5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 48423 Repeat Deficiency Based on observation, interview, and record review, it was determined that the facility failed to provide a means of communication for a resident identified as having a language barrier. This deficient practice was identified for Resident #122, 1 of 1 resident reviewed for communication and was evidenced by the following: On 1/29/25 at 12:58 PM, the surveyor observed Resident #122 in bed. The surveyor was unable to communicate with the resident. On 1/30/25 at 8:29 AM, the surveyor observed Resident #122 eating breakfast in the bed. Resident #122 spoke in Spanish when the surveyor was in the resident's room. The surveyor was not able to understand or communicate with the resident. On 1/30/25 at 10:15 AM, the surveyor reviewed the electronic medical record for Resident #122 which revealed: According to the Admission Record (admission summary), Resident #122 was admitted to the facility with diagnoses which included but were not limited to; type 2 Diabetes mellitus and dementia. A review of the Annual Minimum Data Set Assessment, (an assessment tool) dated 10/27/24, revealed that the Resident #122 scored 00 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated that the resident had a severely impaired cognition. Further review of the MDS revealed that Resident #122 was Spanish speaking. A review of Resident #122's individual Care Plan (CP) included a focus area dated 5/14/24, that the resident required the services of an interpreter because their primary language was not English. Primary language: Spanish. Interventions included: Provide resident with a communication board with common words in English and resident's preferred language to aide in communication for simple daily needs. On 2/5/25 at 9:06 AM, during an interview with the surveyor, the Certified Nurse Aide (CNA #1) stated Resident #122 was Spanish speaking. The CNA #1 stated when she had taken care of the resident, she would not understand the resident because the resident did not speak English. CNA #1 stated when she did not understand the resident then she would use hand gestures during care. CNA #1 further stated she would tap on Resident #122's side to turn to the other side when she provided toileting hygiene. CNA #1 acknowledged that when the resident spoke in their language, CNA #1 did not understand the resident and the only way she would communicate with Resident #122 was with hang gestures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 9:55 AM, during an interview with the surveyor, CNA #2 who was assigned to the resident, stated Resident #122 was mainly Spanish speaking. The surveyor inquired about how was the resident able to make their needs knows and CNA #2 stated that the resident used hand gestures a lot. CNA #2 stated that the resident had a communication board in their room. The surveyor accompanied the CNA #2 to Resident #122's room. Both observed the resident sitting in bed and resident spoke only Spanish and tried to have conversation with CNA #2. The surveyor and the CNA both were not able to understand and/or communicate with the resident. The CNA #2 searched, and she could not find a communication board in resident's room. On 2/5/25 at 10:12 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) stated Resident #122 was mainly Spanish speaking. The LPN stated she was able to understand the resident because some of her language vocabulary matched with resident's language, so she did not utilize any devices to communicate with the resident. The LPN further stated if she was not able to understand the resident, she would take the Spanish speaking CNA with her to resident's room. The LPN stated the communication board wouldn't be effective for Resident #122 because it was used for people who have hard time speaking or if they were hard of hearing. On 2/5/25 at 1:53 PM, the survey team met with Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS). The surveyor informed them of the above-mentioned concerns for the Resident #122. The DON acknowledged that Resident #122 should have had a communication board in the room so that the resident would be able to express their needs. Review of the facility provided policy Translation and/or Interpretation Services dated 8/2021, included under policy interpretation and implementation: 3. The facility utilizes cue cards (Communication Board) to assist health professionals and residents who have English language difficulties or communication difficulties to communicate. On 2/7/25 at 12:34 PM, the survey team met with DON, RDCS and the Regional Director of Operations for an Exit Conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-13.3(b), 27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint #s NJ 165805, 166524, 166709, 169246, 178803 Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to consistently provide appropriate incontinence care, and personal hygiene care for all residents. The deficient practice was identified for Resident #89, #100, #132, #152, #370, #123, #71, #122, #82, #35, and #77, for 2 of 3 resident units (Maple and Ridge Units) and evidenced by the following: 1. On 2/04/25 AM at 7:20 AM, the surveyor observed Resident #100 in bed, the head of the bed was elevated, and the resident was able to answer questions. Upon inquiry, the resident informed the surveyor that they were wet and needed to be changed. The surveyor asked the resident to activate the call light. The surveyor left the room and informed staff that Resident needed assistance. On 2/4/25 at 10:00 AM, the surveyor observed Resident # 100 in bed. The call device was on the floor. The resident informed the surveyor that they had not been changed. The surveyor left the room and asked a random Certified Nurse Aide (CNA) to assist with a care tour and the resident's brief was observed soaked with urine. The resident stated that they were last assisted with incontinence care the previous night. Resident #100 had a care plan for incontinence care initiated 12/08/23. The intervention was to provide incontinence care and apply moisture barrier as needed. Resident #100 had a Brief Interview for Mental Status (BIMS) Score of 14 out of 15 indicative of intact cognition. 2. On 1/29/25 at 9:27 AM, the surveyor observed Resident #89 in bed with long facial hair, and all nails were long and jagged. On 1/30/25 at 10:45 AM, the surveyor observed Resident #89 in bed, after morning care had been provided with nails long and jagged, black substance underneath the finger nails, and Resident #89 was unshaven. On 1/31/25 at 8:00 AM, the surveyor returned to the room and observed that Resident #89 had just completed breakfast. The resident's nails were still long, jagged and not trimmed and Resident # 89 had not been shaved. On 2/04/25 at 9:19 AM, the surveyor interviewed the resident who stated that they would like their nails to be trimmed and cleaned. On 2/05/25 at 8:35 AM, the surveyor observed the resident in bed, the resident stated again they would like to be shaved. On 2/05/25 at 12:15 AM, the surveyor reviewed Resident #89's medical record which revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 89 was admitted to the facility with diagnoses which included but were to limited to: Parkinsonism, cerebral infraction, adult failure to thrive. According to the Minimum Data Set (MDS) dated [DATE], Resident #89 had a BIMS score of 14 out of 15 indicative of intact cognition. The MDS also indicated that Resident # 89 required extensive assistance for Activities of Daily Living (ADL). Resident # 89 had an ADL Self Care Performance Deficit related to weakness and deconditioning due to recent hospital stay. Review of the Care Plan (CP) for Resident #89 initiated on 5/10/24 revealed a Focus for ADL self care performance deficit related to weakness, deconditioning. The goal was for Resident #89 to reduce risks for complications of self care deficit and impaired mobility daily. The interventions included, provide assistance with all activities of daily living including hygiene. On 2/5/25 at 10:30 AM, the surveyor interviewed the Assistant Director of Nursing regarding the care. She stated that the manager and the nurses were to make rounds and ensure the residents were being cared for. On 2/4/24 at 11:30 AM, the surveyor interviewed the CNA regarding nails care. The CNA who cared for Resident #89 stated that nail care could be offered daily with the morning care or shower days. Resident # 89 had a shower scheduled on Tuesday, had not been shaved, and the nails were not being trimmed. On 2/5/25 at 8:30 AM, the surveyor interviewed the CNA assigned to Resident #89. The CNA revealed that Resident #89 could feed themselves after set-up, was able to assist with turning and able to make their needs known. The CNA stated that she would ask the resident if they wanted to be shaved today. When asked regarding the resident nail care, the CNA did not have any comments. 3. Resident #132 was admitted to the facility with diagnoses which included but were not limited to muscle wasting and atrophy, anemia and low back pain. On 1/30/25 at 10:00 AM, the surveyor observed Resident #132 in bed, and reported being cold. Resident #132 was observed with thick facial hair. On 1/31/25 at 6:45 AM, the surveyor observed Resident #132 in bed. Resident #132 had not received care yet. A random CNA completed incontinence care for Resident #132 who was observed soaked with urine. The resident had not been shaved and the surveyor asked the resident if they would like to be shaved and they stated, Oh yes I would like to. On 1/31/25 at 11:15 AM, the surveyor observed Resident #132 in bed. The surveyor observed that the resident had not been shaved The surveyor esorted the Assistant Director of Nursing to the room where we both observed that the resident had not been shaved. On 2/5/25 at 10:30 AM, the surveyor reviewed Resident #132's electronic medical record. Resident #132 had a CP in place for ADL's Self Care Performance Deficit related to adult failure to thrive. The interventions was to provide Resident #132 with assistance with care. 4. On 1/30/25 at 9:50 AM, the surveyor observed Resident #150 in bed, their nails were long, discolored with dark substances underneath the finger nails, and Resident #150 was unshaven. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/31/25 at 11:30 AM, the surveyor observed Resident #150 was sitting in a wheelchair at the bedside and the nails were long, discolored and jagged. The Surveyor asked the resident if they would like their nails to be trimmed and cleaned, the Resident stated, yes. On 1/31/25 at 11:45 AM, the surveyor escorted the Unit Manager (UM) to the room where we both observed Resident #150's nails and facial hair. The UM confirmed that Resident #150's nails needed to be trimmed and cleaned and the resident shaved. On 1/31/25 at 10:00 AM, the surveyor reviewed Resident #150's electronic medical record which revealed: The Resident was admitted to the facility with diagnoses which included but were not limited to; hemiplegia, cerebral infarction and dysphagia. The Quarterly Minimum Data Set (MDS) dated [DATE], revealed that Resident #150 had intact cognition with a score of 15 out of 15 on the BIMS (Brief Interview for Mental Status). Resident #150 had a care plan initiated on 12/04/24 for ADL Self Care Performance Deficit related to left sided weakness. The goal was the resident will be clean, well groomed and appropriately dressed daily with staff assistance. The interventions was to provide Resident #150 assistance with grooming and personal hygiene, and treatments. 48423 5. On 1/29/25 at 9:20 AM, during initial tour, the surveyor observed Resident #370 in bed and observed a urine odor in the room. The resident was not able to tell the surveyor when the last time they had incontinence care. The surveyor observed Resident #370's both hands with square shape long fingernails with jagged edges. The nail on the right index finger was half broken. Both thumb nails had dried brown colored substance around the cuticles. On 1/29/25 at 9:34 AM, the surveyor returned with the assigned CNA #1 for Resident #370 to observe the resident for incontinence rounds. The CNA #1 checked Resident # 370's brief and the resident brief was soaked with urine. The CNA #1 stated that she reported to work at 7:00 AM that morning, she delivered the breakfast tray, and she had not yet provided any care to Resident #370 (2.5 hours after she started working). CNA #1 then closed the brief without changing the resident, and informed the resident that she would come back to clean the resident after she provided a shower to resident's roommate. On 1/30/25 at 9:03 AM, the surveyor observed Resident #370 in bed. The surveyor observed Resident #370's both arms were shaking, and resident's hands were noted with square shaped long nails with jagged edges. The right index fingernail was half broken. The resident stated they would like their nails to be trimmed. On 1/31/25 at 8:18 AM, the surveyor observed Resident #370 eating breakfast in their bed. Resident #370's both arms were shaking. The surveyor observed resident #370's long nails with jagged edges in the same condition as observed on 1/29/25 and 1/30/25. On 1/30/25 at 11:34 AM, the surveyor reviewed the electronic medical record for Resident #370 which revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Admission Record (admission summary), Resident #370 was admitted to the facility with diagnoses which included but were not limited to; Urinary tract infection, Osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), and urge incontinence (a type of urinary incontinence that causes an urgent, uncontrollable need to urinate several times during the day and night). A review of the Annual Minimum Data Set (MDS) Assessment, an assessment tool, dated 11/13/24, revealed that the Resident #370 scored 05 out of 15 on the BIMS which indicated that the resident had a severely impaired cognition. Further review of the MDS revealed that Resident #370 required partial/moderate assistance with personal hygiene. Section H of the MDS revealed that Resident #370 was occasionally incontinent of urine. A review of Resident #370's Care Plan (CP) initiated on 11/10/24, reflected that Resident #370 had an ADL (Activities of Daily Living) self-care performance deficit related to dementia. Interventions included: Personal Hygiene: I am dependent on staff for grooming/personal hygiene; and Toileting: I am dependent on staff for toileting. On 1/31/25 at 9:07 AM, during an interview with the surveyor, the CNA #1 stated that she had not made incontinence rounds on Resident #370 and was unsure about nail care, and stated, I am assuming we can provide nail care and cut resident's nails? CNA #1 further stated it was important to provide nail care and clean nails with wash rags every day during morning care because the residents got stuff like feces and germs under their nails, and they (the residents) put their nails in their mouth and for infection control. The CNA #1 stated that Resident #370 might be able to trim their own nails if you provided assistance or sat by the resident and told them what to do. At 9:45 AM, the surveyor returned and accompanied the CNA #1 to Resident #370's room and both observed the resident with shaky arms. CNA #1 acknowledged that the resident was not able to cut their own nails. The CNA #1 looked at resident's nails and stated the nails got a lot of food under them and they needed to be cleaned and cut down. 6. On 1/29/25 at 9:31 AM, during initial tour, the surveyor observed Resident #123 in bed and observed a strong urine odor in the room. Resident stated, I am wet, I am wet. On 1/29/25 at 9:34 AM, the surveyor returned with the assigned CNA #1 for Resident #123 to check on the resident for incontinence rounds. The CNA #1 checked Resident # 123's brief and the resident brief was soaked with urine. The CNA #1 looked at the brief and stated it is kind of wet and informed the resident that she would take the resident to shower since it was their shower day. On 1/30/25 at 12:16 PM, the surveyor reviewed the electronic medical record for Resident #123 which revealed: According to the Admission Record, Resident #123 was admitted to the facility with diagnoses which included but were not limited to; Pacemaker (a small electronic device that is implanted in the chest to help control abnormal heart rhythms), Atrial Fibrillation (irregular heart rhythm), and hemiplegia (total paralysis on one side of the body). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the quarterly MDS, dated [DATE], revealed that the Resident #123 scored 09 out of 15 on the BIMS which indicated that the resident had a moderately impaired cognition. Further review of the MDS revealed that Resident #123 was frequently incontinent of urine and was dependent on staff for toileting hygiene. A review of Resident #123's CP initiated on 8/8/24, reflected that Resident #123 had an ADL self-care performance deficit related to impaired mobility. Interventions included: Toileting: I am dependent on staff for toileting. A further review of the Resident #123's CP revealed a Focus area that the resident had urinary incontinence related to impaired mobility that was created on 8/8/24 and the interventions included check resident approximately every 2 hours and provide incontinence care as needed. 7. On 1/29/25 at 9:43 AM, during an initial tour, the surveyor observed Resident #71 walking on the unit and was holding a cup in their right hand, and the surveyor observed resident's long half broken nails with jagged edges on their right hand. On 1/31/25 at 8:59 AM, the surveyor observed resident walking on the unit. Resident #71 and both hands were observed with long nails, same as observed on 1/29/25. On 1/30/25 at 10:12 AM, the surveyor reviewed the electronic medical record for Resident #71 which revealed: According to the Admission Record, Resident #71 was admitted to the facility with diagnoses which included but were not limited to; dementia, Alzheimer's disease, lack of coordination and muscle weakness. A review of the Annual MDS, dated [DATE], revealed that the Resident #71 scored 07 out of 15 on their BIMS which indicated that the resident had a severely impaired cognition. t Resident #71 also required setup or clean up assistance with Personal hygiene. A review of Resident #71's CP Initiated on 1/10/24, reflected that the resident had an ADL self-care performance deficit result to other lack of coordination. Interventions included: Personal Hhygiene: I require supervision/setup with grooming/personal hygiene. 8. On 1/30/25 at 8:29 AM, the surveyor observed Resident #122 in their bed, eating breakfast. The surveyor observed Resident #122's both hands with long square shaped and pointy nails. Resident #122 had food type debris under their nails. On 1/30/25 at 10:15 AM, the surveyor reviewed the electronic medical record for Resident #122 which revealed: According to the Admission Record, Resident #122 was admitted to the facility with diagnoses which included but were not limited to; Type 2 Diabetes Mellitus and dementia. A review of the Annual MDS, dated [DATE], revealed that the Resident #122 scored 00 out of 15 on their BIMS which indicated that the resident had a severely impaired cognition also required substantial/maximal assistance with personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #122's CP Initiated on 5/14/24, reflected that the resident had an ADL self-care performance deficit result to dementia. Interventions included: Monitor/record/report PRN (as needed) changes in ADL ability, potential for improvement, and/or inability to perform ADLs. 9. On 1/30/25 at 8:38 AM, the surveyor observed Resident #82 sitting up in their bed. The surveyor observed the resident's left hand placed on the left side rail and the nails were long and had brown colored discoloration and substance under their thumb nail. The surveyor was not able to observe resident's right hand. On 1/30/25 at 1:00 PM, the surveyor reviewed the electronic medical record for Resident #82 which revealed: According to the Admission Record, Resident #82 was admitted to the facility with diagnoses which included but were not limited to; hypertension (high blood pressure) and major depressive disorder. A review of the Quarterly MDS, dated [DATE], revealed that the Resident #82 BIMS interview was not conducted. Section C of the quarterly MDS reflected that Resident #82 had Short-term and Long-term memory problems, and required partial/moderate assistance with Personal hygiene. A review of Resident #82's CP Initiated on 6/5/22, reflected that Resident #82 had an ADL self-care performance deficit result to dementia. 10. On 1/29/25 at 12:11 PM, the Surveyor #2 (S #2) observed Resident #77 eating lunch in the room. The surveyor observed Resident #77's long and jagged nails with dark substance underneath the fingernails. On 1/30/25 at 8:14 AM, Surveyor #1 and S #2 observed the resident eating breakfast in their bed. Both surveyors observed Resident #77's long and jagged nails with dark substance underneath the fingernails. On 1/31/25 at 12:58 AM, Surveyor #1 and S #2 observed Resident #77 sitting in bed. Both surveyors accompanied the Assistant Director of Nursing (ADON) to the resident's room and observed Resident #77's nails. The ADON acknowledged that the nails were long. On 2/4/25 at 10:15 AM, the surveyor reviewed the electronic medical record for Resident #77 which revealed: According to the Admission Record, Resident #77 was admitted to the facility with diagnoses which included but were not limited to; type 2 diabetes mellitus (a condition where there is too much glucose in the blood), hypertension (high blood pressure) and primary open-angle glaucoma (is an eye condition that damages the optic nerve, which can lead to vision loss or blindness). A review of the quarterly MDS, dated [DATE], revealed that the Resident #77 scored 02 out of 15 on their BIMS which indicated that the resident had a severely impaired cognition. Further review of the MDS revealed that Resident #77 had moderately impaired vision and was dependent on staff for personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #77's Care Plan initiated on 12/04/22, reflected that the resident had an ADL self-care performance deficit result to dementia. 11. On 1/30/25 at 8:35 AM, the surveyor observed Resident #35 eating breakfast in their room. The surveyor observed resident had long dark colored nails and right thumb nail was half broken horizontally. The surveyor asked the resident about their nails and the resident stated, I want my nails cut. The resident was having difficulty opening butter. The resident asked for assistance with opening up butter. The surveyor notified the staff of resident's requests. On 1/31/25 at 8:44 AM, the surveyor observed the resident eating breakfast in their bed. Resident's nails were same as observation on 1/30/25. On 2/4/25 at 10:30 AM, the surveyor reviewed the electronic medical record for Resident #35 which revealed: According to the Admission Record, Resident #35 was admitted to the facility with diagnoses which included but were not limited to; hypertension, hemiplegia and hemiparesis (Weakness or partial paralysis on one side of the body), and lack of coordination. A review of the Comprehensive MDS, dated [DATE], revealed that the Resident #35 scored 05 out of 15 on their BIMS which indicated that the resident had a severely impaired cognition. Further review of the MDS revealed that Resident #35 required partial/moderate assistance with Personal hygiene. A review of Resident #35's Care Plan initiated on 1/23/25, reflected that the resident had an ADL self-care performance deficit result to debility (weakness caused by an illness). Interventions included: Personal Hygiene: I am dependent on staff for grooming/personal hygiene. On 2/5/25 at 10:15 AM, the surveyor interviewed the UM regarding her responsibilities. The UM stated that her role was to ensure the care was being delivered, communicate with staff, check assignment, and make rounds. The surveyor then asked the UM who supervise the care, the UM replied all the nurses and during medication. On 2/5/25 at 11:30 AM, the DON informed the surveyor that she was not aware of the above concerns with nails and incontinence care and would in-serviced the staff. On 2/5/24 at 11:45 AM, the surveyor escorted the UM to Resident #150's room we both observed the condition of the resident's hands and nails. The nails were jagged and a black coated substance was noted underneath the finger nails. On 2/5/25 at 1:53 PM, the survey team met with DON and the Regional Director of Clinical Services (RDCS). The surveyor informed them of the above-mentioned concerns for all the residents regarding their nail care and incontinence care. The DON stated if two residents were incontinent, and one resident was scheduled to have a shower then incontinence care should be provided to a resident who wouldn't be getting a shower first and the other resident would be next . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided LPN Nurse Job Description under section Peronnel Functions included: Make daily rounds of your unit/shifts to ensure that assigned CNAs/GNAs and other nursing personnel are performing their work assignments in accordance with acceptable nursing standards .Evaluate daily performance of assigned CNAs/GNAs . Under section Nursing Care Functions included: Ensure that personnel providing direct care to residents are providing such care in accordance with the resident's care plan and wishes. Under section Care Plan and Evaluation Functions included: Review care plans daily to ensure that appropriate care is being rendered. Ensure that assigned CNAs/GNAs (Geriatric Nursing Assistants) and other nursing personnel are aware of the resident care plans. Ensure that the CNAs/GNAs . refer to the resident's care plan prior to administering daily care to the resident. A review of the facility provided responsibilities Certified Nursing Assistant/Geriatric Nursing Assistant under section Purpose of your job position included: The primary purpose of your job position is to provide each of our assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors. Under Personal Care Functions: Assist residents with nail care (i.e., clipping, trimming, and cleaning the finger/toenails). Keep hair on female residents clean shaven (i.e., facial hair) as instructed. Keep residents dry (i.e., change, clothing, etc, when it becomes wet or soiled). Keep incontinent residents clean and dry. Ensure that residents who are unable to call for help are checked frequently. A review of the facility provided policy Fingernails/Toenails, Care Of revision date 2/2018, included under Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Under General guidelines:1. Nail care included daily cleaning and regular trimming. Under Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual(s) who administered the nail care. A review of the facility provided policy Activities of Daily Living (ADL), Supporting revision date 3/2018 included under Policy statement: Resident who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Under Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (.grooming, and oral care); c.) elimination (toileting) On 2/7/25 at 12:34 PM, the survey team met with DON, RDCS and the Regional Director of Operations for an Exit Conference and no additional information was provided. NJAC 8:39-27.1 (a)(e)(f)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 165805, 166524 Based on interview, record review and document review, it was determined the facility failed to ensure quality of care was provided in accordance with professional standards of practice for wound care by failing to monitor, identify and report changes in a wound on 2/17/23. The Resident Representative (RR) insisted the resident to be sent to the hospital and the resident was admitted to the hospital with cellulitis of the neck, chest, and infected sacral wound. This deficient practice occurred for 1 of 1 resident reviewed for wound care (Resident #10) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 2/5/25 at 10:30 AM, the surveyor reviewed Resident #10 electronic medical record. The Admission Face Sheet reflected that Resident #10 had diagnoses which included but were not limited to; adult failure to thrive ,cellulitis unspecified, muscle waisting and atrophy, unspecified calorie malnutrition, seizure disorder. . A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/12/24 reflected that Resident #10 was totally dependent on staff for care. Resident #10 was non verbal. A review of the individual comprehensive care plan included a focus area for pressure ulcers initiated on 8/24/24. The interventions included to monitor and document changes in skin status such as: appearance, color, wound healing, signs and symptoms of infection, changes in wound size or stage, report to physician or designee as clinically indicated. Administer treatments as ordered and monitor for effectiveness. The resident's pressure ulcer will show signs of healing and remain free from infection by/ through the review date. On 2/9/23 the Wound Care Specialist documented the following: Assessment Notes: Wound is deteriorating, noted (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with 20% slough and 80% granulation tissue. No debridement performed due to pain. Low air-loss mattress noted in place. Wound #1 Sacral Other Orders Treatment Recommendations Discontinue prior treatments Cleanse the wound with Normal Saline. Do not scrub or use excessive force. Pat dry. Apply Honey (Medical Grade) Gel to the wound Apply Calcium Alginate cut to size to the wound base Cover with a bordered foam dressing. Change dressing daily and when soiled. Additional Orders Other Orders Off-Loading Continue turning and repositioning as per standard of care, avoiding position directing pressure to Wound site, limiting side lying to 30 degree tilt, and limiting the head of the bed elevation to 30 degrees in bed except for meals. Low Air-Loss (LAL) mattress in place with correct settings. Plan of Care Plan of Care discussed with Facility staff. signed 02/09/2023 at 8:24:33 PM. There was no documentation in the medical record that the wound was assessed daily or the wound was being monitored. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Nursing Progress Notes (NPN) from 2/09/23 to 2/15/23 did not include any documentation/data entry made by the nursing staff on regarding the resident's wound or possible infection. A nurse's notes dated 2/15/23 timed 2:12 PM, reflected that Resident #10 was transferred to the Hospital via 911 per family member request. There was no assessment to indicate why Resident #10 was transferred to the hospital. Resident #10 was transferred back to the facility on [DATE]. The hospital record revealed that Resident #10 was admitted with cellulitis of neck and chest. Infected sacral wound., Fever. The Initial history and physical dated 3/3/2023 revealed the following: Resident #10 with history of advanced multiple sclerosis, adult failure to thrive syndrome, has PEG tube, cognitive deficits, seizure disorder, nonverbal at baseline, history of sacral decubitus ulcer presented to the (ED) Emergency Department with fever, concerning for worsening sacral ulcer. Patient was admitted for further evaluation and management. Resident #10 was seen by ID (Infectious Disease) for stage 4 ulcer that is infected and treated with IV (Intravenous) zosyn (Antibiotic) for 15 days. Assessment/Plan: 1.Decubitus ulcer of back, stage 4- Patient non-verbal at baseline - Wound cultures with proteus and many beta hemolytic step - Blood cultures are negative to date General surgery recommended local wound care, antibiotics and placement of wound VAC (medical device that uses negative pressure to promote wound healing). They did not recommend surgical debridement. - ID recommended IV antibiotics Zosyn -has received 15 days. Augmentin for additional 2 weeks along with a probiotic to complete antibiotic course. Patient will continue to follow-up with general surgery outpatient to reassess wound and have ongoing wound VAC changes at rehab Monday, Wednesday, Friday. 2. Cellulitis- Left side of the buttock; also chest and neck on presentation Leukocytosis has resolved. Blood cultures remain negative Transition top.o. antibiotics as recommended by infectious disease. Patient will be discharged on oral (Antibiotic) Augmentin for additional 14 days 3. Seizure disorder (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Continue on keppra, valium. Follow-up with outpatient neurologist 4. Multiple sclerosis; adult failure to thrive syndrome - Supportive care -Tolerating tube feeds. The facility did not have any investigation regarding the change in condition. On 2/7/25 at 12:30 PM, the Director of Nursing indicated that she was on vacation and could not comment on the issue. However she stated the nurse should have assessed the resident, called the physician prior to transfer to the hospital. A review of the facility change in a Resident's Condition Status provided by the DON on 2/7/25 at 12:55 PM, revealed the following: Our facility promptly notifies the resident, Resident Representative the attending physician of changes in the resident's medical/mental condition or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Prior to notifying the physician, or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the interact SBAR Communication Form. NJAC 8:39-11.2(b); 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 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** 27193 Complaint #s NJ 165805, 166524 Based on observation, interview, and record review, it was determined that the facility failed to: a.) ensure a treatment dressing was applied to a sacral pressure ulcer in accordance with a physician order, and b.) ensure a skin assessment was completed for a resident upon return from the hospital, and c) implement measures to prevent the development of pressure ulcers in a timely manner in accordance with professional standards of practice. This deficient practice was identified for 2 of 2 residents reviewed with pressure ulcers (Resident # 10 and #29), and was evidenced by the following: 1. On 2/04/25 at 6:05 AM, during incontinence tour, the surveyor observed Resident #10 with a deep wound to the sacral area that was not covered with a dressing. The soiled dressing was dislodged and noted in the resident's brief along with the wound packing. The Certified Nursing Aide (CNA) stated that it must have come off the wound when the resident was being turned. The incontinent brief had brown and yellow drainage in the area of contact with the resident's pressure ulcer. The surveyor observed 2 other dressing on the left and right buttocks. The CNA then stated to the surveyor that Resident #10 had only one wound. The dressing on the right and left buttocks were to protect the areas from reopening. The CNA informed the surveyor that the dressing was being changed every 3 days and when the dressing was soiled. On 2/4/25 at 7:58 AM, the surveyor inquired about the wound care and the nurse confirmed that the order was for the sacral dressing to be changed every 3 days and as needed. On 2/5/24 at 11:30 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare the table for a wound treatment. The LPN observed the resident's wound and stated that the resident had a stage 4 pressure ulcer (full thickness tissue loss wound) to the sacrum for a long time. The wound was cleansed and measured. The surveyor observed the LPN wash her hands, and don (put on) a new pair of gloves. She then cleansed the resident's sacral wound with Normal Saline Solution, pat the wound dry, removed her gloves and cleansed her hands. The LPN don gloves picked up the scissors that were on top of the treatment cart, cut the medicated packing, and was about to insert the packing when the surveyor stopped the treatment. The surveyor informed the nurse that the scissors needed to be disinfected prior to be used. The Unit Manager who was in the room to assist with the wound care, removed her gloves and gown, sanitize her hands, cleansed the scissors and assist the LPN to complete the wound care. The LPN cut a piece of the Maxsorb dressing (absorbent dressing for moderate to heavily draining wounds). She then applied a foam dressing for optimum coverage and protection. The dressing was dated and timed appropriately with a permanent marker. The LPN then cleaned and disposed the contents in the trash, removed her gloves, washed her hands, and cleaned the over bed table with germicidal wipes. The LPN then signed the resident's Treatment Administration Record (TAR) for completion of the appropriate wound treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed Resident #10 electronic medical record. The admission Face Sheet reflected that Resident #10 had diagnoses which included but were not limited to; Adult failure to thrive,cellulitis unspecified, muscle waisting and atrophy, unspecified calorie malnutrition. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/12/24, reflected that the resident was at high risk for developing pressure ulcers and had a stage 4 pressure ulcer to the sacral area. A review of the electronic Progress Notes dated 1/28/25, reflected that the resident had a stage 4 pressure ulcer injury to the sacrum which measures 3.0 centimeters (cm) x 3.0 cm x 1.4 cm. with undermining from 9-3 o'clock measuring 2.4 cm. The note reflected that the resident was on a low air loss mattress and is offloading using repositioning wedges. A review of Physician's Orders sheet (POS) for January 2025, reflected an order dated 10/29/24 for the sacral wound to be cleansed with Normal Saline, apply Prisma moistened with saline, lightly pack with Maxsorb rope, then foam dressing every day shift every 3 days for pressure injury as needed when soiled The surveyor then reviewed the wound care consult and noted that the order for the wound care was changed on 12/3/24. At the last visit, the wound was debrided (removal of dead tissue). The recommendations was for wound care daily and as needed when soiled. A review of the TAR for January and February 2025, reflected that the order was not transcribed. On 12/07/25 at 10:49 AM, the surveyor reviewed the 12/3/24 consult with the Director of Nursing (DON). The DON confirmed that the resident only had one pressure ulcer to the sacrum. She further acknowledged the surveyor findings and stated that the nurses were to review the consult and transcribe the order. The wound care order was changed on 12/3/24 and the staff was not aware. 2. Resident #2 was transferred to the Maple Unit on 5/5/23. The nurse's progress notes dated 5/5/23 at 12:59 AM indicated the following: Note Text: Resident received in room in bed at 11:00 PM. Resident is alert and able to make needs known with periods of confusion. Resident is a new admission. Had no signs and symptoms of pain, Resident has no skin issue. Resident is incontinent of bladder and bowel and clean and dry currently. Frequent rounds made through shift. will monitor. On 5/6/2023 at 06:23 AM, the nurse wrote: Upon assessment of resident's skin, noted redness to her sacrum with a 2 cm scratch going horizontal. The left upper back appears to have some scratches that are red. Bilateral upper and lower extremities appears intact. There was no documentation of any wound to the sacral area. No treatment in place. On 5/17/23 at 3:35 AM, Resident #29 sustained a fall with fracture at the facility and was transferred to the hospital where they underwent surgery to repair the fracture. Resident #29 returned to the facility on [DATE]. The assessment revealed that Resident #29's left thigh area noted with purplish dark red bruises. Left thigh area noted with purplish dark red bruises. Pubic/Groin area redness in skin folds (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no mention of a wound or redness to the sacral area. On 5/22/23 at 11:31 AM, The nurse's notes indicated that Resident #29 had a deep tissue injury (DTI) surrounding an open skin pressure injury. Resident has had these skin issues present during readmission. There was no documented evidence that the area was measured or the physician was called for wound care. There was no wound treatment in place. A nurse's note entered as a late entry on 5/30/23 (11) days after being readmitted , indicated the following: Type: Skin/Wound Note Focus: Monitor and document wound healing. Measure length, width, and depth (where possible). Assess and document status of wound perimeter, wound bed, and healing progress. Report changes in wound to physician or designee as clinically indicated. A nurse's notes dated 5/23/2023 timed 5:17 PM, indicated that the Resident Representative was notify of the sacral wound on 5/23/23. Resident #29 returned from the hospital on 5/19/23. A Late entry progress notes created 5/30/2023 at 5:41 by the Unit Manager reflected the following: Note Text: Late entry- Resident #29, was seen by wound care team for initial exam of an acute sacral pressure ulcer measures 5.8 x 8 x 0.2 cm in size with moderate amount serous drainage. There is 20% granulation tissue and 80% black discoloration. Treatment includes cleansing wound with NSS. Pat dry. Apply medical grade honey to wound. Apply Calcium alginate, cut to size wound base. Cover with bordered foam dressing. Change daily and when soiled. Recommend alternating pressure mattress for offloading. Turn and reposition as per standard of care. Avoid direct pressure to wound site. Limit Head of bed (HOB) elevation to 30 degrees except in bed for meals. Plan of care discussed with family and staff. The facility could not provide documentation of wound care done prior to 5/25/23 prior to the wound care initial visit. On 2/7/25 at 11:30 AM, the surveyor reviewed the skin assessment dated [DATE]. The skin assessment indicated that the resident was at moderate risk for pressure ulcer. Resident #29 received a score of 16. There was no documentation that a sacral wound was identified, measured and communicated to the physician or the resident representative. There was no wound treatment in place. However, Resident #29 had a fracture and was totally dependent on staff for bed mobility and transfer. The Comprehensive Care Plan initiated 5/4/23 had a focus for potential skin breakdown related to impaired mobility. The interventions were to document skin checks weekly and as needed. Notify the physician and resident representative of new areas if observed, dated 5/04/23. A review of the facility Prevention of Pressure Injuries provided by the facility on 2/7/25 at 12:55 PM last revised April 2020, reflected the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: Provide information regarding identification of pressure injury [NAME] factors and interventions for specific risk factors. Preparation Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Skin Assessment During the skin assessment, inspect: Presence of erythema Temperature of skin and soft tissue; and Edema. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs, NJAC 8:39-27.1 (e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 27193 Complaint # NJ 173844 Based on observation, interview, record review, and document review it was determined that the facility failed to provide adequate monitoring and supervision to prevent falls with injury for a resident who was assessed as a high risk for falls. On 12/23/24, Resident #92 who had a fall and the nurse documented that the resident was on one staff-to-one resident (1:1) monitoring, had a second fall within one hour that required emergency services to transfer the resident to the hospital. The resident sustained from the fall: an acute comminuted fracture (breaks in three or more pieces) of the left inferior orbital rim (eye socket); an acute comminuted and mildly displaced fracture of the left lateral orbital rim; an acute comminuted and mildly displaced and depressed fracture of the left anterior maxillary sinus wall; left periorbital and facial soft tissue contusion with soft tissue swelling; and a laceration to left cheek that required five sutures. This deficient practice occurred for 1 of 5 residents (Resident #92) reviewed for accidents. This deficient practice was evidenced by the following: On 01/29/25 at 9:15 AM, the surveyor toured the Maple Unit of the facility and observed Resident #92 seated in a recliner chair in the dayroom with a Certified Nursing Aide (CNA) at their side. Resident #92 was observed with purplish bruises to the facial area, both eyes were closed, and the resident did not engage in a conversation with the surveyor. On 01/30/25 at 10:15 AM, the surveyor observed Resident #92 in the dayroom. The CNA was observed seated next to the resident and informed the surveyor that the resident was on 1:1 observation. On 02/04/25 at 10:30 AM, the surveyor reviewed Resident #92's electronic medical record. A review of the Admission Record face sheet (an admission summary) reflected that Resident #92 was admitted to the facility with diagnoses which included but were not limited to; unspecified dementia, major depressive disorder, restlessness and agitation, and other abnormalities of gait. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/30/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 03 out of 15, indicating that the resident had severe cognitive impairment. Further review of the MDS indicated that Resident #92 required supervision or touching assistance for bed mobility, required moderate assistance for transfers from the bed to the chair and utilized a wheelchair. Resident #92 was coded as Yes as having falls since admission, and coded 2 for J 1900 B. Fall with injury (except major)- including skin tears, abrasions, lacerations, superficial bruises, hematoma's and sprains; or any fall related to injury that causes the resident to complain of pain, and coded 1 for J 1900 C. Fall with Major Injury- bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma. On 02/05/24 at 9:46 AM, the Director of Nursing (DON) provided the following Fall Risk Evaluations which revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	-On 01/01/24, Resident #92 received a score of 24, which indicated a high risk for falls. -On 02/04/24, Resident #92 scored 20, which indicated a high risk for falls. -On 04/20/24, Resident #92 received a score of 23, which indicated a high risk for falls. -On 11/01/24, Resident #92 received a score of 26, which indicated a high risk for falls. A review of the Progress Notes and Care Plan (CP) revealed the following fifteen falls and the interventions implemented: 1. On 01/01/24 at 10:40 AM, the resident had a fall in the resident's bathroom. Upon assessment, the resident had moderate blood on the back of their head with a small gash. Resident #92 was sent to the hospital and the resident returned with four staples to their head from the fall. A review of the CP indicated that on 01/01/24, the intervention for staff to remain within easy reach of the resident while washing in the bathroom was added. 2. On 01/14/24 at 9:06 PM, the resident was found lying on their back with the wheelchair on side. The resident stated I hit my head. Neurological checks (neuro checks; assessment to ensure neurological functions were working correctly) were started and the resident went to the hospital. The resident returned with no injuries. A review of the CP indicated that no new interventions were added post fall on 01/14/24. 3. On 01/20/24 on 12:45 AM, the resident was found lying on top of the fall mat in their room, and the resident stated that their head was hurting. The resident reported that they fell while trying to go to the bathroom. The resident was sent to the hospital and returned to the facility with no new orders. A review of the CP indicated that no new interventions were added post fall on 01/20/24. 4. On 02/08/24 at 11:30 PM, the resident was found in their room on their knees on top of the fall mat that was next to their bed. There were no injuries noted at that time. When asked what happened, the resident stated they did not know why they were getting up since they were already in the room. A review of the CP indicated that no new interventions were added post fall on 02/08/24. 5. On 02/21/24 at 4:20 AM, the resident was found on the floor in their room, and the resident stated they were trying to get some water. The resident was noted with a skin tear to the top upper mid back and a dime sized abrasion that was reddened to their right elbow. A review of the CP indicated that no new interventions were added post fall on 02/21/24. 6. On 03/01/24 at 4:58 AM, the resident was found lying on top of the fall mat noted with redness to the inside of their bottom lip along with some blood and an abrasion to the right side of their forehead. The resident stated they had fallen and did not remember where they were going. A review of the CP indicated that on 03/01/24, the interventions to keep mobility devices close at hand and check on the resident frequently to offer assistance were added. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	7. On 03/21/24 at 2:16 AM, Resident #92 was noted lying on the floor near the closet door and upon assessment, the resident was noted bleeding from their left temple and a large skin tear was seen on their lower left arm. The resident was sent to the hospital and returned with an order for Dermabond (sterile liquid, topical skin adhesive) on left eyebrow to close the laceration. A review of the CP indicated that no new interventions were added post fall on 03/21/24. 8. On 04/21/24 at 6:25 AM, the CNA went into the resident's room and notified the writer that she had observed the resident fall and hit their head on the nightstand. The resident was noted with a bump to top of scalp 1 inch by 0.5 inch, and the resident was brought to the nurse's station for monitoring and safety. A review of the CP indicated that no new interventions were added post fall on 04/21/24. 9. On 05/13/24 at 1:48 AM, the CNA and the writer (nurse) went into Resident #92's room and assisted the resident into the wheelchair to be assisted to the bathroom per the resident's request. When putting the resident back to bed, the CNA called and informed the nurse that Resident #92 complained of chest pain and upon assessment, an irregular in size bruise, red and purple in color, was observed on the resident's sternum (breastbone) area. An x-ray was ordered with no evidence of a fracture but soft tissue swelling presternal region (upper segment of breastbone). A review of the CP indicated that no new interventions were added post fall on 05/13/24. 10. On 06/16/24 at 5:40 PM, the resident attempted to get out of the geriatric (geri) chair and slid to the floor. The resident denied hitting their head, and the resident stated they only hit bottom. The resident was assessed; vital signs were stable; and denied pain. A review of the CP indicated that no new interventions were added post fall on 06/16/24. 11. On 08/15/24 at 1:05 PM, the resident was found sitting on floor in the dayroom in front of a chair and upon assessment, the resident had bleeding from a small laceration to the left side of head. Treatment services were rendered to control bleeding. A review of the CP indicated that no new interventions were added post fall on 08/15/24. 12. On 08/16/24 at 9:00 PM, the resident had fallen in the dayroom and upon assessment, the resident had bleeding from small laceration to the left side of head. Treatment services were rendered to control the bleeding. The resident was transferred to the hospital and returned with an order for cefdinir (antibiotic used to treat bacterial infection) 300 mg; give one capsule by mouth every 12 hours for a urinary tract infection. A review of the CP indicated that on 08/16/24, the intervention to provide the resident a snack was added. 13. On 08/22/24 at 7:34 PM, the resident and their primary aide were walking in the hallway when Resident #92 fell . The primary aide who witnessed the incident stated, [Resident] didn't hit [their] head. The primary aide was asked how the resident ended up falling, and the primary aide stated [Resident] turned around, I literally just saw [them] going down slowly. The resident complained of pain in the sacrum (lower back) and a noted abrasion to their right elbow area. When the nurse asked the aide how the resident fell , the CNA replied, I'm not going to be here trying to chase [resident]. A review of the CP indicated on 08/23/24, the intervention to sit and rest when noted to be fatigued was added. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Actual harm

Residents Affected - Few

14. On 09/07/24 at 5:00 PM, the resident was noted to be on the floor in the dayroom sitting on their buttocks with the chair alarm still attached to the resident and the chair. The resident was assessed and no new injuries were noted. A review of the CP indicated on 09/09/24, the intervention of hospice ordered another [specialized chair] allowing resident's feet to touch the floor was added.

15. On 12/11/24 at 6:33 PM, the resident was noted to be on the floor and upon assessment, Resident #92 was noted to have a laceration with bright red blood drainage noted to the right side of eye. The resident was sent to the hospital and returned to the facility with Dermabond to top of right eye to close the laceration. A review of the CP indicated that on 12/12/24, the intervention to keep close observation when sitting in the chair was added.

The following progress notes detailed two falls that occurred within one hour on 12/23/24, and revealed the following:

On 12/23/24 at 5:55 AM, this nurse was notified by staff that resident had fallen. When asked what happened staff stated, I was walking resident to the bathroom and above resident lost balance and fell . The resident was unable to give an account of what happened. The supervisor was notified; Primary Care Physician (PCP) made aware; and the Resident Representative was made aware. An assessment was conducted and the resident was at baseline, no injury noted. The resident was able to move all extremities and did not hit their head per staff. The resident had no discomfort noted on assessment and personal care needs were met. The resident was made comfortable and 1:1 was in place with safety maintained.

- A subsequent note, documented by the same nurse revealed:

On 12/23/24 at 7:30 AM; around 6:30 AM, this nurse was notified by staff that the resident was bleeding from their face. Upon entering the resident's room, the resident was noted with blood on their face, a cut to their left cheek area, and the resident was unable to tell what happened. The supervisor and PCP were notified. An order was obtained to send the resident to the hospital. The resident's face was cleaned, bleeding was controlled, and no further cut or open area noted. An assessment was conducted, neuro checks started, and emergency services were called. The resident was sent to the hospital at 7:05 AM, for evaluation, and the family was notified. The progress note did not include the 1:1 supervision that was documented as in place for safety being maintained in the previous note on 12/23/24 at 5:55 AM, after the resident fell .

On 12/24/24 at 3:31 AM, it was documented that Resident #92 returned from the hospital around 1:33 AM, with a fracture to their left orbit [eye socket] and left maxillary sinus. They had a laceration to their left cheek with five sutures and bruising and swelling was noted to their left orbit, left cheek, left side of the neck, above left eyebrow, and upper chest. Redness was also noted to their mid-back. Care was given to the resident when they returned from the hospital. New orders for Augmentin 875-125 mg (an antibiotic) for seven days to prevent infection, Mucinex 600 mg for congestion, nasal sprays for congestion, and bacitracin to sutures. As needed Morphine (narcotic pain medication) and Ativan (sedative) were given and noted to be effective. The supervisor was made aware of the resident's return and new orders.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315128	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the CP provided by the Director of Nursing (DON), in effect during the time of the fall, dated last revised 01/04/25, revealed the resident was at risk for falls related to confusion, reconditioning/weakness, history of falls, poor safety awareness. The goal, dated initiated 05/24/23, with a target date of 04/07/25, included risk for serious injury from falls will be mitigated with proper interventions through review date. A second goal, dated initiated 06/07/23, with a target date of 04/07/25, included the resident will be free of falls related to injury through the next review date. The interventions included: to monitor resident at nurses station when awake overnight initiated 10/17/23, to provide staff interaction during episodes of restlessness initiated 12/17/23; and the resident receives sedatives/hypnotics at night for sleep; monitor for safety throughout the night initiated 09/04/23. A review of the Emergency Department Encounter with a Date of Service of 12/23/24 at 9:58 AM, revealed: Assessment and Plan: resident on Eliquis, presented after fall. The resident was at increased fall risk and had a history of dementia and was not a reliable historian. There was a skin tear to the left cheek, ecchymosis peri-orbitally on the left, having active epistaxis from the left nare [bleeding from left nostril]. Radiology Final Results: CT scan to head or brain without Contrast: acute left facial fractures including involving the left inferior orbital rim and the left maxillary sinus walls, with adjacent fascial contusions and hemorrhage within the sinus and nasal cavity/nasopharynx; CT Facial Bones without Contrast Final Result: Acute comminuted fracture of the left inferior orbital rim . Acute comminuted and mildly displaced fracture of the left lateral orbital rim . Mild left orbital proptosis [protrusion of eye from socket]. Acute comminuted and mildly displaced and depressed fracture of the left anterior maxillary sinus wall. Acute comminuted mildly displaced fracture of the left lateral maxillary sinus wall. Left periorbital and facial soft tissue contusion with soft tissue swelling and gas related to sinus injury. Hemorrhage near completely filling the left maxillary sinus as well within the left nasal cavity and nasopharynx . On 02/05/25 at 11:01 AM, the surveyor interviewed the DON regarding Resident #92's multiple falls. The DON stated that Resident #92 needed constant redirection and was very impulsive. The DON added that all falls were discussed in the morning meeting. When inquired about the two falls that occurred on 12/23/24, which resulted in an injury requiring hospitalization , the DON was unable to explain why after the resident fell the first time, the resident sustained the second fall within one hour. A review of the facility provided Falls- Clinical Protocol dated revised 3/2018, and updated 1/2023, which indicated the following: Under Cause and Identification: For an individual who has fallen, the staff and the practitioner will begin to try to identify possible causes within 24 hours of the fall. After a fall, Clinical staff should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. The staff will continue to collect and evaluate information until the cause of the falling is identified, or it is determined that the cause cannot be found or it is not correctable. Under Treatment /Management: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on the preceding assessment, the clinical staff will identify pertinent interventions to try to prevent subsequent falls and address the risks of clinical consequences of falling. NJAC 8:39-27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Complaint #s NJ: 165805, 166524, 166709, 169246, 170726, 173844, 175487, 178803 Based on observation, interview and document review it was determined that the facility failed to have sufficient and competent nursing staff to consistently provide all related nursing services to ensure residents received care to ensure resident safety, and maintain the highest practical physical and mental well-being by failing to ensure staff provided a) appropriate and timely incontinence and nail care for residents dependent on staff for Activities of Daily Living (ADLs) care, b) resident supervision for safety, c) appropriate wound care per physician orders, d) a communication tool for a resident who who was known to speak a foreign language (Resident #122), and e) consistent access to the call bell (Resident #20 & #29). The deficient affected, or had the potential to affect all residents who resided on 3 of 3 units, and was evidenced by the following: Refer to F558E, F600G, 676E, 677E, 684G, 686E, 689G a) 1. On 2/4/25 AM at 7:20 AM, the surveyor observed Resident #100 in bed, the head of the bed was elevated, and the resident was able to answer questions. Upon inquiry, the resident informed the surveyor that they were wet and needed incontinence care. The surveyor asked the resident to activate the call light. The resident's call device was observed lying on the floor. The surveyor informed staff that Resident needed assistance. On 2/4/25 at 10:00 AM (over 2.5 hours later), the surveyor observed Resident #100 in bed. The call device was observed on the floor. The resident informed the surveyor that they had not been changed. The surveyor left the room and asked a random Certified Nursing Aide (CNA) to assist with a care tour. The resident's incontinent brief was observed saturated with urine, and the resident stated that they were last assisted with incontinence care last night. 2. 01/29/25 at 9:27 AM, the surveyor observed Resident #89 in bed, with long facial hair, and the nails were long and jagged. On 1/30/25 at 10:45 AM, the surveyor observed Resident #89 in bed, after morning care had been provided with nails long and jagged, black substance under [NAME] the finger nails, and Resident #89 was unshaven. On 1/31/25 at 8:00 AM, the surveyor returned to the room and observed that Resident #89 had just completed breakfast. The resident's nails were still long, jagged and not trimmed. Resident #89 had not been shaved. On 2/4/25 at 9:19 AM, the surveyor interviewed the resident who stated that they would like their nails to be trimmed and cleaned. On 2/5/25 at 8:35 AM, the surveyor observed the resident in bed, the resident stated again they would like to be shaved. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/5/25 at 10:30 AM, the surveyor interviewed the Assistant Director of Nursing regarding the expectations for resident care. She stated that the manager and the nurses were to make rounds and ensure the residents were being cared for properly. On 2/4/24 at 11:30 AM, the surveyor interviewed the CNA regarding Resident #89's nail care. The CNA stated that nail care could be offered daily with the morning care or on shower days. The CNA stated that Resident #89 had a shower scheduled on Tuesday and they had not been shaved, and the nails were not trimmed. On 2/5/25 at 8:30 AM, the surveyor interviewed the CNA assigned to Resident #89. The CNA revealed that Resident #89 was able to feed themselves after set-up, able to assist with turning and able to make their needs known. The CNA stated that she would ask the resident if they wanted to be shaved. When asked regarding the resident nail care, the CNA did not offer any comments. 3. On 1/30/25 at 10:00 AM, the surveyor observed Resident #132 in bed, and was observed with thick facial hair. On 1/31/25 at 6:45 AM, the surveyor observed Resident #132 and had not received care yet. Resident #132 was observed saturated with urine upon during the care observation provided by a random CNA. The resident had not been shaved, and the surveyor asked the resident if they would like to be shaved, they stated, oh yes I would like to. On 1/31/25 at 11:15 AM, the surveyor observed Resident #132 in bed and observed that the resident had not been shaved. The surveyor then escorted the Assistant Director of Nursing to the room where we both observed that the resident had not been shaved. 4. 1/30/25 at 9:50 AM, the surveyor observed Resident #150 in bed, their nails were long, discolored with dark substances underneath the finger nails. Resident #150 was unshaven. On 1/31/25 at 11:30 AM, the surveyor returned to the room, the resident was sitting in a wheelchair at the bedside, The nails were long, discolored and jagged. The Surveyor asked Resident if they would like their nails to be trimmed and cleaned, the Resident stated, yes. On 1/31/25 at 11:45 AM, the surveyor escorted the Unit Manager (UM) to the room where we both observed Resident #150's nails and facial hair. The UM confirmed that Resident #150's nails needed to be trimmed and cleaned. 5. On 1/29/25 at 9:20 AM, during initial tour, the surveyor observed Resident #370 in bed and observed a strong urine odor in the room. The resident was not able to tell the surveyor when the last time was, when they were changed. The surveyor observed Resident #370's both hands with square shape long fingernails with jagged edges. The nails on the right index finger was half broken and both thumb nails had dried brown colored substance around the cuticles. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/29/25 at 9:34 AM, the surveyor returned with the assigned Certified Nurse Aide (CNA #1) for Resident #370 to observe the resident for incontinence rounds. The CNA #1 checked Resident # 370's brief and the resident brief was saturated with urine. The CNA #1 stated that she reported to work at 7:00 AM this morning, delivered the breakfast tray, and she stated she had not yet provided any care to Resident #370 (2. 5 hours after beginning her assignment). CNA #1 then closed the brief without changing the resident, and informed the resident that she would come back to clean the resident after she provided a shower to resident's roommate. CNA #1 exited and left the resident soiled. On 1/30/25 at 9:03 AM, the surveyor observed Resident #370 in bed. The surveyor observed Resident #370's both arms were shaking, and resident's hands were noted with square shaped long nails with jagged edges. The right index fingernail was half broken. The resident stated they would like their nails to be trimmed. On 1/31/25 at 8:18 AM, the surveyor observed Resident #370 eating breakfast in their bed. Resident #370's both arms were shaking. The surveyor observed resident #370's long nails with jagged edges in the same condition as observed on 1/29/25 and 1/30/25. On 1/31/25 at 9:07 AM, during a follow-up interview with the surveyor regarding the 1/29/25 observation, the CNA #1 stated that she had not made incontinence rounds on Resident #370 until the incontinence rounds that the surveyor observed on 1/29/25. The CNA #1 stated she was familiar with Resident #370. The CNA #1 stated, I am assuming we could provide nail care and cut resident's nails. The CNA #1 further stated it was important to provide nail care and clean nails with wash rags every day during morning care because the residents got stuff like feces and germs under their nails, and they [the residents] put their nails in their mouth, and for infection control. The CNA #1 stated that Resident #370 might be able to trim their own nails if you provided assistance or sat by the resident and told them what to do. At 9:45 AM, the surveyor accompanied the CNA #1 to Resident #370's room and both observed the resident with shaky arms. The CNA #1 acknowledged that the resident was not able to cut their own nails. The CNA #1 looked at resident's nails and stated the nails got a lot of food under them, and they needed to be cleaned and cut down. 6. On 1/29/25 at 9:31 AM, during initial tour, the surveyor observed Resident #123 in bed and observed a urine odor in the room. Resident stated, I am wet, I am wet. On 1/29/25 at 9:34 AM, the surveyor returned with the assigned CNA #1 for Resident #123 to check on the resident for incontinence rounds. The CNA #1 checked Resident #123's brief and the resident brief was saturated with urine. The CNA #1 looked at the brief and stated it is kind of wet, and informed the resident that she would take the resident to shower since it was their shower day. On 1/30/25 at 12:16 PM, the surveyor reviewed the electronic medical record for Resident #123 which revealed: 7. On 1/29/25 at 9:43 AM, during an initial tour, the surveyor observed Resident #71 walking on the unit and was holding a cup in their right hand. The surveyor observed resident's long half broken nails with jagged edges on their right hand. On 1/31/25 at 8:59 AM, the surveyor observed resident walking on the unit. Resident #71 was pleasant, and the surveyor observed resident's both hands with long jagged nails, same as observed on 1/29/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. On 1/30/25 at 8:29 AM, the surveyor observed Resident #122 in their bed, eating breakfast. The surveyor observed Resident #122's both hands with long square shaped and pointy nails with food like debris under their nails. 9. On 1/30/25 at 8:38 AM, the surveyor observed Resident #82 sitting up in their bed. The surveyor observed the resident's left hand placed on the left side rail with long brown colored discoloration with substance under their thumb nail. The surveyor was not able to observe resident's right hand. 10. On 1/29/25 at 12:11 PM, the Surveyor #2 (S #2) observed Resident #77 eating lunch in the room. The surveyor observed Resident #77's long and jagged nails with dark substance underneath the fingernails. On 1/30/25 at 8:14 AM, Surveyor #1 and S #2 observed the resident eating breakfast in their bed. Both surveyors observed Resident #77's long and jagged nails with dark substance underneath the fingernails. On 1/31/25 at 12:58 AM, Surveyor #1 and S #2 observed Resident #77 sitting in bed. Both surveyors accompanied the Assistant Director of Nursing (ADON) to the resident's room and observed Resident #77's nails. The ADON acknowledged that the nails were long. 11. On 1/30/25 at 8:35 AM, the surveyor observed Resident #35 eating breakfast in their room. The surveyor observed resident had long dark colored nails and right thumb nail was half broken horizontally. The surveyor asked the resident about their nails and the resident stated, I want my nails cut. The resident was having difficulty opening butter. The resident asked for assistance with opening up butter. The surveyor notified the staff of resident's requests. On 1/31/25 at 8:44 AM, the surveyor observed the resident eating breakfast in their bed. Resident's nails were same as observation on 1/30/25. On 2/5/25 at 10:15 AM, the surveyor interviewed the UM regarding her responsibilities. The UM stated that her role was to ensure the care was being delivered, communicate with staff, check assignment, and make rounds. The surveyor then asked the UM who supervise the care, the UM replied all the nurses and during medication. On 2/5/25 at 11:30 AM, the DON informed the surveyor that she was not aware of the above concerns with nails and incontinence care, and would in-serviced the staff. On 2/5/24 at 11:45 AM, the surveyor escorted the UM to Resident #150's room we both observed the condition of the resident's hands and nails. The nails were jagged and a black coated substance was noted underneath all the finger nails. On 2/5/25 at 1:53 PM, the survey team met with DON and the Regional Director of Clinical Services (RDCS). The surveyor informed them of the above-mentioned concerns for all the residents regarding their nail care and incontinence care. The DON stated if two residents were incontinent, and one resident was scheduled to have a shower then incontinence care should be provided to a resident who wouldn't be getting a shower first and the other resident would be next. The DON did not offer the survey team how long a resident should have to wait to receive incontinence care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b) On 2/5/25 at 10:30 AM, the surveyor reviewed Resident #29's electronic medical record. On 2/5/25 at 9:40 AM, the surveyor requested the facility investigation for review, and the DON submitted the Reportable Event Record (RER) that was forwarded to the Department of Health on 5/17/23. There were no statements attached to the RER and the summary provided, dated 5/2023, under Investigation the following was documented: Per the Certified Nurse Aide (CNA #1), patient was last seen at 2:37 AM and was in bed. At 3:30 AM, CNA heard a loud bang and Resident was noted on the floor. Resident was noted in pain, new order received to be sent to hospital . Conclusion: Per hospital records, Resident #29 sustained a fracture of the left hip. Resident #29 will be evaluated by therapy upon return. Will follow their recommendations. No abuse or neglect could be substantiated. The document was not signed. The incident occurred on 5/17/23. The surveyor reviewed the document with the DON and requested any statements from all staff involved with Resident #29's care during the 11:00 PM-7:00 AM shift (during the time the unwitnessed fall occurred). The Fall Witness Statement signed by CNA #1 revealed: Last seen resident at 2:37 AM. Resident was last toileted at 1:00 AM. Heard a loud bang and rushed to resident room. On 2/5/25 at 11:15 AM, the surveyor reviewed LPN #2's statement with the DON. The DON informed the surveyor that she had not reviewed the statements she had not been aware that the CNA assigned to provide supervision for Resident #29 was found sleeping instead of watching the resident as she was assigned. The surveyor then asked the DON what the facility protocol was if a CNA refused an assignment, and the DON stated that the nurse should cover the assignment with someone else then notify the nursing supervisor immediately. The surveyor reviewed the facility provided Quality Assessment Report (incident type report) provided by the DON. The following was documented: Problem Statement: Patient had to go the bathroom and fell . Why 1: Patient had been toileted four hours prior. Why 2: Patient did not have to go and was asleep during next round. Root Cause: Patient was dry and asleep during last round. Awoken, self-transferred from bed and fell attempting to go the bathroom. The surveyor requested the CNA and the nurses phone number for interviews. The DON informed the surveyor that the CNA and the nurses were no longer employed by the facility. No contact information was provided. The surveyor reviewed both the CNA and both nurses' files and the incident was not documented. On 2/07/25 at 9:00 AM, the surveyor interviewed the DON regarding the incident dated 5/17/23 when the CNA refused the assignment and the resident had fallen and sustained an injury, and the DON stated that the protocol was for the nurse to carry the assignment, then reported the incident immediately to the Nursing Supervisor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c) On 1/29/25 at 9:15 AM, the surveyor toured the Maple Unit of the facility and observed Resident #92 seated in a recliner chair in the dayroom with a Certified Nursing Aide (CNA) at their side. Resident #92 was observed with purplish bruises to the facial area, both eyes were closed, and the resident did not engage in a conversation with the surveyor. On 1/30/25 at 10:15 AM, the surveyor, again, observed Resident #92 in the dayroom. The CNA seated next to the resident informed the surveyor that the resident was on a 1:1 observation. On 2/04/25 at 10:30 AM, the surveyor completed an initial review of Resident #92's electronic medical record. The Admission Record (an admission summary) reflected that Resident #92 was admitted to the facility with diagnoses which included, but were not limited to; unspecified dementia, major depressive disorder, restlessness and agitation and other abnormalities of gait. The Significant Change Minimum Data Set (MDS) dated [DATE], (an assessment tool used by the facility to prioritize care) reflected that Resident #92 scored 03 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely cognitively impaired. Resident #92 also required supervision or touching assistance for bed mobility, required moderate assistance for transfers from the bed to the chair and utilized a wheelchair. Resident #92 was coded Yes as having falls since admission, and coded 2 for J1900B. Fall with injury (except major)- including skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall related to injury that causes the resident to complain of pain, and coded 1 for f J1900C. Fall with Major Injury- bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma. The Progress Notes revealed the following: -Type: Health Status Note: Effective: 12/23/24 at 5:55 AM; This nurse was notified by staff that resident had fallen, when asked what happened staff stated, I was walking resident to the bathroom and above resident lost balance and fell . Resident unable to give account of what happened. Supervisor was notified, PCP [primary care physician] made aware, Resident Representative made aware. Assessment obtained, Resident at baseline, no injury noted, resident able to move all extremities, no head hitting noted per staff. No discomfort noted on assessment. Personal care needs met; resident was made comfortable. 1:1 in place safety maintained. - A subsequent note, documented by the same nurse revealed: Type: Health Status Note: Effective: 12/23/24 at 7:30 AM; Around 6:30 AM, this nurse was notified by staff that resident was bleeding on their face. Upon entering resident's room, noted resident with blood on their face, noted cut to left cheek area, resident unable to tell what happened. supervisor was notified. Primary Care Physician notified. Obtained an order to send resident to hospital. Face cleaned, bleeding was controlled, no further cut or open area noted. Assessment was obtained. Family made aware of the fall, Neuro check started, 911 was called and resident was sent to the hospital for evaluation at 7:05 AM. d)On 1/29/25 at 12:58 PM, the surveyor observed Resident #122 in bed. The surveyor was unable to communicate with the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/30/25 at 8:29 AM, the surveyor observed Resident #122 eating breakfast in the bed. Resident #122 spoke in Spanish when the surveyor was in the resident's room. The surveyor was not able to understand or communicate with the resident. A review of Resident #122's individual comprehensive care plan (ICCP) included a focus area dated 5/14/24, that the resident required the services of an interpreter because their primary language was not English. Primary language: Spanish. Interventions included: Provide resident with a communication board with common words in English and resident's preferred language to aide in communication for simple daily needs. On 2/5/25 at 9:06 AM, during an interview with the surveyor, the Certified Nursing Assistance (CNA #1) stated Resident #122 was Spanish speaking. The CNA #1 stated when she had taken care of the resident, she would not understand the resident because the resident did not speak English. CNA #1 stated when she did not understand the resident then she would use hand gestures during care. CNA #1 further stated she would tap on Resident #122's side to turn to the other side when she provided toileting hygiene. CNA #1 acknowledged that when the resident spoke in their language, CNA #1 did not understand the resident and the only way she would communicate with Resident #122 was with hang gestures. On 2/5/25 at 9:55 AM, during an interview with the surveyor, CNA #2 who was assigned to the resident, stated Resident #122 was mainly Spanish speaking. The surveyor inquired about how was the resident able to make their needs knows and CNA #2 stated that the resident used hand gestures a lot. CNA #2 stated that the resident had a communication board in their room. The surveyor accompanied the CNA #2 to Resident #122's room. Both observed the resident sitting in bed and resident spoke only Spanish and tried to have conversation with CNA #2. The surveyor and the CNA both were not able to understand and/or communicate with the resident. The CNA #2 searched, and she did not find a communication board in resident's room. On 2/5/25 at 10:12 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) stated Resident #122 was mainly Spanish speaking. The LPN stated she was able to understand the resident because some of her language vocabulary matched with resident's language, so she did not utilize any devices to communicate with the resident. The LPN further stated if she was not able to understand the resident, she would take the Spanish speaking CNA with her to resident's room. The LPN stated the communication board wouldn't be effective for Resident #122 because it was used for people who have hard time speaking or if they were hard of hearing. On 2/5/25 at 1:53 PM, the survey team met with Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS). The surveyor informed them of the above-mentioned concerns for the Resident #122. The DON acknowledged that Resident #122 should have had a communication board in the room so that the resident would be able to express their needs. e) On 1/30/25 at 10:00 AM, the surveyor observed Resident #29 lying in bed, with the call bell on the the bedside table. Resident #29 was unable to reach the call bell. On 1/31/28 9:10 AM, the surveyor observed Resident # 29 in bed. The call bell was in the same position as observed on 1/30/25 at 9:25 AM, when Resident #29 was in bed and the call bell on the bedside table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/5/25 at 9:00 AM, the surveyor observed Resident #29 lying in bed with the call bell hanging over the side rail, and was tucked underneath the mattress, away from the resident. The resident stated they knew how to use the call bell, but that they could not locate it to demonstrate the process to the surveyor. On 2/5/25 at 9:20 AM, the surveyor escorted the Unit Manager (UM) to the resident's room and the UM confirmed that the call bell was not accessible. During an interview with the surveyor on 02/05/25 at 9:00 AM, the Certified Nursing Assistant (CNA) stated that the resident uses the call bell sometimes when they need assistance. The CNA further stated that she placed the call bell on the side of the resident's bed prior to leaving the room. During an interview with the surveyor on 2/5/25 at 9:20 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) confirmed that the resident could use the call bell to ask for assistance. The surveyor then escorted the LPN/UM to the room where we both observed the call bell was tucked underneath the mattress and not accessible to the resident. The UM stated that she expected staff to secure the call bell to prevent the call bell from falling out of reach. f) The facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the State of New Jersey as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of staffing from 8/06/2023 to 8/19/2023, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts; deficient in total staff for residents on 1 of 14 evening shifts; and deficient in CNAs in total staff on 1 of 14 evening shifts as follows: -8/06/23 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -8/07/23 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. -8/12/23 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. -8/13/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-8/14/23 had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. -8/15/23 had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. -8/18/23 had 16.5 CNAs for 135 residents on the day shift, required at least 17 CNAs. -8/19/23 had 14 CNAs for 135 residents on the day shift, required at least 17 CNAs. -8/19/23 had 12 total staff for 135 residents on the evening shift, required at least 13 total staff. -8/19/23 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. 2. For the 2 weeks of staffing from 8/27/2023 to 9/09/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -8/27/23 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -8/29/23 had 16 CNAs for 137 residents on the day shift, required at least 17 CNAs. -8/31/23 had 16.5 CNAs for 140 residents on the day shift, required at least 17 CNAs. -9/01/23 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -9/03/23 had 15.5 CNAs for 135 residents on the day shift, required at least 17 CNAs. -9/05/23 had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs. -9/07/23 had 8.5 total staff for 135 residents on the overnight shift, required at least 10 total staff. -9/09/23 had 16.5 CNAs for 138 residents on the day shift, required at least 17 CNAs. 3. For the 2 weeks of staffing from 10/06/24 to 10/19/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -10/06/24 had 12.5 CNAs for 157 residents on the day shift, required at least 20 CNAs. -10/07/24 had 18.5 CNAs for 156 residents on the day shift, required at least 19 CNAs. -10/08/24 had 14 CNAs for 156 residents on the day shift, required at least 19 CNAs. -10/09/24 had 18 CNAs for 156 residents on the day shift, required at least 19 CNAs. -10/10/24 had 16 CNAs for 156 residents on the day shift, required at least 19 CNAs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10/11/24 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -10/12/24 had 15 CNAs for 163 residents on the day shift, required at least 20 CNAs. -10/12/24 had 15 total staff for 163 residents on the evening shift, required at least 16 total staff. -10/14/24 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -10/15/24 had 16.5 CNAs for 163 residents on the day shift, required at least 20 CNAs. -10/16/24 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -10/17/24 had 18 CNAs for 163 residents on the day shift, required at least 20 CNAs. -10/18/24 had 18 CNAs for 163 residents on the day shift, required at least 20 CNAs. -10/19/24 had 12 CNAs for 161 residents on the day shift, required at least 20 CNAs. 4. For the 2 weeks of staffing prior to survey from 1/05/2025 to 1/18/2025, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -1/05/25 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs. -1/06/25 had 12 CNAs for 161 residents on the day shift, required at least 20 CNAs. -1/09/25 had 20 CNAs for 168 residents on the day shift, required at least 21 CNAs. -1/10/25 had 19 CNAs for 168 residents on the day shift, required at least 21 CNAs. -1/11/25 had 19 CNAs for 168 residents on the day shift, required at least 21 CNAs. -1/12/25 had 15 CNAs for 171 residents on the day shift, required at least 21 CNAs. -1/13/25 had 13.5 CNAs for 171 residents on the day shift, required at least 21 CNAs. -1/14/25 had 16.5 CNAs for 171 residents on the day shift, required at least 21 CNAs. -1/15/25 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs. -1/16/25 had 15.5 CNAs for 170 residents on the day shift, required at least 21 CNAs. -1/17/25 had 18.5 CNAs for 169 residents on the day shift, required at least 21 CNAs. -1/17/25 had 16 total staff for 169 residents on the evening shift, required at least 17 total staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1/18/25 had 15 CNAs for 169 residents on the day shift, required at least 21 CNAs. -For the 2 weeks of AAS-12 staffing from 1/05/2025 to 1/18/2025, the facility was deficient in RN staffing hours as follows: For the week of 1/12/25 Required Staffing Hours: 462.50 -1/18/25 had 460 actual staffing hours, for a difference of -2.50 hours. On 2/7/25 at 9:18 AM, the Staffing Coordinator stated she was aware of the mandated staffing ratios and that the facility met those standards most of the time unless there was a call out. She further stated that the staff would be determined by the resident census and would be reassessed daily. A review of the facility provided policy, Staffing Levels dated 8/2021, was for a assisted living facility and not long-term care. The Certified Nursing Assistant Job Position document provided by the facility on 2/5/25 at 1:05 PM revealed: The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care, and services in accordance with the resident's assessment and care plan and as may be directed by your supervisors. The Personal Nursing Care Functions: Assist residents with nail care (i.e. clipping, trimming, and cleaning the finger/toenails); Shave male residents; Keep hair on female residents clean shaven (i.e. facial hair, under arms, on legs, etc.) as instructed; Keep residents dry (i.e. change gown, clothing, linen etc. when it becomes wet or soiled). The Licensed Practical Nurse Job Description revealed: The primary purpose of your position is to provide direct nursing care to the residents, and to supervise the day to day nursing activities performed by the Certified Nurse Assistants or other nursing personnel. To monitor the performance of the Certified Nurse Assistants, nursing and non-licensed personnel, provide education and counseling . Nursing Care Functions: Ensure that personnel providing direct care to resident are providing such care in accordance with the resident's care plan and wishes. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 1/31/25, two surveyors observed four nurses administer medications to six residents. There were 34 opportunities, and two errors were observed which calculated to a medication administration error rate of 5.8%. This deficient practice was identified for 2 of 6 residents (Resident #89 and Resident #44) that were administered medications by two of four nurses observed. The deficient practice was evidenced as follows: 1. On 1/31/24 at 8:04 AM, Surveyor #1 observed the Licensed Practical Nurse (LPN) #1 administer medications to Resident #89. LPN #4 checked the blood pressure prior to administering the medications. The blood pressure was 95/50 mm/Hg [millimeters mercury]. LPN #1 administered the following medications: Primidone (an anticonvulsant) 50 mg (milligram) 1 tablet Methimazole (to treat an overactive thyroid) 5 mg Naglimere (to treat Type 2 Diabetes) 100 mg Eliquis (a blood thinner) 5 mg Oxycontin ER (pain medication) 15 mg Pyridostigmine (a muscle stimulant) 30 mg 1 tablet The LPN informed Surveyor #1 that the Midodrine (medication used to treat low blood pressure) which was to be administered was not available, and she would follow up with the physician. A review of the Admission Record documented that Resident #89 was admitted to the facility with diagnoses which included but were not limited to; Parkinsonism, cerebral infraction, adult failure to thrive. According to the Minimum Data Set (MDS) an assessment tool used to prioritize care, dated 11/16/24, Resident #89 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicative of intact cognition. A review of the Physician Order Summary Sheet dated February 2025, revealed an order dated 1/29/25 for Midodrine 5 mg to be administer three times daily for hypotension. DO NOT GIVE AFTER EVENING MEAL OR WITHIN 4 HOURS OF BEDTIME TO AVOID SUPINE HYPERTENSION -HOLD SBP greater than 140. On 1/31/25 at 11:17 AM, Surveyor #1 followed up with LPN #1 regarding the Midodrine. The LPN stated that she was busy and did not follow up. Resident #89 did not receive the Midodrine as prescribed by the physician. The surveyor asked the LPN if she addressed the issue with the Unit Manager, she stated, No. [ERROR #1] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 1:30 AM, the surveyor interviewed the Unit Manager (UM) regarding the protocol for ordering and addressing missing medication. The UM informed the surveyor that staff were to order any medication prior to reaching the blue line noted on the Bingo Cart (tablet #8). The UM further added that some medications can be retrieved from the facility back up supply. The surveyor then inquired about Midodrine. The UM stated that Midodrine was included in the medication box. The UM added that she was not aware that Resident #89 missed the 8:00 AM dose of Midodrine that morning. The UM added that if the medication was not in the back up supply then the pharmacy would need to be called and the physician notified. The UM then stated that there should be documentation in the electronic records which indicated the reason why a medication was not administered. On 1/31/25 at 12:30 PM, Surveyor #1 reviewed a nurse's notes created 1/31/25 timed 11:56 AM, which reflected the following: Created Date : 1/31/2025 11:56:04 Note Text: Midodrine HCl Tablet 5 MG [milligrams] Give 1 tablet by mouth three times a day for hypotension. Medication unavailable; reordered from pharmacy; Will call Medical Doctor to make aware. LPN #1 did not call the physician nor attempt to get the medication from the facility back-up box until 11:38 AM. On 2/7/25 at 12:30 PM, the above concerns were discussed with the Clinical Regional Nurse and Nurse and the Director of Nursing (DON), the DON provided in-service education which addressed medication administration. No additional information was provided. 38079 2. On 1/31/25 at 8:07 AM, during the morning medication pass Surveyor #2 observed the LPN #2 preparing medications to be administered to Resident #44. At that time, the breakfast tray was delivered to Resident #44. LPN #2 delivered a cup with medications while the resident was actively eating. Resident #44 was administered and swallowed their medications at 8:11 AM. A review of the Admission Record revealed Resident #44 had diagnoses which included but were not limited to; gastro-esophageal reflux disease (GERD - a backflow of stomach acid into the esophagus). A review of the Admission MDS dated [DATE], documented a BIMS of 07 out of 15 indicating severely impaired cognition. A review of the Order Summary Report, active orders as of 1/31/25, included a physician's order dated 1/31/25, Esomeprazole Magnesium Delayed Release (gastric acid secretion reducer) 40 mg, give 1 capsule by mouth in the morning for GERD. Give at least 1/2 hour prior to meals. A review of the ICCP focus area dated 12/20/24, revealed a nutritional problem . related to GERD. A review of the MAR dated 1/1/25 - 1/31/25, documented Esomeprazole Magnesium Delayed Release 40 mg, give 1 capsule by mouth one time a day for GERD. Give at least 1/2 hour prior to meals. The MAR indicated LPN #2 signed as administered on 1/31/25. On 1/31/25 at 9:01 AM, LPN #2 stated the order was to administer the Esomeprazole half an hour prior to the meal. She further stated, I am aware. I have many medications to give but I am aware. I don't think she/he ate all their breakfast when I gave it (the Esomeprazole). [ERROR #2] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 9:42 AM, the Assistant Director of Nursing (ADON) stated an order that indicated to give half hour before a meal meant to administer the medication a half hour before the meal. She stated that it could be because of the action of the medication or just because the physician ordered it that way. A review of the facility provided, Medication Administration Competency dated 7/18/24, included but was not limited to; medication cautionaries are reviewed and followed. The Competency documented that LPN #2 demonstrated competency and was signed by LPN #2 as observed by a Registered Nurse. A review of the facility provided policy, Administering Medication revised 4/2019, included but was not limited to; 4. Medications are administered in accordance with prescriber orders . 7. Medications are administered within 1 hour of their prescribed time . 10. check the label 3 times to verify . right time before giving the medication. On 2/5/25 at 1:54 PM, the Director of Nursing (DON) and the Regional Director of Clinical Services were made aware of the above concerns. The facility had no additional information to provide. NJAC 8:39-27.1(a); 29.2(d)(5)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31654 Based on observation, interview and review of pertinent documents it was determined that the facility failed to maintain the kitchen environment and equipment in a clean and sanitary manner to limit the potential for bacterial growth and potential food borne illness. The deficient practice was evidenced by the following: On 1/29/25 at 8:17 AM, an initial tour of the kitchen was conducted with the Regional Dining Director (RDD) and the surveyor observed the following: - The 1st walk in refrigeration unit had a soiled gasket, debris throughout the ceiling and on the fan. The RDD confirmed the observation and stated it needed attention right away. -There was various debris throughout the floor and on a shelf liner in the dry food storeroom. The RDD stated there was a new Food Service Director and he was helping to develop a cleaning schedule. -The meat slicer was covered and the RDD confirmed that it was clean. The cover was lifted and the surveyor observed debris on the base and by the blade. The surveyor asked the RDD if it was clean, and the RDD stated, not as clean as it should be. The Sanitization Policy, Revised November 2022 revealed a Policy Statement: The food service area is maintained in a clean and sanitary manner. 1. Al kitchen, kitchen areas and dining areas are kept clean, free from garbage and debris . NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 62 Richmond Avenue Lumberton, NJ 08048	

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on interview and document review, it was determined that the facility failed to ensure that residents were explicitly informed of, and an understanding was assessed, prior to having the residents enter into a binding arbitration agreement (AA) which was identified as a part of the Admission Agreement. This deficient practice was identified for 3 of 3 residents (Resident #71, Resident #123, and Resident #370) reviewed for arbitration agreement and was evidenced as follows: On 1/29/25 at 8:50 AM, an entrance conference was conducted with the Licensed Nursing Home Administrator (LNHA) and Regional Director of Clinical Services (RDCS). The surveyor inquired if the facility used AA and the LNHA stated that it was part of the Admission Agreement, but there were no residents that entered into an AA. The facility provided the names of two staff members responsible for the AA. A review of the facility provided Admission Agreement included but was not limited to; Attachment J, Alternative Dispute Resolution Agreement Between Resident and Facility. Alternate Dispute Resolution (ADR) Agreement Provisions, section ii.) scope of ADR included any and all claims or controversies . whether arising out of State or Federal law, whether existing or arising in the future . for statutory, compensatory or punitive damages . in breach of contract, tort or breach of statutory duties including, without limitation, any claim based on violation of rights, negligence, medical malpractice, or any other departure from the accepted standard of health care or safety or violation of federal and/or state laws or regulations' . shall be submitted to ADR. The parties understand this ADR contains provision for both mediation and binding arbitration. Binding arbitration meaning the parties are waiving their right to trail including by a jury or judge and their right to appeal the decision of the arbitrator . The Admission Agreement Signature Page included in bold print that the Agreement and its Attachments, including . Alternative Dispute Resolution Agreement . are legally binding on all parties. A review of the Admission Record (an admission summary) revealed Resident #71 was admitted with diagnoses which included but were not limited to; dementia, and Alzheimer's Disease. The most recent annual Minimum Data Set (MDS) an assessment tool used to facilitate care, dated 1/17/25, included a BIMS score of 07 out of 15 which indicated a severe cognitive impairment. The individual comprehensive care plan (ICCP) included a focus area dated 4/10/24, the resident had impaired cognitive function and/or impaired thought process. The Admission Agreement documented that Resident #71 had signed the AA which was marked as accept, signed by the guest services staff member, dated 1/29/24, and noted the facility representative has presented the AA to the resident and/or legal representative. A review of the Admission Record revealed Resident #123 was admitted with diagnoses which included but were not limited to; altered mental status. The Admission MDS dated [DATE], indicated a BIMS score of 09 out of 15 which indicated moderately impaired cognition. The Admission Agreement documented that Resident #123 had signed the AA which was marked as accept, initialed by the guest services staff member, dated 8/13/24, and noted the facility representative has presented the AA to the resident and/or legal representative. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Admission Record revealed Resident #370 was admitted with diagnoses which included but were not limited to; altered mental status and depression. The Admission MDS dated [DATE], documented a BIMS of 05 out of 15 which indicated severely impaired cognition. The ICCP included a focus area of impaired cognitive function and impaired thought processes related to dementia dated 11/10/24. The Admission Agreement documented that Resident #370 had signed the AA which was marked as accept, initialed by the guest services staff member, dated 11/11/24, and noted the facility representative has presented the AA to the resident and/or legal representative. On 2/04/25 at 8:15 AM, the facility Admissions staff member was in the conference room with three surveyors. The Admissions staff member stated she was one of two staff responsible for the AA. She stated the process was when a resident was admitted , she and the guest services staff member would review the resident's Brief Interview for Mental Status. She stated they would need to make sure the resident was able to understand the AA. If a resident was cognitively impaired, they would reach out to the resident representative to sign the agreement. When asked the process to determine the resident's cognition via the BIMS score, she stated they would not have a cut off number but would just have a conversation. On 02/04/25 at 8:34 AM, the surveyor interviewed, in the presence of another surveyor, a second person that was responsible for the AA at the facility who was identified as the guest services staff member. She stated she was responsible to let residents know that arbitration meant that if they wanted to sue the facility, they would allow a mediator to come between the facility and the resident to see if they can come to an agreement prior to going to court. When asked what procedure was followed to present the AA, she stated, I don't have a script but that's my presentation. When asked if she explained the AA documented that arbitration was binding, she stated, I did not know if was binding. I understood it was so we can come to an agreement. I don't use the word binding. The Admission staff member was present and stated they would present the AA to the resident to read on their own. When asked how they assessed the resident's understanding of the agreement, the guest services staff member stated she would look at the BIMS score and often asked clarifying questions such as the residents address, date of birth, where they are? She then stated she asked, general questions so I can see if the answers were accurate. When asked where the surveyors could find the documentation of the process presented to the residents and the residents understanding of the AA that was just presented to the surveyors, the guest services staff member stated there was no documentation to provide. She stated it was all verbally presented, and she would ask the resident if they understood, and the resident would answer yes or no, but she was not able to document in the electronic medical record. When asked if the staff members had reviewed the AA, they both replied yes. When asked if the two had been trained, they both replied no, but they had a briefing. The surveyor asked about the comment in the AA that a signature was not sufficient, and the resident must verbally acknowledge their understanding which would be documented by staff. The two staff members again, informed the surveyors they did not document any type of assessment of understanding. The guest services staff member further stated they would, try to say a BIMS of 10 and above and that if they were having a conversation, they might not check the BIMS at all. On 2/04/25 at 9:00 AM, the Licensed Practical Nurse (LPN) on the secure dementia unit stated she was familiar with Resident #123 and Resident #370. She stated both had dementia but could answer some general questions. When asked if they were able to sign legal documents, the LPN replied, No. I don't think so. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/04/25 at 9:03 AM, Resident #71 who resided on the secure dementia unit, was observed in their room. The surveyor asked Resident #71 if they knew what an AA was. The resident stated nobody ever asked them to sign one, but, I may have had to sign one in [NAME] in order to get back here. On 2/04/25 at 9:13 AM, the surveyor telephoned Resident #71's emergency contact #1, and financial and care power of attorney (POA). The POA was asked if they were ever asked to sign the AA on behalf of Resident #71. The POA replied, What is that? What does that mean? The surveyor explained it was a binding legal agreement that in case of a lawsuit, they would not sue the facility but use an arbitrator to come to an agreement. The POA stated, No. On 2/7/25 at 8:35 AM, the Director of Nursing (DON), RDCS, and the Regional Director of Operations (RDO) were in the conference room with the survey team. The surveyor informed them of the above concerns. The facility had no policy, procedure or additional information to provide. NJAC 8:39-4.1(a 8, 33) (b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Mount Holly Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Richmond Avenue Lumberton, NJ 08048	

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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Keep all essential equipment working safely. 31654 Based on observation, interview and document review, it was determined that the facility failed to immediately address the smell of natural gas in the kitchen. Observations conducted on 1/29/25 at 8:30 AM and 8:40 AM, with two surveyors, and interviews conducted that same day confirmed the smell of natural gas was present on 1/29/25, and the facility used a lighter to regularly light the gas stove. The facility's failure to address the natural gas smell, while utilizing a lighter to light the stove top burners, placed all residents at risk from an explosion or fire and resulted in an Immediate Jeopardy (IJ) Situation. The IJ began on 1/29/25 at 8:30 AM, and the Licensed Nursing Home Administrator (LNHA) was provided the IJ template on 1/29/25 at 11:20 AM. The facility provided an acceptable Removal Plan (RP) which was verified on-site by the survey team on 1/29/25 at 2:36 PM. The evidence was as follows: On 1/29/25 8:17 AM, the surveyor conducted an initial tour of the kitchen in the presence of the Regional Director of Dining (RDD). At 8:30 AM, the surveyor approached the cooking area and observed the strong smell of natural gas was present and then observed a large lighter was directly opposite of the stove on top of a metal table. At that time, the surveyor asked the RDD what the smell was, and the RDD stated it was gas, and stated, the pilot light was out, and the staff needed to use the lighter to light the stove. The surveyor asked the RDD how long the staff have been using the lighter to light the stove, and he stated, not today. The surveyor then asked the RDD if you needed to light the stove with the lighter all the time, and the RDD stated, most of the time. On 1/29/25 at 8:40 AM, the surveyor asked the RDD if he had informed the LNHA of the stove not working properly and he stated he did not recall if he informed the LNHA. The surveyor then exited the kitchen and returned with a second surveyor and the LNHA. On 1/29/25 at 8:44 AM, in the kitchen, in the presence of the RDD, the LNHA and another surveyor (Surveyor #2) confirmed the smell of natural gas was present and the LNHA confirmed he was not made aware of the issue of the gas and using a lighter to light the stove. On 1/29/25 at 10:09 AM, the surveyor conducted an additional interview with the RDD regarding what could happen if gas leaked and a lighter was used, and he stated, not good, disaster. The surveyor then asked if it could explode, and he confirmed, yes. The RDD stated it was the pilot light, and the surveyor asked the RDD how he would know if it was the pilot light, and the RDD stated, he did not know for sure. The surveyor asked the RDD how long it had been an issue, and he confirmed that he did not know for sure. On 1/29/25 at 10:38 AM, the surveyor interviewed the [NAME] who confirmed she used the stove on 1/29/25, to cook eggs for the breakfast meal. The [NAME] stated she had been working at the facility for the past two months and has always had to use the lighter to light the stove. When asked if she smelled the natural gas smell that was still present, she confirmed that she smelled the gas. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/29/25 at 11:42 AM, the surveyor interviewed the facility Maintenance Director (MD) regarding the stove. The MD stated he was unaware that the stove was not functioning but he had been aware that the lighter was used to light the pilot lights. The MD confirmed that the stove was now turned off, and if he had known it was not working properly it would have been addressed, right away. The MD also stated that a repair person was coming to fix the stove. On 1/29/25 at 1:11 PM, the surveyor entered the kitchen and observed a repairman was working on the stove and was in the presence of the Regional Director of Operations (RDO) for the facility. The surveyor asked the repairman what was wrong with the stove and the repairman stated, right now it was going to need parts, some of the pilots [pilot lights on the range] have failed, and he stated he did not have the parts to fix the pilot lights. The surveyor asked the repairman if the pilot lights failed would gas leak from the stove? The repairman stated, yes and confirmed that gas would leak from the failed pilot lights. The repairman stated it would be a small leak, but it will leak gas. On 01/30/25 at 10:07 AM, the LNHA provided the manufacturer's Owner Manual for the stove which indicated the following: Page 1. [Manufacturer's name redacted] Ranges: WARNING: Improper installation, adjustment, alteration, service or maintenance can cause property damage, injury or death . Page 2. SAFETY PRECAUTIONS: Before installing and operating this equipment, be sure everyone involved in its operation is fully trained and aware of precautions. Accidents and problems can be caused by failure to follow fundamental rules and precautions . WARNING: In the event a gas odor is detected, shut down equipment at the main gas shut- off valve and immediately call the emergency phone number of your gas supplier. Improper ventilation can result in headaches, drowsiness, nausea, and could result in death . Page 8. OPERATION: DANGER, EXPOLSION and ASPHYXIATION HAZARD; In the event a gas odor is detected, shut down equipment at the main gas shut- off valve and immediately call the emergency phone number of your gas supplier. Improper ventilation can result in headaches, drowsiness, nausea, and could result in death . CAUTION: If top burner pilots go out, the flow of gas to the burners is NOT interrupted . Consequently, it is the responsibility of the operator to check the ignition of the burners, immediately after burner valve has been turned ON . On 2/5/25 at 10:51 AM, the RDO provided the service report from the repairman. The report indicated the following: Describe the Nature of the Problem? Pilot Light Issues; What is the fuel type of the equipment? Gas; What type of commercial appliance is being repaired? Range. The report Timeline documented the following dated communication entries that were completed by the repairman to the facility: -1/29/25, Tech [Technician] Arrived: 12:31 PM and Tech Departed 2:55 PM; The work for this job is not yet complete for the following reason: Temporarily fixed, Quote needed. Comments: As reported unit had pilots not lighting. I found the front right pilot not working and the other 5 pilots degraded. Unit needs new pilots. I shut the gas off to the right front pilot to prevent any gas leaking out . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Holly Rehabilitation & Healthcare Center	62 Richmond Avenue Lumberton, NJ 08048

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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-1/30/25, . Extension Approval Timelines: failed pilots. front right pilot does not light, other 5 also are degraded. shut off the gas to the failed right front pilot so no gas will leak. [documented by repairman] -1/30/25 at 11:06 AM, We ordered a new stove. [facility's response] An acceptable Removal Plan (RP) was received on 01/29/25 at 1:09 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the staff were immediately instructed to stop manually lighting the pilot light, the gas line was disabled at 10:30 AM, to prevent further manual lighting until repairs were made, the stove was replaced on 01/29/25. The survey team verified the RP was implemented on-site on 1/29/25 at 2:36 PM. NJAC 8:39-31.7 (d)