STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dellridge Health & Rehabilitation Center	532 Farview Ave Paramus, NJ 07652

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, and review of facility-provided documents, it was determined that the facility failed to ensure that a) meals were consistently provided in a dignified and homelike manner and b) resident meal assistance was provided in a dignified manner. The deficient practice was observed in the recreation dining room for 2 of 6 residents (Residents #15 & #44). The deficient practice was evidenced by the following: On 12/15/24 at 11:46 AM, the surveyor observed the Kitchen Staff (KS) deliver the food truck to the recreation room, there were 6 residents, 4 residents at one table, 1 resident at one table, and another resident at one table, there were 2 Recreation Aides (RA) inside the dining area and later Registered Nurse Supervisor (RNS) came and assisted in distributing lunch trays. The surveyor observed RA #1, RA#2, and RNS assisted 5 of 6 residents with hand hygiene using individually wrapped hand wipes on each resident's lunch trays. The facility staff did not offer Resident #44 hand hygiene and the staff then proceeded to set up the resident's meal. At that same time, the surveyor observed 5 out of 6 residents eating lunch except for Resident #15, who was seated at the same table with the other 3 residents. The surveyor then asked RA#2 why Resident #15 had no tray, and RA#2 responded that she would get back to the surveyor. Later, the surveyor asked the RNS why Resident #15 had no tray while the rest of the residents at the same table were eating, and the RNS responded that she would ask someone to get the resident's tray. On 12/15/24 at 11:56 AM, the surveyor observed the KS delivered a tray to Resident #15, the RNS provided the tray, set up the tray, and the RNS left the recreation room. The surveyor observed there was no diet slip in the tray and the piece of paper with black marker written 19W. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/15/24 at 12:01 PM, the surveyor interviewed RA#2 regarding Resident#44's hand wipes not use, and RA#2 responded that the resident should have been provided an opportunity to perform hand hygiene and the hand wipes should have been used. RA#2 further stated that she was not the one who provided Resident #44's tray. The surveyor also asked RA#2 why Resident #15 had no diet slip and what 19W in the paper meant. RA#2 stated that 19W was the room number and resident should receive a meal ticket (diet slip; that included the resident's name and diet). She further stated that the resident was in room [ROOM NUMBER]W and not 19W. The surveyor then asked RA#2 what the diet of 15W was and 19W, and why Resident #15 received the wrong tray. RA#2 then went to the next table and took the paper, and RA#2 stated that according to the paper, Resident #15 who was in room [ROOM NUMBER]W diet was regular and room [ROOM NUMBER]W was also regular diet. RA#2 stated that Resident#15 should have a diet slip and should receive the right diet. The surveyor asked RA#2 why Resident #15 had to wait for 10 minutes while the 3 other residents were eating lunch at the same table, and RA#2 did not respond. A review of the medical records revealed: Resident#15's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/5/24, section C Cognitive Patterns included the brief interview for mental status (BIMS) score of 5 out of 15 which reflected that the resident's cognitive status was severely impaired. Resident#44's most recent significant change in status MDS with an ARD of 10/21/24, section C Cognitive Patterns included the BIMS score of 5 out of 15 which reflected that the resident's cognitive status was severely impaired. On 12/17/24 at 11:09 AM, the surveyor interviewed the Director of Nursing (DON) regarding dining services. The surveyor asked the DON what the facility's process for dining services was. The DON stated that the food truck comes in from the kitchen, the dietary staff brings the food truck trays, and then the recreation staff distributes the trays, always one assigned nurse for lunch and dinner, and breakfast residents eat in their room. The surveyor asked the DON who verified the meal ticket, and the DON responded that it was the recreation people who must check the meal ticket versus what was in the tray. The surveyor asked when and who offered assistance with hand hygiene during mealtime, the DON stated that the recreation staff or whoever bringing the tray to the resident should offer and assist residents in performing hand hygiene by using individual packets of hand wipes in the resident's tray be done before and after eating. On that same date and time, the surveyor notified the DON of the concerns with Resident # 15. The DON stated that the staff should have brought the resident inside their room or asked for the tray because residents should be eating all at the same time. The surveyor also notified the DON of the concerns with Resident # 44 with hand hygiene during lunch observation, and the DON stated that the staff should have checked and if not opened should been offered for hand hygiene. On 12/18/24 at 11:14 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON. The surveyor notified the LNHA and the DON of the above findings and concerns. A review of the facility's Food, Dining Service and HS (bedtime) Snacks Policy with a reviewed date of 6/2024 that was provided by the LNHA revealed: Policy Explanation and Procedures: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing staff will remind all residents/patients of the meal. Nursing is responsible for assisting those needed help. Individuals are assisted to prepare for the meal (glasses on, hearing aids in, hands washed, etc) . -Food service staff members will serve the food choices made with consideration given to dietary restrictions/texture modifications. Plates will be verified for accuracy of service . -Individuals are offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room . Eating Environment: -Staff will develop appropriate measures to try to maximize appropriate seating, positioning, and interactions among residents and to assure that each resident receives his or her prescribed diet A review of the Handwashing/Hand Hygiene Policy with a revised date of April 2010 that was provided by the LNHA revealed: Policy Interpretation and Implementation: 5. Employees must wash their hands for at least 20 seconds using antimicrobial soap and water under the following conditions: g. Before and after assisting a resident with meals . On 12/19/24 at 01:48 PM, the survey team met with the LNHA, DON, Regional DON #1 (RDON#1), RDON#2, Assistant Director of Nursing, and Co-President for an exit conference, and there was no additional information provided by the facility. NJAC 8:39-4.1(a),12,28;27.1(a);27.3(a)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49078 Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to ensure accurate documentation of a resident's advance directives for 1 of 7 residents (Resident #10) reviewed. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (electronic and paper) medical records of Resident #10 which revealed: The Admission Record (a summary of important information about the resident) revealed that the resident was admitted with diagnoses that included but were not limited to, chronic respiratory failure (a chronic condition when the airways in the lungs become damaged and narrow), anxiety disorder, and type 2 diabetes mellitus. A Significant Change Minimum Data Set (MDS) assessment tool used to facilitate the management of care, dated 11/30/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #10 scored a 14 out of 15, which indicated the resident had no cognitive impairment. The New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form, which was undated and not filled out indicating what advance directives (AD) (directions for the type of life sustaining care to be given or not given) nor was it signed by the resident, attending or facility staff. There was no documentation that indicated what AD status the resident desired to have. A review of the physician's orders did not reveal any orders reflecting any AD status. A review of the resident's electronic medical record (eMR) did not reveal any information that reflected any AD status in the resident information area. On 12/16/24 at 11:51 AM the surveyor interviewed the Director of Social Services (DSS) and the Licensed Social Worker (LSW). The surveyor confirmed with the DSS that the Social Workers were part of the process for obtaining and documenting the AD and POLST status for residents. The surveyor asked how the DSS and LSW obtain and document AD and POLST status for residents. The DSS stated that the POLST was addressed in the resident assessment, and, depending on the resident's cognitive status, the forms are brought to the resident, everything was explained to the resident and forms were signed. The form was then signed by the physician, the form uploaded to the resident's eMR and the form was filed. The DSS further stated that the family can be contacted to confirm the resident's AD/POLST status if needed. The status should also be included in the resident's Care Plan (CP). The DSS also stated that as of September 2024, the Social Work department had an ongoing project to ensure all resident's have completed AD/POSLT and the results were reported to the facility's Quality Assurance Performance Improvement (QAPI) committee. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed Resident #10's eMR and paper chart with the DSS. At this time the surveyor showed the DSS the blank POLST form and asked the DSS if there was any information in the medical record that indicates the AD or POLST status. The DSS stated they did not know why the blank form was in the chart and why there was no form uploaded, no note or order for an Advanced Directive. The DSS removed the blank form from the paper chart. The DSS stated they would get back to the surveyor with any additional information. On 12/16/24 at 1:29 PM the surveyor interviewed the LSW. The LSW stated that all residents that were full code prior to September did not have a POLST in the chart. In September, when the need was seen verify that there were AD/POLST in the medical records, the QAPI project was started. The LSW stated there was some difficulty getting the physicians sign POLSTs for residents who were full code. The LSW stated that Resident #10 had an admitted in August. The surveyor asked the LSW what would happen if a resident with no AD/POLST listed in the medical record needed to be checked for code status during an emergency, especially if the nurse on duty was unfamiliar with the resident. The LSW stated that the family would be called. The surveyor asked what if the family could not be reached. The LSW stated that the hospital records would be checked. The surveyor asked if these options could take extra time and possibly delay care. The LSW stated yes, they could. The surveyor asked the LSW if the missing documentation for Resident #10 could have been inadvertently missed or fell through the cracks. The LSW stated yes, it could have. At that time, the LSW stated that a progress note (PN) was placed in chart addressing the missing code status. A review of the resident's eMR revealed a new note by nursing recorded after surveyor inquiry. A review of the PN revealed: 12/16/2024 13:30 Note Text: PMD (primary medical doctor) notified of (redacted name) code status as full code, code status updated. On 12/18/24 at 10:56 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and made them aware of the concern with the missing documentation for Resident #10's code status. A review of the facility's Advance Directive Policy, revised 11/2021, provided by the LSW revealed: 4.executed advance directive be displayed prominently in med record. The policy does not reflect anything specific about full codes and POLST/AD. The facility did not provide any further pertinent information. N.J.A.C. 8:39-9.6(b)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 39885 COMPLAINT NJ#169518 Based on interviews, review of medical records, and pertinent facility documentation, it was determined that the facility failed to notify the Resident's Representative (RR) of a change in condition for 1 of 24 sampled residents (Resident # 239). This deficient practice was evidenced by the following: The surveyor reviewed Resident #239's closed hybrid (paper and electronic) medical record. Resident #239's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to dysphagia (difficulty swallowing foods or liquids), dementia (group of brain disorders that cause a gradual decline in cognitive abilities, such as memory, thinking, reasoning, and judgment) and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). A review of Resident #239's Universal Transfer Form (UTF) from the return to the facility after the first rehospitalization , indicated that the resident did not have any wounds. A review of Resident #239's progress notes (PN) included a wound note written by a Physician Assistant (PA) dated 9/5/23 which included the following: being seen today for a follow up wound evaluation .patient with multiple wounds. I was asked to evaluate and manage wound care for this patient Further review of the wound notes written by the PA indicated that the next visit was 10/3/23. There were three weeks of wound notes that were not in the resident's medical record. The next wound note written by the PA was dated 10/03/23. There was no documented evidence of wound measurements or appearance during those 3 weeks in Resident #239's medical record. There was no documentation in the PA's note that the RR was notified. Further review of Resident #239's PN did not include a documented notification of the RR regarding the DTI (deep tissue injury; a form of pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface might remain intact) identified on 9/5/23. On 12/18/24 at 9:37 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding Resident #239's wound. The ADON stated that the resident did not have any wounds on readmission from the hospitalization but that on 9/5/23 there was a reoccurrence of a DTI on the resident's buttock and bilateral heels. The surveyor asked the ADON if there was documented notification of the family of the DTI's. The ADON stated that she would have to check the medical record. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 3:00 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that there was no documented evidence that the RR was notified of the change in condition, specifically the DTIs that were investigated on 9/5/23 in the resident's medical record. On 12/19/24 at 9:59 AM, in the presence of the survey team, the ADON stated that the notification of the DTIs to the RR was documented in the Facility Acquired Pressure Injury Investigation Form. The surveyor asked if the investigation form was part of the medical record. The ADON stated that she would have to ask because she was not sure. The ADON then confirmed that there was no documentation in the electronic medical record that the RR was notified of the DTI on 9/5/23. On 12/19/24 at 10:18 AM, in the presence of the survey team, the ADON confirmed that the investigation form was not part of the medical record. On 12/19/24 at 12:31 PM, in the presence of the survey team, LNHA, DON, ADON, Regional DON #1, Regional DON #2 and the Co-President, the surveyor asked if the notification of the RR should be documented in the resident's medical record and the ADON stated yes. A review of the facility provided policy titled, Acute Condition Changes-Clinical Protocol with a revised date of 6/2024, included the following under Cause Identification: .2. As needed, the Physician will discuss with the staff and resident and/or family the benefits and risks of diagnosing and managing the situation in the facility or via hospitalization . The facility did not provide any additional information. N.J.A.C. 8:39-13.1(a)(d)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48781 Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding. This deficient practice was identified for 3 of 21 residents reviewed, Resident #48, #71 and #47. The deficient practice was evidenced by the following: 1. During the initial tour of the facility on 12/15/24 at 11:35 AM, the surveyor observed room [ROOM NUMBER]-LW and Resident #48 was not in the room. The surveyor observed dressers on both sides of the bed. Some areas of the wood on the left dresser and the edges of the right dresser were peeled, exposing the underlying particle board which created a rough surface and edges on the dressers. The heater unit in room [ROOM NUMBER]-LW was observed without the front grill cover. The front grill cover was observed laying against the wall. The surveyor also observed Resident #48's bed frame visibly soiled with a dry, brown substance on the right, foot side of the bed frame. On 12/15/24 at 11:51 AM, the surveyor observed the Resident #48 in the activity room, sitting on a wheelchair. The surveyor attempted to interview the resident but did not answer any questions. The surveyor reviewed the medical records of Resident #48 and revealed: The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with a diagnoses which included but not limited to unspecified dementia unspecified severity without behavioral, psychotic, mood and anxiety disturbance, and Alzheimer's late onset. According to the Quarterly Minimum Data Set (QMDS), an assessment tool which drives the plan of care, dated 11/1/24 revealed a Brief Interview of Mental Status (BIMS) score of 0 out of 15 indicating impaired cognition. On 12/16/24 at 12:18 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) and stated, I have reported about the drawers being jammed, and the grill cover since last week. I wrote on the maintenance book about the drawers. I told the Unit Manger (UM), that the grill was falling off. I did not notice the stain on the bed board. The resident does not complain, the resident is not alert. At that same time, the surveyor and the CNA reviewed the Maintenance Logbook together and found a log for 12/12/24 for dresser drawer being jammed but not for the wood edges peeling or heating unit grill cover missing. On 12/16/24 at 12:49 PM, the UM of the B Unit confirmed in room [ROOM NUMBER]-LW the two side drawers with peeled wood, and the bed stain on right side of the bed frame. The UM stated, I was not aware that the wood for the dressers were like that, and I do not know what that brown substance on the bed frame is. I will call maintenance and housekeeping. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 1:51 PM, the surveyor observed maintenance staff in room [ROOM NUMBER]-LW putting new drawers in the room after surveyor's inquiry. The surveyor interviewed the Regional Maintenance Director (RMD) who was also in the room at that time. The RMD, who has been with the company for four years stated, Usually the turnaround time for work orders is 24 hours. The surveyor requested for the policy for work orders. On 12/17/24 at 9:00 AM, the surveyor interviewed the License Nursing Home Administrator (LNHA), regarding the facility Policy and Procedure for maintenance work orders and he stated, We do not have a formal work order policy but usually if the equipment needs to be ordered, it can take time, it depends but we usually get it done as soon as we can. The LNHA stated that the facility did not have a maintenance policy. On 12/17/24 at 9:15 AM, the surveyor notified the LNHA, regarding the drawers with the rough edges near the Resident #48's head of the bed, the heating system grill cover off and laying against the wall and the brown substance on the foot of the bed frame found during initial tour on 12/15/24. 2. During the initial tour of the facility on 12/15/24 at 11:12 AM, the surveyor observed the Resident #71 lying in bed in room [ROOM NUMBER]-D, and the resident was unable to answer questions at that time but waved at the surveyor. The surveyor observed the closet with no door. The surveyor reviewed the medical records of Resident #48 and revealed: The AR reflected that the resident had diagnoses which included but not limited to obstructive and reflux uropathy unspecified, cerebral infarct due to thrombosis (formation of blood clot) of left middle coronary artery, vascular dementia unspecified severity with behavioral disturbance. According to the Annual MDS (AMDS) dated [DATE], revealed a BIMS score of 2 out of 15 indicating severely impaired cognition. On 12/16/24 at 9:47 AM, the surveyor observed room [ROOM NUMBER]-D still missing the closet door. The surveyor interviewed the UM of the B Unit, who confirmed the closet had no door. The UM stated, I will find out why there is no door to the closet. I did not notice that before. On 12/16/24 at 11:56 AM, the surveyor reviewed the Maintenance Request Book in the nursing unit from October to December 2024 and found no work order submitted for room [ROOM NUMBER]-D's missing closet door. On 12/16/24 at 12:07 PM, the UM stated, [Name Redacted] from maintenance took the door out on Friday to replace it with a lighter door. I do not know why it was not on the maintenance book log. On 12/16/24 at 12:12 PM, the surveyor interviewed the Director of Maintenance (DoM), who has been working in the facility for two years. The DoM stated, That door was heavy, off the track, one of the aides told me, a lot of things are not listed on the logbook, and we do it when it happens. I had to order the door, already picked up the door, will put it in today or tomorrow. On 12/16/24 at 1:57 PM, the surveyor requested for the requisition order form from the RMD for the new closet door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 9:15 AM, the surveyor notified the LNHA regarding the above findings and concerns with the closet door missing in room [ROOM NUMBER]-D observed during the initial tour. On 12/17/24 at 10:40 AM, the surveyor interviewed the DoM who stated, I ended up picking up the door at the other facility in [Name Redacted], we share things. I do not work on weekends that was why I put the door in on Monday. On 12/17/24 at 11:45 AM, the surveyor requested for the facility's Maintenance Policy and the LNHA stated, We do not have a Maintenance Policy. On 12/19/24 at 9:00 AM, the surveyor requested from the LNHA any Policy and Procedure for Environment, specifically, residents' rooms. On 12/19/24 at 10:50 AM, the surveyor requested from the LNHA the policy for Environment. There was no policy for Environment was provided. On 12/19/24 at 11:38 AM, the survey team met with the LNHA, DON, Regional DON#1 (RDON#1), RDON#2, Assistant Director of Nursing (ADON), and the Co-President. The LNHA stated, Hinge was broken in the closet door, we removed it, it was fixed after the surveyors saw it. The surveyor notified the LNHA and his staff that the RMD confirmed that maintenance issues had a 24 hour turn around. The closet door was reported and taken out on Friday and not replaced until 3 days later. On 12/19/24 at 1:05 PM, the LNHA stated, Some projects take more time, we were going to order the door, but we found one off site. 3. On 12/17/24 at 1:28 PM, the surveyor conducted the Resident council meeting. During the Resident Council meeting, Resident #47 stated, There are still cobwebs on top of my mirror, ceiling, and on top of my dresser, they have not cleaned it. I told them last month. I think it's dust bunnies I do not think it was cobwebs because I do not see anything crawling. A review of the Resident Council minutes completed on 11/22/24, revealed that Resident #47 complained of spider webs in the resident's room. The previous Activity Director, who was no longer working in the facility, filled out the grievance form titled Resident Council Concern Form on 11/22/24. The Housekeeping Director signed the form ten days later 12/2/24 and under action taken, Had [Name Redacted] clean the cobwebs. On 12/17/24 at 2:32 PM, the surveyor and Resident #47 observed room [ROOM NUMBER]-W, with dust above the top of the dresser, cobwebs on the ceiling on the right side of the windows, heating unit grill covered with dust and dirt, and the windowsill with dirt and dust. On 12/17/24 at 2:41 PM, the Licensed Practical Nurse (LPN) confirmed dust on top of dresser, spiderwebs on the right side of the room by the ceiling, the windowsill dirty and heating unit grill with dirt and dust. The LPN stated, I have not seen that before. On 12/17/24 at 3:00 PM, the surveyor requested from the LNHA the facility Policy and Procedure for housekeeping. (continued on next page)

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Dellridge Health & Rehabilitation Center	532 Farview Ave Paramus, NJ 07652

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the medical records of Resident #47 and revealed: The AR reflected that the resident was admitted to the facility with diagnoses which included but not limited to emphysema (a long-term lung condition that causes shortness of breath), anemia (a blood disorder in which the blood has a reduced ability to carry oxygen), and peripheral vascular disease (a slow and progressive disorder of the blood vessels). According to the AMDS, dated [DATE], which revealed a BIMS score of 14 out of 15 indicating intact cognition. On 12/18/24 at 11:13 AM, the surveyor discussed above concerns with the DON and the LNHA and both were notified of the Resident Council minutes for November which mentioned cobwebs. A review of the facility's Cleaning and Disinfecting Residents' Rooms Policy and Procedure revealed that Housekeeping surfaces will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. NJAC 8:39-31.4(a)(c)(f)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. 38327 REPEAT DEFICIENCY Based on interview and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 1 of 24 residents, (Residents #88), reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: The surveyor reviewed the medical records of Resident #88 and revealed: The Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to, wedge compression fracture of unspecified lumbar vertebra (the fracture occurs when the bone collapses and the front (anterior) part of the vertebral body forms a wedge shape), subsequent encounter for fracture with routine healing, pain in unspecified joint, and encounter for other specified surgical aftercare. The most recent Discharge Return Not Anticipated (DRNA) MDS, Section A-Identification Information revealed that the resident had an unplanned discharge (d/c) to a short-term general hospital (acute hospital). A Review of the Progress Notes, documented as a Late Entry, with an effective date of 10/02/24 was electronically signed by the Director of Nursing (DON) revealed that Resident #88 was d/c to home and was picked up by Resident's Representatives. On 12/16/24 at 01:41 PM, the surveyor interviewed the MDS Coordinator/Licensed Practical Nurse (MDSC/LPN) who informed the surveyor that the facility followed the Resident Assessment Instrument (RAI) manual as their policy and protocol for doing MDS. The MDSC/LPN stated that information in the MDS was gathered from the resident's medical records, interviews of staff and resident, and assessment of the resident. The surveyor then notified the MDSC/LPN of the above findings and concerns that the resident's MDS for DRNA was coded as d/c to the hospital when the PN of the DON revealed that the resident was d/c to home. The MDSC/LP stated that she had to check the records and would get back to the surveyor. She further stated that the MDS and the medical records should match. On 12/16/24 at 01:56 PM, the MDSC/Registered Nurse (MDSC/RN) informed the surveyor that after review of the concern regarding MDS coding accuracy for Resident # 88, the Section should have been coded d/c to community and not to the hospital and it was a mistake. On 12/19/24 at 01:48 PM, the survey team met with the Licensed Nursing Home Administrator, DON, Regional DON #1 (RDON#1), RDON#2, Co-President, and Assistant DON for an exit conference and there was no additional information provided. NJAC 8:39-33.2 (d)

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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. 38327 Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to adhere to professional standards of clinical practice by failing to: a.) follow the residents' meal tickets for 2 of 2 meal observations for Residents #41, #43, and #44; b.) clarify the physician's order with regard to supplement for 1 of 24 residents, Resident #41; and c.) ensure medication was administered in accordance with the manufacturer's specifications, and d.) ensure proper disposal of excess medication in a safe and approved manner for 2 of 6 residents, Residents #45 and #339, reviewed during the medication pass observation. 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 12/15/2024 at 11:46 AM, the surveyor observed in the recreation room during lunch 6 residents and 3 staff. The surveyor observed Resident #41 received their tray and the meal ticket revealed that the resident should receive a magic cup. Resident #41 did not receive a magic cup. The surveyor asked Recreation Aide #1 (RA#1) about the magic cup in the resident's meal ticket, and RA#1 could not state where the magic cup was. The surveyor asked the Registered Nurse Supervisor (RNS) about Resident #41's magic cup and the RNS asked RA#1 to get it from the kitchen. The RNS acknowledged that the resident should receive what was on the meal ticket, including the magic cup. On 12/15/24 at 12:01 PM, the surveyor observed RA#1 offered the with magic cup that was taken from the kitchen and Resident #41 refused the magic cup. A review of the provided Minimum Data Set (MDS) by the Director of Nursing (DON) revealed: -Resident # 41's most recent quarterly MDS (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/7/24, Section C Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 1 out of 15 reflected that the resident's cognitive status was severely impaired. A review of the Order Listing Report revealed an active physician's order (PO) dated 9/2/24 for Magic cup two times a day for supplement provide with lunch and dinner for Resident #41. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above order for the magic cup was transcribed to the December 2024 electronic Medication Administration Record (eMAR) and signed by nurses as administered (provided). On 12/15/24 at noon eMAR, the Registered Nurse (RN) electronically signed the eMAR as administered. The eMAR did not include information of resident's amount of intake and refusal. On 12/19/24 at 8:42 AM, the surveyor interviewed the RN who signed the eMAR on 12/15/24 at noon for Resident #41's magic cup. The RN confirmed that she was the nurse who signed the 12/15/24 at noon eMAR of Resident #41 for the magic cup. The RN acknowledged that she was not in the recreation dining room on 12/15/24 to observe the resident's intake of the magic cup and did not receive a report about the resident's refusal to take the magic cup. The surveyor asked the RN why she signed the magic cup on 12/15/24 if the resident did not take the magic cup at lunchtime, and the RN did not respond. On that same date and time, the RN informed the surveyor that the PO for the magic cup for Resident #41 should have been clarified with the physician to include the amount or percentage of intake of the magic cup as what was ordered in the health shake as best practice. 2. On 12/17/24 at 8:31 AM, the surveyor observed the recreation room for breakfast and there was a total of 4 residents and 2 staff. The surveyor observed Resident#43's meal ticket and revealed that the resident should receive a nectar-thickened orange juice (oj). The surveyor observed there was no nectar-thickened oj in the resident's tray. The surveyor asked RA#2 and RA#3 why the resident did not have nectar-thickened oj, and RA#2 responded that there was no nectar-thickened oj in the kitchen that was why the nectar-thickened cranberry juice was provided instead. On that same date and time, the surveyor observed Resident #44's meal ticket for 2 cups of coffee and the resident did not receive two cups of coffee. The surveyor asked RA#2 and RA#3 why the resident did not receive 2 cups of coffee according to what was in the meal ticket and RA#3 responded that it was the Certified Nursing Aide (CNA) who brought the breakfast tray and there was only one cup of coffee in the tray. On 12/17/24 at 8:44 AM, the surveyor went to the kitchen and interviewed the Food Service Director (FSD). The FSD showed what the facility fluids could offer to the residents during mealtime. The surveyor observed the kitchen stocks for the pre-thickened honey and nectar water, pre-thickened honey and nectar cranberry juice, cranberry juice, apple juice, oj, and strawberry juice. The surveyor did not see a supply of pre-thickened nectar oj and the FSD confirmed. Later, the Regional FSD (RFSD) joined the FSD during the interview. The FSD stated that the facility had thickened powder that could be mixed with water and juice. The FSD further stated that she was responsible for mixing the thickened powder and ensuring that the meal ticket corresponded with what should be on the tray. The surveyor notified the RFSD and the FSD of the above findings and concerns regarding meal tickets of Residents #41, #43, and #44. The surveyor also asked both FSDs, if the facility had a supply of thickened powder and oj, and why Resident #43 did not receive nectar oj, and both FSDs did not respond. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24 at 11:09 AM, the surveyor interviewed the DON regarding dining services. The surveyor asked the DON what the facility's process for dining services was and who verified the meal tickets. The DON responded that it was the recreation people responsibility to check the meal ticket and what was in the tray. She further stated that it was an expectation if there was a discrepancy with the meal ticket, it should be checked with the nurse or dietary. The surveyor notified the DON of the above findings and concerns. The surveyor asked the DON why Resident #43 did not receive nectar oj when there was a thickened powder and oj, and the DON did not respond. At that same time, the surveyor also notified the DON of the concern with Resident # 44 that the resident did not have two cups of coffee in their tray and the meal ticket revealed that the resident should have two cups of coffee. the DON had no response when asked by the surveyor what should be the expectation when verifying the meal ticket and the tray, and the DON had no response. On 12/18/24 at 10:20 AM, the surveyor interviewed the Clinical Dietitian (CD). The CD informed the surveyor that everybody should have meal tickets in their trays. The surveyor asked what the importance of the preferences was in the meal ticket, and the CD responded that everybody was unique and for safety. The surveyor asked who should be checking the meal ticket and what was in the tray, and the CD responded that the aide serving should check. The surveyor notified the CD of the concern regarding Resident#43, and the CD responded that the RAs should follow the meal ticket for oj. At that same time, the surveyor notified the CD of the concern regarding Resident#44's coffee, the CD stated the meal ticket should have been followed for 2 cups of coffee. Furthermore, the surveyor notified the CD of the concerns regarding Resident #41. The CD stated that Resident #41 was on the magic cup and multiple supplements. She further stated that her notes on 12/5/24 reflected that the resident had a stable weight for the past 3 months and a one-month history of fluctuating weight due to advancing dementia. The CD also stated that the FSD was responsible for the tray line and following the diet according to the meal ticket. On 12/18/24 at 11:14 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON. The surveyor notified the LNHA and the DON of the above findings and concerns. On 12/18/24 at 3:01 PM, the RFSD acknowledged that the meal ticket should be followed. The RFSD stated that Resident#43's preference was cranberry juice which was why the resident received the nectar cranberry juice. The surveyor then asked the RFSD and the CD, if the resident's preference was cranberry juice and why the meal ticket did not specify that. The surveyor asked the RFSD and the CD if was there documented evidence of the resident's preference for nectar cranberry juice and not nectar oj, and the CD responded that she would get back to the surveyor. A review of the provided documents by the DON revealed: -Resident # 43's most recent qMDS with an ARD of 10/11/24, Section C Cognitive Patterns revealed a BIMS of 5 out of 15 reflected that the resident's cognitive status was severely impaired. -Resident # 44's most recent significant change in status MDS with an ARD of 10/21/24 revealed a BIMS score of 5 out of 15 which reflected that the resident's cognitive status was severely impaired. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at 11:38 AM, the survey team met with the LNHA, DON, Regional DON #1 (RDON#1), RDON#2, Assistant DON (ADON), and the CO-President. The surveyor notified the facility management of the above concerns and findings regarding Resident #41. A review of the facility's Food, Dining Service and HS (bedtime) Snacks Policy with a reviewed date of 6/2024 that was provided by the LNHA revealed: Policy Explanation and Procedures: -Food service staff members will serve the food choices made with consideration given to dietary restrictions/texture modifications. Plates will be verified for accuracy of service . Eating Environment: -Staff will develop appropriate measures to try to maximize appropriate seating, positioning, and interactions among residents and to assure that each resident receives his or her prescribed diet On 12/19/24 at 01:48 PM, the survey team met with the LNHA, DON, RDON#1, RDON#2, Co-President, and the ADON for an exit conference. The facility did not provide additional information. 49078 3. On 12/17/24 at 8:23 AM, the surveyor began the Medication (med) Pass Observation task. At 9:02 AM, the surveyor observed Licensed Practical Nurse #1 (LPN#1) prepare and administer medications (meds) to Resident #45. The resident had a total of 4 meds to be administered. The meds included 10 milliliters (ml) of guaifenesin DM (Dextromethorphan belongs to a group of medications called antitussives (cough suppressants) liquid. The surveyor observed LPN#1 poured the guaifenesin DM more than the order indicated. Then LPN#1 poured the excess liquid into a second dose cup to get the proper amount. The surveyor observed LPN#1 dispose of the second dose cup with the excess liquid in the trash receptacle located on the side of the med cart (medcart). The surveyor observed the cup remain upright and not spill into the trash. Resident #45 refused the guaifenesin DM liquid. The surveyor observed LPN#1 dispose of the refused med into an approved med disposal system located in the bottom of the medcart. The surveyor asked LPN#1 what the policy or procedure on disposal of unused, refused, or extra meds was, and LPN#1 responded that they should be put in the med disposal system. At 9:15 AM, the surveyor observed LPN#2 prepare and administer meds to Resident #339. The resident had a total of 2 meds to be administered. The meds included 1 tablet (tab) of Sucralfate 1 gram (a drug used to treat ulcers and protect the stomach), ordered for 10:00 AM. During the administration of the meds to Resident #339, the surveyor observed the resident's breakfast tray present on a bedside table next to the resident. The surveyor observed that at least 50% of the meal was consumed. The surveyor asked Resident #339 when and if they had finished with the breakfast meal. The resident stated that they eat quickly and was finished eating approximately 8:15 AM to 8:20 AM. The surveyor reviewed the electronic medical records (eMR) for Resident #45 and Resident #339. Resident #45's eMR revealed a PO and eMAR for guaifenesin DM 10 ml TID (3 times a day) for cough for 7 days scheduled at 9:00 AM, 1:00 PM, and 5:00 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #339's eMR revealed a PO and eMAR for Sucralfate Oral Tab 1 gram, 1 tab by mouth TID a day for gastric ulcer scheduled at 10:00 AM, 2:00 PM, and 8:00 PM. Resident #339's eMR also reflected a nurse's progress note that revealed an assessment that the resident was alert and oriented. A review of the manufacturer's informational package insert (PI) for Sucralfate which reflected, the recommended adult oral dosage for duodenal ulcer was 1 gram four times per day on an empty stomach. On 12/18/24 at 11:15 AM, the survey team met with the LNHA and DON, and the surveyor notified the above findings and concerns. The surveyor asked the DON when meds were administered, what would be considered an empty stomach. The DON stated that it was usually 1 hour before a meal or 2 hours after a meal. The surveyor asked the DON what the policy or procedure was for properly disposing of excess meds. The DON stated that meds should be disposed of in the drug disposal system in the medcart. On 12/18/24 at 12:19 PM, the surveyor interviewed the facility Consultant Pharmacist (CP) by telephone. The surveyor discussed the concerns with the med pass observation. The surveyor asked the CP when meds were administered, what would be considered an empty stomach. The CP stated the standard would be 1 hour before meals or 2 hours after meals. The surveyor asked the CP if excess meds should be disposed of in the trash receptacle on the side of the medcart. The CP stated, no, meds should be disposed of in the approved med disposal system in the cart. On 12/19/24 at 11:39 AM, the survey team met with the LNHA and DON, and the facility had no further pertinent information to provide. A review of the facility's Administering Medications Using Electronic System Policy dated 6/2024. The policy reflected under 3. Meds must be administered in accordance with doctor's orders, including any required time frame and following med cautionary. The policy did not reflect any information regarding disposal of unused or excess meds during the med pass. NJAC 8:39-11.2(b); 29.2 (d); 29.4(g)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48781 Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary service to maintain good personal grooming for a resident who was unable to carry out activities of daily living (ADL). This deficient practice was identified for 1 of 21 residents reviewed for care, Resident #71. The deficient practice was evidenced by the following: On 12/15/24 at 11:12 AM, the surveyor observed Resident #71 lying on an air mattress inside their room. The resident waved to the surveyor but was unable to answer questions at that time. The surveyor observed Resident #71 unshaven, with hair stubbles on both cheeks, and beard on chin. On 12/16/24 at 11:28 AM, the surveyor observed the Resident #71 sitting on the wheelchair (w/c) inside their room, unshaven, and Certified Nursing Assistant #1 (CNA#1) was combing the resident's hair. The resident communicated to the surveyor and whispered their name when the surveyor asked for the name of the resident. On 12/16/24 at 11:39 AM, the surveyor interviewed CNA #1, who stated, I wash them, answer call bells, the resident is total assist. I have not been the regular aide, I was not here this weekend, sometimes the resident does not like to be shaved because he/she gets angry, says don't touch me but today the resident is fine and will try later to shave. The surveyor reviewed the medical records of Resident #71 and revealed: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with a diagnosis which included but not limited to cerebral infarct due to thrombosis (formation of a clot) of left middle cerebral artery, vascular dementia unspecified severity with behavioral disturbance, adjustment disorder with mixed anxiety and depressed mood, and delusional disorders. According to the Annual Minimum Data Set (MDS), an assessment tool to drive the plan of care dated 9/27/24 revealed a Brief Interview of Mental Status (BIMS) score of 2 out of 15 indicating severe impaired cognition. The section GG in the MDS revealed ADLs for personal hygiene, the resident requires substantial/maximal assistance from staff. On 12/17/24 at 11:15 AM, the surveyor observed the resident sitting on the w/c in the resident's room, with both cheeks and chin shaven. On 12/18/24 at 9:30 AM, the surveyor interviewed License Practical Nurse #1 (LPN#1). The LPN stated, The resident is a total care, will nod to questions, does not usually refuse care for me. On 12/18/24 at 10:46 AM, the surveyor interviewed CNA #2. CNA#2 stated, I do hygiene care every morning. The resident likes care later in the morning, sometimes they will refuse shaving but once you tell the resident and explain, they will allow you to do it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 11:13 AM, the surveyor notified the above concerns to the Director of Nursing (DON) and the License Nursing Home Administrator (LNHA). A review of the facility's Activities of Daily Living Policy, last reviewed on 10/2024 revealed that A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. On 12/19/24 at 11:38 AM, the survey team met with the LNHA, DON, Assistant DON, Regional DON #1 (RDON#1), RDON#2, and the Co-President. The LNHA stated, [Name Redacted] was observed not to be shaved. The care plan was updated to include refusal to be shaved and to reflect in the documentation the refusal and to ask the resident to be shaved in a later time. NJAC 8:39-27.2(g)

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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. 46049 REPEAT DEFICIENCY Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice and facility policies and procedures for 1 of 24 residents, Resident #86, reviewed for quality of care. 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. On 12/18/24 at 9:31 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #86. The Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, type 2 diabetes mellitus with chronic kidney disease, dementia, colostomy (a surgical opening into the colon from the outside of the body), and anxiety disorder. A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/19/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #86 scored a 9 out of 15, which indicated the resident had moderate cognitive impairment. A physician's order dated 9/25/24 documented chest x-ray (CXR) stat for congestion. A skilled progress note (PN) dated 9/25/24 at 12:31 PM revealed Licensed Practical Nurse #1 (LPN#1) documented the physician visited the resident and orders for intravenous (IV) hydration, blood lab works, and a CXR. There was no further documentation about the CXR status in the PN. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation of the stat CXR results in the paper chart or the EMR. A review of the resident's blood pressure (BP) results revealed: -9/26/24 at 5:32 AM, the resident's documented BP was 88/55. There were no other vital signs (VS; includes BP, pulse, respiratory rate, temperature, oxygen saturation) documented for the resident at this time. -9/26/24 at 6:05 AM, the resident's documented BP was 96/67. There was no other VS documented for the resident at this time. A review of the resident's BP in September 2024 revealed the resident's systolic (top number and refers to the amount of pressure experienced by the arteries while the heart is beating) BP was higher than 139 for 75 of the 98 BPs documented for the resident. A review of the PN, indicated there was no documentation of the physician being notified of the resident's low BP. On 12/18/24 at 10:25 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that if there was a change of condition with the resident an SBAR [Situation, Background, Assessment, and Recommendation; a tool that can be used to help healthcare teams share information about a patient's condition or concerns] and the physician should be notified for any orders to be carried out. The surveyor asked the RN/UM if a resident's BP was outside of the baseline for the resident, what would be expected of the nurses. The RN/UM stated that the physician should be made aware of the resident's BP for any orders. The surveyor asked the RN/UM about what would be expected for a stat CXR. The RN/UM stated that the CXR would be called in or entered in their electronic system and the technician would be expected within 3-4 hours. The RN/UM further explained that she had never experienced any issues with stat orders and if they did not arrive that it would be expected to call the vendor, notify the physician, and the DON (Director of Nursing). The surveyor discussed the concern that the results for Resident #86's stat CXR was not found in the paper chart and the EMR. The RN/UM stated she would follow up to provide additional information. On 12/18/24 at 10:54 AM, the surveyor interviewed LPN #2 over the phone. The LPN stated that if there was a change with a resident, the resident needed to be assessed, an SBAR completed, the physician notified for orders and the RN supervisor notified to assess the resident. LPN #2 stated if a change in BP from baseline occurred, the physician and supervisor should be notified for interventions. The surveyor asked if it would be documented in the EMR. The LPN replied that it would be documented in the PN of the EMR. The surveyor asked about Resident #86. LPN #2 replied that she could not recall everything as some time had passed and that anything pertinent would be documented in her PN in the EMR. On 12/18/24 at 11:14 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the DON of the above concerns of the stat CXR that was not completed, and no documentation of the physician being made aware of the resident's low BP results. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 11:44 AM, the RN/UM provided a CXR requisition form for Resident #86 and attached email. A review of the email document indicated that the vendor called the facility a notified a named facility staff member that they were overwhelmed and would be able to send a technician in the morning of 9/26/24. On 12/19/24 at 11:38 AM, the LNHA, the DON, the Assistant Director of Nursing (ADON), Regional DON #1, Regional DON #2, and the Co-President met with the survey team. The surveyor asked who was the staff that was notified by the vendor that would not be able to do the CXR stat and what would be expected of the staff once notified. The DON stated it was a nurse supervisor who was notified, and it was protocol to call the physician to notify that there would be a delay. The RDONs and the DON stated the nurse supervisor spoke with the physician. The surveyor asked if there was any documentation that the physician was notified. The facility stated they would review to provide any additional information. The surveyor asked if there was any response for the resident's BP and the physician not being notified. The facility stated they would also review to provide additional information. On 12/19/24 at 1:05 PM, the LNHA stated that the resident's BP went back up upon the resident's re-check and that was why the nurse did not notify the physician. There was no additional information provided by the facility. A review of the facility's Acute Condition Changes-Clinical Protocol Policy, with a last revised dated of June 2024. Under Assessment and Recognition, it specified, .5. Before contacting a physician about someone with an acute change of condition, the nursing staff will make pertinent observations and collect appropriate information to report to the Physician; for example, history of present illness and previous and recent test results for comparison. Under Treatment/Management it documented, The physician will help identify and authorize appropriate treatments. Under Monitoring and Follow-Up, it documented, 1. The staff will monitor and document the resident's progress and responses to treatment and the Physician will adjust treatment accordingly. A review of the facility's Lab (laboratory) and Diagnostic Test Results- Clinical Protocol Policy, with a last revised dated of June 2024. The policy did not address the protocol for when a diagnostic test could not be performed by the diagnostic radiology provider. N.J.A.C. 8:39-3.2 (a), (b); 27.1 (a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49078 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services of residents that were receiving oxygen, according to the standard of clinical practice and the facility's policy and procedure, specifically, administer oxygen therapy according to the physician's order by documenting the date and time the oxygen tubing was changed for 1 of 1 resident, Resident #10. 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. On 12/15/24 at 11:55 AM, during initial tour the surveyor observed Resident #10 in a wheelchair (w/c), awake, with oxygen (O2) being administered by nasal cannula (N/C) (tubing that fits around the face and provides O2 into the nostrils) attached to and O2 concentrator (a machine that gathers O2 from room air and delivers it by tubing to a resident). The surveyor did not observe a label or other marking on the O2 tubing denoting when it was changed for a new set. On that same date and time, the surveyor interviewed Resident #10. The surveyor asked the resident how they use the O2 and if the staff prepares it or replaces the tubing. The resident stated that the staff does change the tubing but was unsure when that happens. The resident also stated they were in the process of weaning off the O2, and sometimes does not use it. On 12/16/24 at 10:11 AM, the surveyor observed Resident #10 in a w/c with O2 being used. The surveyor observed that the O2 tubing had date written on a piece of surgical tape and applied near the connection to the O2 concentrator. The date reflected 12/16/24 (Monday). The surveyor reviewed the hybrid (electronic and paper) medical record for Resident #10. The Resident Admission Record (a summary of important information about the resident) revealed that the resident was admitted with diagnoses that included but were not limited to, chronic respiratory failure (a chronic condition when the airways in the lungs become damaged and narrow), anxiety disorder, and type 2 diabetes mellitus. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/30/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #10 scored a 14 out of 15, which indicated the resident had no cognitive impairment. Further review of the MDS, Section O, revealed the resident was using O2. A review of the resident's Care Plan (CP) initiated 8/21/24, (a list of interventions and goals related to the resident's care), revealed that Resident #10 received O2 for difficulty breathing and symptoms of poor O2 absorption. A review of the resident's Physician Order Sheet (POS) revealed an order dated 8/22/24: Change O2 tubing, cannula/mask weekly. Label with date, time, and nurse's initials every night shift every Wed (Wednesday) for preventative care and as needed for soiled/wet. The above orders for O2 tubing was transcribed to the December 2024 electronic Medication Administration Record (eMAR). There was no documented evidence that the PRN order for O2 tubing change was signed on 12/16/24 according to the POS. On 12/18/24, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor notified the LNHA and the DON of the above findings and concerns. On 12/19/24 at 11:39 AM, the survey team met with the LNHA, DON, Assistant Director of Nursing (ADON), Regional DON #1 (RDON#1), RDON#2, and Co-President for facility's responses from the above concerns and findings. The facility management response included documentation that reflected that the facility considered it an isolated event and was immediately corrected, and there was a possibility the date label fell off at some time. On 12/19/24 at 11:45 AM, the surveyor interviewed the DON and the ADON after the response. The surveyor asked how the date was applied to the tubing. The ADON stated that it was written on a piece of surgical tape, then applied to the tubing. The surveyor further inquired if there was any additional documentation that the label was replaced, would the nurse document the current day, would the nurse document under the PRN order and if the tape fell off, would it be considered not secure. The DON responded that the reasoning that the tape fell off or was knocked off by the resident was a possible answer being provided, and there was no absolute way to know. After the facility response, the facility did not provide any further pertinent information. A review of the facility's Oxygen Administration Policy dated 10/2024 revealed: Preparation: 1. Verify that there is a physician's order (PO) for this procedure. Review the PO or facility protocol for O2 administration. Documentation: 1. The date and time that the procedure was performed. The policy did not reflect any mention of applying a date to the O2 tubing specifically. NJAC 8:39-11.2(b); 27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46049 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to ensure that residents who require dialysis receive such services, consistent with professional standards of practice for 1 of 1 resident (Resident #25), reviewed for dialysis services. The 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. On 12/15/24 at 10:36 AM, the surveyor observed Resident #25 sitting in a wheelchair at their bedside. Resident #25 was alert, oriented, and verbally responsive. The resident stated they went to dialysis 3 times a week and had no concerns with their care. On 12/16/24 at 11:48 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to care for Resident #25. The LPN stated the nurses documented on the dialysis communication form (DCF) when sending the resident to the dialysis center, including vital signs (VS; blood pressure (BP), pulse, respiratory rate, and temperature) and any changes or concerns. The dialysis center would document on the second portion of the form, which included pre and post treatment dialysis weight and BP, any medications (meds) given to the resident during dialysis and any concerns during the dialysis session. The LPN provided the dialysis communication binder for Resident #25. The binder included 2 DCF. The surveyor requested the additional DCF for Resident #25. On 12/16/24 at 12:02 PM, the Registered Nurse/Unit Manager (RN/UM) stated the DCF were uploaded to the resident's EMR and the original copies were kept in a binder for the year. The RN/UM, in the presence of the surveyor reviewed the resident's EMR which revealed the scanned copies of November and December 2024 DCFs. On 12/18/24 at 9:28 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #25. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, end stage renal (kidney) disease, and dependence on renal dialysis. A comprehensive Minimum Data Set (MDS), an assessment tool to facilitate the management of care, dated 11/15/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #25 scored a 15 out of 15, which indicated the resident was cognitively intact. A review of the scanned DCF for December 2024, revealed the following: On 12/7/24, under the facility section it was written I left a Zofran (a medication (med) indicated for nausea and vomiting) in book .Please give before leaving. There was no further documentation on the form about the Zofran med. On 12/10/24, under the facility section of the form it was written Zofran in Book. Under the dialysis section of the form it was written pt [patient] vomited post tx [treatment]. On the bottom of the form it was written, Zofran 4 mg[milligram] tab[tablet] was sent to dialysis, not given still in binder. On 12/12/24, under the dialysis section of the form it was written Zofran given. There was no further documentation on the form about the Zofran med. On 12/14/24, a dialysis center communication log form, under the post dialysis section it was written for meds given Zofran 4 mg given. There was no further documentation on the form about the Zofran med. On 12/17/24, under the dialysis section of the form it was written Ondansetron [Zofran] given post dialysis. There was no further documentation on the form about the Zofran med. A physician's order (PO) dated 11/09/24 documented the resident had dialysis on Tuesday (Tue), Thursday (Thu), and Saturday (Sat) with a pickup time of 8:15 AM. A PO dated 12/17/24 documented the resident was to receive Zofran (Ondansetron Hydrochloride) 4 mg tablet (tab), 1 tab by mouth in the morning every Tue, Thu, Sat for nausea at 7:45 AM. A PO dated 12/17/24 documented the resident was to receive Zofran (Ondansetron Hydrochloride) 4 mg tab, 1 tab by mouth every 6 hours as needed (PRN) for nausea. There were no additional orders for Zofran. A review of progress notes (PN) for December 2024 revealed: On 12/10/24 at 5:47 PM a PN written by the RN/UM indicated per the DCF the resident vomited post dialysis tx and the Zofran sent to dialysis with the resident was not administered, still in the binder. The dialysis nurse was called, reviewed that the resident had a Zofran order, the med was in the binder to be given to the resident. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no other PN related to the resident receiving Zofran in dialysis. On 12/18/24 at 9:52 AM, the surveyor interviewed the LPN who stated that the resident had episodes of having nausea when returning from dialysis and the physician ordered Zofran for the resident. The LPN stated the Zofran was an individual dose sealed in its original packaging. The Zofran packaged dose would be placed in a clear plastic bag and attached inside of the binder. The LPN stated it would be documented on the dialysis communication book if the resident received the med in dialysis. On 12/18/24 10:07 AM, the surveyor interviewed the RN/UM about Resident #25 receiving Zofran in dialysis. The RN/UM stated the PO for the resident to receive med post dialysis due to nausea and vomiting. The RN/UM further explained the dialysis center did not have the med and that was why the med was being sent with the resident. The RN/UM confirmed there should be a PO for sending the med with the resident to dialysis and stated that the resident did have one. The RN/UM showed the surveyor the resident binder which had a print out of a PO to send Zofran 4 mg with the resident to dialysis, dated 12/3/24. The surveyor asked the RN/UM to review the PO in the EMR. The RN/UM could not find an active order for Zofran 4 mg to be sent to dialysis with the resident. The RN/UM found an order that was discontinued (d/c) on 12/13/24. The RN/UM could not speak to what happened and would have to follow up. The surveyor asked the RN/UM about accountability for the Zofran med. The RN/UM stated that it would be written on the DCF if the resident received the med and if the med returned in the binder the med was not given. The RN/UM added if the DCF did not document if the resident received or if there was a concern about Zofran administration, the staff would call the dialysis center to confirm it was given or not. The surveyor asked about the documentation of the time the Zofran med was administered in dialysis as the resident also had a PRN Zofran order. The RN/UM stated that it was given post dialysis. The RN/UM acknowledged the exact time the med was received was not known as it was not documented on the DCF and the facility nurse would have to call the dialysis center to find out that information. The surveyor informed the RN/UM of the concern that the administration time was unknown and Zofran was sent with the resident without a PO. On 12/18/24 at 11:14 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the above concerns related to the resident's Zofran med. On 12/19/24 at 11:38 AM, the LNHA, the DON, the Assistant Director of Nursing (ADON), Regional DON #1 (RDON#1), Regional DON #2 (RDON#2), and the Co-President met with the survey team. The facility stated the there was a PO for Zofran and provided the Medication Administration Record (MAR). A review of the MAR revealed the Zofran order was dated 12/17/24 and timed for administration 7:45 AM. It did not indicate Zofran 4 mg should be sent with the resident to dialysis. The surveyor rediscussed concern for Resident #25's Zofran. The facility stated they would review to provide any additional information. On 12/19/24 at 12:59 PM, RDON#2 provided a physician PN, dated 12/17/24, which indicated the physician wanted to continue the Zofran orders. The surveyor asked RDON#2 if it would be expected for there to be PO for the nurses to follow. RDON#2 acknowledged that there should have been a PO for it. There was no additional information provided by the facility. A review of the facility's End-Stage Renal Disease, Care of a Resident Policy with a last updated date of 10/2024 revealed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under the Policy Statement it was written Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Under Policy Interpretation and Implementation, it documented, .7. Facility will send dialysis communication form or communication book to dialysis Center. This communication form/book will be returned to the facility for review for orders, med administered at the Center, latest lab works, resident weights, or any significant changes . A review of the facility's Administering Medications Using Electronic System, with a last reviewed date of 6/2024 revealed: Under the Policy Statement it was written Meds shall be administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation, it documented, .3. Meds must be administered in accordance with doctor's orders, including any required time frame . NJAC 8:39 - 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 39885 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour staffing report posted was accurate and in a prominent place within the facility readily accessible to the residents and the visitors. This deficient practice was evidenced by the following: On 12/15/24 at 8:56 AM, the survey team entered the facility. The surveyor did not observe a 24-hour staffing report in the initial hallway leading to the nursing station or at the nursing station. The surveyor then turned right and proceeded down a different hallway, which contained the lower odd numbered resident rooms and observed a staffing report sheet that was posted on the right wall next to the menu. The surveyor observed that the posting would not be accessible or visible to residents and visitors that were located or visited the resident rooms that were in the hallway that contained the higher odd numbered rooms. The posting observed was dated 12/13/24 evening shift with a census of 85. The posting had not been updated for that day and did not include the accurate census which the Registered Nurse Supervisor informed the survey team was 86. On 12/16/24 at 9:15 AM, the surveyor observed the staffing report that was posted was dated 12/16/24 day shift with a census of 85. The posting was accurate. On 12/17/24 at 8:45 AM, the surveyor observed the staffing report that was posted was dated 12/16/24 evening shift. The posting had not been updated for that day. On 12/17/24 at 10:43 AM, the surveyor interviewed the Director of Nursing (DON) regarding the posting of the staffing report. The DON stated that the Unit Clerk (UC) posted the staffing report and that she believed it was posted for the whole day. On 12/17/24 at 11:31 AM, the DON stated that the UC placed the 3 different sheets, 1 sheet for each shift, in the clear plastic sleeve that was located on the wall. She added that when the UC comes into the facility around 8 AM, she placed all 3 shifts and that when the UC left, she would remove the day shift report to reveal the evening shift report. The DON then stated that the 3-11 Supervisor at the end of the evening shift would remove the evening shift report to reveal the night shift report. The surveyor asked the DON who was responsible on the weekend to post the staffing reports. The DON stated that the UC would print out all 3 days on Fridays and that the Supervisors on the weekend were supposed to post them each shift. The surveyor asked the DON if the posting should be prominent for all residents and visitors. The DON stated that it should be prominent. On 12/17/24 at 12:26 PM, the surveyor interviewed the UC regarding posting of the staffing report. The UC stated that she would print all 3 shifts which included the next day's day shift report and put them in the sleeve. She added that the Supervisor on the night shift would reveal the day shift report. The surveyor asked the UC who was responsible on the weekend. The UC stated that the Supervisors were responsible on the weekend. (continued on next page)

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Dellridge Health & Rehabilitation Center	532 Farview Ave Paramus, NJ 07652

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 10:01 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a facility policy for the posting of the staffing report. The LNHA stated that the facility did not have a policy for posting and that they followed the regulation. The LNHA then stated that the staff brought it to his attention about the concerns with the posting and that he placed an additional posting in a different area. On 12/18/24 at 11:38 AM, in the presence of the survey team, the surveyor notified the LNHA and DON the concern that the staffing report was not posted in a prominent place within the facility readily accessible to the residents and the visitors and was not accurate and up to date on 12/15/24 and 12/17/24. On 12/19/24 at 11:47 AM, in the presence of the survey team, DON, Regional DON #1 (RDON#1), RDON#2 and Co-President, the LNHA stated that he had a statement from the person that switched out the posting. The LNHA then stated that he felt that the posting was visible since that was where the menus were located but that however he added a posting to another area. RDON# 1 stated that all 3 shifts were posted in the sleeve but that they were behind the one posted and that each shift was not visible. The COO stated that she talked to the UC and other staff to make sure it was visible at all times. The facility did not provide any additional information. N.J.A.C. 8:39-41.2 (a)(b)(c)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On [DATE] at 9:28 AM, the surveyor, in the presence of the Food Service Director (FSD) and Regional FSD (RFSD), observed the following during the kitchen tour: 1. In the juice dispenser area, there were three 5-gallon beverage boxes that were past their best used by date. A thickened water (nectar consistency) 5-gallon box had a best if used by date of [DATE]. A thickened water (honey consistency) 5-gallon box had a best if used by date of [DATE]. A diet lemonade 5-gallon box had a best if used by date of [DATE]. The FSD stated that the beverage boxes were good for 6 months after their best if used by date. The FSD acknowledged the diet lemonade was expired. The surveyor requested documentation from the RFSD and FSD which indicated the beverage boxes were still good to be used 6 months after the best if used by date. 2. On a food preparation (prep) table there was a food processor machine. The surveyor observed a single fiber- like strand, more than 3 inches long with the top compartment cover of the machine. The surveyor pointed out the observation to the RFSD who took off the top of the machine off and took the hair strand. On the food prep table next to the machine there were food items covered with clear plastic wrap. The surveyor asked the RFSD and FSD if there was any concern with the fiber strand being found on the food processor machine and the area being a food prep area. The RFSD stated the strand was part of a hairnet, it was outside of the machine, and there was no food in the machine. The RFSD and FSD confirmed the items on the table were being prepared for the next meal and the table was a food prep area. 3. In the drying rack storage area, 1 of 3 small veggie steam pans checked was observed to be soiled with a dry, hard food-like debris on the side wall of the pan. The FSD confirmed the pan was soiled that it was expected to have been clean and would put the pan to be re-washed. On [DATE] at 10:48 AM, the surveyor, in the presence of the FSD and RFSD, observed the following during a kitchen tour: 4. The surveyor observed Dietary staff (DS) #1 exit the dishwashing area and walking through the food prep area to exit the kitchen. DS #1 had facial hair including a mustache and facial hair on their chin. DS #1 was not wearing a beard restraint (used to contain facial hair, such as, beards, mustaches, and goatees to prevent it from falling into food and contaminating it). The surveyor asked the RFSD about the observation of DS #1 with facial hair and not wearing a beard restraint. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The RFSD stated DS #1 did not have facial hair. The surveyor interviewed DS #1 in the presence of the RFSD. The DS #1 acknowledged he had a mustache, facial hair on his chin, and that it should have been covered with a beard restraint. The surveyor asked DS #1 if there were any available beard restraints for him. DS #1 was not able to provide a verbal response. The surveyor asked the RFSD about beard restraints available for staff. The FSD went to look for the beard restraint supplies for the staff. 5. In the dishwashing area, the three-compartment sink had 1 of the 3-compartment filled with sanitizing solution water, and soaking dishes. No staff were in the dishwashing area. The RFSD stated the dishes were still in progress of being washed by staff. On a metal table in which clean dishware would come out from the dishwasher there was white solid, food-like debris on the table. 6. In the dishwashing area on a shelf above the 3-compartment sink, there were three serving trays filled with dessert bowls which were faced down on it. The RFSD stated it was to dry the dish ware and the shelf area was considered a clean area. The surveyor asked about the soiled dishes still being washed in the 3-compartment sink below the shelf and if there was a risk of contamination of the dishes. The RFSD replied that the clean dishes were not kept on that shelf when dirty dishes were being washed. The surveyor informed the RFSD of the dishwashing area being in use prior to the surveyor entering area. There was no additional verbal response by the RFSD about the clean bowls on the trays. Next to the trays on the shelf were four 5-gallon food bins on the shelf right side up and uncovered. The surveyor asked the RFSD what the bins were used for. The RFSD stated that the bins were considered clean and were used to store the dessert bowls when they dried. The RFSD further stated the bins would be covered once the bowls were stored inside. The surveyor asked to check the inside of all 4 of the uncovered bins. The first bin had an accumulation of clear liquid on the bottom of the bin. The RFSD stated that the bin was drying. The second bin had 1 dessert cup inside of it. The third bin had several loose dessert cups stored in it, and the last bin was empty. The outside of the bins had discolored stains/spots. The surveyor asked the RFSD if it was considered clean. The RFSD replied that the dishware was stored inside and covered for storage. 7. In the dishwashing area on the shelf above the 3-compartment sink there was a crumpled washcloth against the wall and next to one of the trays of the dessert bowls. The RFSD took the washcloth, confirmed it was wet and acknowledged it should not have been up there. The FSD stated she did not find any beard restraints and told DS #1 to wear a face mask to cover their facial hair. The FSD acknowledged DS #1 had facial hair and stated that he should have been wearing a beard restraint. The surveyor asked the FSD about the clean and soiled areas of the dishwashing area. The FSD stated the metal table in which the clean dishware comes out of dishwashing machine was considered a clean area. The surveyor asked about the white colored food-like debris observed on the table. The FSD acknowledged that the area was not clean and that it should have been clean. The surveyor asked the FSD about the concern of clean dessert bowls being stored on the shelf above the 3-compartment sink and the use of the 5-gallon bins being used to store dishware. The FSD replied that the clean dishware would be removed from the dishwashing area placed on a cart which was kept between the dishwashing and food prep areas. There was no additional verbal response by the FSD. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. The surveyor accompanied by the FSD in the drying rack storage area, observed 1 of 2 long vegetable pans was soiled with dry, solid, food-like debris on the side wall of the pan. The FSD confirmed the pan was soiled and that it needed to be washed again. The surveyor requested from the RFSD and FSD for policies on kitchen cleanliness, storage, and hair restraints. On [DATE] at 12:46 PM, the surveyor interviewed the LNHA about if it was expected for beard restraint supply to be available in the kitchen for staff. The LNHA, replied Yes. The surveyor informed the LNHA of the concern that there was none available as per the FSD. The LNHA stated he would follow up. On [DATE] at 10:47 AM, the surveyor with the Registered Nurse/Unit Manager (RN/UM) inspected the nutrition refrigerator on the unit. The RN/UM stated the refrigerator was used to store snacks from the kitchen and resident food items, including food from outside the facility. The RN/UM further explained items were stored for up to 3 days in the refrigerator, housekeeping (HK) would clean the refrigerator, throw away outdated food every 3 days. The surveyor in the presence of the RN/UM observed the following: 9. In the refrigerator, there was a white bag with packaged food items that was labeled with a resident's name and room number. There was no date on the bag to indicate when it was placed in the refrigerator. There was also a fast-food brand bag which had the resident's name and room number written on it. There was no date on the bag to indicate when it was placed in the refrigerator. 10. In the freezer of the refrigerator, there were 3 wrapped foiled food items in a plastic storage bag which had the resident's name and room number written on it. The items were not dated to indicate when it was placed in the refrigerator. Additionally, there was an unopened bag of edadame beans which was dated [DATE]. The packaging did not have a resident's name or a room number on it. The RN/UM stated that the items should have the appropriate labeling which would include the resident's name, room number and the date the item was placed in the refrigerator. The RN/UM stated she would follow up with the residents about the items. She would discard outdated and food items that could not be verified. On [DATE] at 10:57 AM, the surveyor interviewed the Housekeeping Director (HKD) who stated HK would clean the refrigerator every Friday. The HKD further explained the refrigerator was cleaned thoroughly inside, anything not labeled with a name or date would be thrown away. The HKD added that items more than 3 days after their written date would be thrown away. The surveyor asked if the refrigerator was checked by HK on other days besides Friday. The HKD stated that during the week the refrigerator would be checked periodically by HK staff. The HKD further explained there was no set schedule besides the Friday and it would not be documented if the refrigerator was checked on other days of the week. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The HKD stated there was a log for when the refrigerator was cleaned and checked on every Friday. The HKD added besides the log, he had additional documentation in his office. The surveyor accompanied the HKD to check the log posted on the refrigerator which read that the refrigerator was to be cleaned every Friday. A review of the log which included the date and the signature of the staff cleaning the refrigerator revealed there was no documentation for [DATE] and no signature indicating that the refrigerator was cleaned. The HKD stated he was the one who cleaned the refrigerator and that he must have forgotten to sign the form. The surveyor accompanied the HKD to his office to check for any additional documentation of the refrigerator being cleaned on [DATE]. The HKD was unable to provide any additional documentation for the date in question. On [DATE] at 11:03 AM, the RN/UM informed the surveyor for the foiled food item in the freezer (Resident #61) it was brought in on Friday and was discarded. The fast-food bag was brought in last night. The RN/UM stated she still had to find out who the edamame package belonged to and when the white bag of food items was brought in. The RN/UM added if unable to determine the food items would be disposed. The surveyor asked the RN/UM about the protocol for the food storage in the nutrition refrigerator. The RN/UM stated it was expected for the food items to be labeled with the resident's name, room number, and date the item was brought in. The RN/UM stated HK cleaned out the refrigerator every Friday. The RN/UM further explained the staff that placed food items for residents in the refrigerator were responsible for ensuring the food items were labeled appropriately and she was not aware if anyone else was responsible for checking food items in the refrigerator. On [DATE] at 11:14 AM the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the above concerns during the kitchen tours and inspection of the nutrition refrigerator on the unit. The LNHA was also informed that the FSD and RFSD stated they were going to provide supportive documentation that the beverage boxes were good for use 6 months after their best if used by date and no documentation had been provided. On [DATE] at 12:05 PM, during observation of tray line in the kitchen, the surveyor observed DS #2 enter the kitchen from the dining area. DS #2 was observed with hair bangs uncovered with the rest of their hair contained with a hair net. DS #2 walked through the food prep area and went to back area of the kitchen. DS #2 returned the same way, her hair bangs remained uncovered and exited the kitchen to the dining area. The surveyor asked the RFSD about hair restraint protocol. The RFSD stated all hair should be covered with a hairnet. The surveyor informed the RFSD of the observation. The RFSD acknowledged all of DS #2's hair should be contained with the hairnet. The RFSD stated she would go to speak with DS #2 and exited the kitchen. On [DATE] at 12:41 PM, the surveyor informed the LNHA and DON of the observed concern of DS #2's hair bangs remaining uncovered while passing through the food prep area during tray line. On [DATE] at 11:38 AM, the LNHA, the DON, the Assistant Director of Nursing (ADON), Regional DON #1, Regional DON #2, and the Co-President met with the survey team. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The LNHA stated for the nutrition refrigerator that the HKD forgot to sign off the log and that he cleaned all refrigerators including the break room refrigerator in which he had signed the log. The surveyor asked the LNHA if it was expected for the HKD to have signed the cleaning log for the nutrition refrigerator after cleaning. The LNHA acknowledged that it should have been signed by the HKD. The LNHA stated for the fiber strand found on the food processor machine, stated that it was outside of the machine not inside and that there was no food in the machine. The surveyor asked if there would be a concern for something like that being found in a food prep area. The LNHA replied that staff wore hairnets in the kitchen. There was no additional response provided by the facility. The LNHA stated for the pans found soiled in the clean drying rack storage areas, the items were cleaned by the FSD after the observations. LNHA acknowledged it would be expected that the items were cleaned. The LNHA stated DS #2 was in-serviced on use of hairnet and that a restraint did not have to be used unless it was longer than ,d+[DATE] inch. The surveyor asked the LNHA about the guidance followed for kitchen policies. The LNHA replied that the references for their hair restraint policy was provided. The surveyor asked if the references and facility policies were based on regulations and from nationally recognized organizations and based on regulations. Regional DON #2 stated that the regulations did not specify the length and only indicated facial hair should be covered. The surveyor asked if the regulations did not specify the length of facial hair that should be restrained, was it ok for less than ,d+[DATE] inch to be without a beard restraint. There was no additional response by the facility. The LNHA stated the clean dishware were removed from the dishwashing area and would be stored in another area for drying storage. The LNHA stated for the nutrition refrigerator that items from the kitchen to the refrigerator were labeled every day prior to delivering. The LNHA stated that resident visitors sometimes brought food and forgot to date the food items. The LNHA added the staff regularly checked food items for dates and discarded when not dated. There was no additional information provided by the facility. There was no documentation provided by the facility to indicate that the beverage boxes were okay to be used up to six months after their best if used by date. A review of the facility's Hair Restraints Policy, with a last reviewed date of [DATE] revealed: Under Policy: All Dietary Staff shall wear hair restraints such as hats, hairnets and beard restraints if you have any facial hair growth, to keep their hair from contacting exposed food, clean equipment's, utensils and linens. Under Procedure: 1. Always cover all head hair with hair restraint .2. Always cover all facial hair with beard net .3. Never leave bangs or other part of your hair hanging outside of hair restraint. A review of the facility's Cleaning and Sanitation Equipment Policy, with a date of [DATE] revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Under Policy: Cleaning and sanitation of equipment is to remove food debris that bacteria need to grow and to kill those bacteria that are present. It is important that the clean and sanitized equipment are stored dry so as to prevent bacteria growth. A review of the facility's Food Storage Policy, with a last reviewed date of [DATE] revealed: Under Policy: Food storage areas shall be maintained in a clean, safe, and sanitary manner. The policy did not further address use of food items by manufacturer best if used by dates. A review of the facility's Food Brought in for Patients and Residents Policy, with an effective date of [DATE] revealed: Under Purpose: To ensure the safe consumption of food brought in to patients/residents. Under Procedure: for food brought in that required refrigeration: .1.2 Food items that require refrigeration must be labeled with the patient/resident's name and the date the food was brought in .1.5 Food will be held in the refrigerator for 3 days following the date on the label and will be discarded by staff upon notification to patient/resident. NJAC 8:,d+[DATE].2(g)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885 Complaint NJ#169518 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 1 of 24 residents reviewed (Resident #239). This deficient practice was evidenced by the following: On 12/18/24 at 9:01 AM, the surveyor reviewed Resident #239's closed hybrid (paper and electronic) medical record. A review of Resident #239's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to dysphagia (difficulty swallowing foods or liquids), dementia (group of brain disorders that cause a gradual decline in cognitive abilities, such as memory, thinking, reasoning, and judgment) and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). A review of Resident #239's Universal Transfer Form (UTF) from the return to the facility after the first rehospitalization , indicated that the resident did not have any wounds. A review of Resident #239's progress notes (PN) included a wound note written by a Physician Assistant (PA) dated 9/5/23, which was approximately a week after return to the facility, included the following: being seen today for a follow up wound evaluation .patient with multiple wounds. I was asked to evaluate and manage wound care for this patient Further review of the wound notes written by the PA indicated that the next visit was 10/3/23. There were 3 weeks of wound notes that were not in the resident's medical record. The next wound note written by the PA was dated 10/3/24. The surveyor also did not observe any documented measurements or appearance of the wounds during those 3 weeks in Resident #239's medical record. On 12/18/24 at 01:53 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding the process of wound PA visits. The ADON stated that the wound PA visited weekly if the resident had a deep tissue injury (DTI) or a wound. The surveyor asked the ADON about the missing 3 weeks of the wound notes by the PA. The ADON stated that it was not followed up by the wound doctor because there were no changes to the DTI and that the wound nurse observed it weekly. The surveyor then asked the ADON if the wound nurse had documented the size and appearance of the DTI in the resident's medical record. The ADON stated that she had the weekly measurements on her tracking form. The surveyor asked the DON if her tracking form was part of the medical record. The ADON stated that the tracking form was not part of the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 3:00 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that the complete medical record was not accessible in the computer system. On 12/19/24 at 9:59 AM, in the presence of the survey team, the ADON stated that the wound PA had the missing 3 weeks of wound PN but that she had not placed them in the electronic medical record. The ADON stated that she had not checked in the computer prior to surveyor inquiry. The ADON stated that she had uploaded the missing notes that day under the miscellaneous tab of the resident's electronic medical record. The ADON provided the surveyor a copy of the wound notes that she uploaded into the medical record. The surveyor then reviewed the resident's electronic medical record and observed that there was an upload of Wound Care PN dated 12/19/24. On 12/19/24 at 12:31 PM, in the presence of the survey team, DON, Regional DON #1, Regional DON #2 and Co-President, the LNHA stated that the PA had done the wound notes. The surveyor asked if the wound notes should have been in the medical record prior to surveyor inquiry. The Regional DON #1 stated that they did not know what happened to the notes. A review of the facility provided policy titled, Medical Records with a reviewed date of 11/2024, included the following: Policy Statement Medical records shall be retained by the facility in accordance with current applicable laws. Policy Interpretation and Implementation 1. Medical records of discharged residents will be retained for a period of [AGE] years. The facility did not provide any additional information. N.J.A.C. 8:39-35.2

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 REPEAT DEFICIENCY Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for 5 of 11 staff (1 Housekeeper,1 Recreation Aide, 2 Dietary Staff, and 1 Physician), b.) disinfect the examination area after use, and follow appropriate infection control practices during meal observation, environment tour, and kitchen tour, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 12/15/24 at 11:58 AM, the surveyor observed the Recreation Aide (RA) with a surgical mask in use while distributing lunch trays in the recreation room. The RA's nose was not fully covered by the surgical mask and it was pulled below his mouth. The surveyor interviewed the RA regarding the surgical mask. The RA stated that the surgical mask kept going down his nose and the RA acknowledged that the surgical mask should be properly worn and cover his nose. The RA further stated that he received education on proper hand hygiene and the use of PPE. On that same date at 12:05 PM, the surveyor observed the RA took the tray of the resident from the table. Afterward, the RA used hand wipes to clean his hands. The RA did not discard the used hand wipes, went to the next dining room, left the dining room, and re-entered the recreation room with the same hand wipes in his hands. The surveyor asked the RA what was on his hands, and he responded that was the hand wipes he used for cleaning both hands. The surveyor asked the RA why he did not dispose of the used hand wipes and whether should he dispose of them immediately after use, and the RA responded, I guess not. A review of the Handwashing/Hand Hygiene Policy with a revised date of April 2010 that was provided by the Licensed Nursing Home Administrator (LNHA) on 12/16/24 at 9:37 AM revealed: (continued on next page)

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	315129	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dellridge Health & Rehabilitation Center	532 Farview Ave Paramus, NJ 07652

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation: 5. Employees must wash their hands for at least 20 seconds using antimicrobial soap and water under the following conditions: g. Before and after assisting a resident with meals . 2. On 12/17/24 at 8:58 AM, Surveyor #1 (S#1) observed the provider (a Physician) and the Infection Preventionist Nurse (IPN) inside room [ROOM NUMBER]. The IPN talked to the Physician and left the room. The surveyor observed the Physician with a luggage bag inside the room and attended to Resident #241, the Physician performed handwashing inside the room, and the she donned (put on) gloves. The Physician took an alcohol individual pack, disinfected the lenses of two equipment, and placed them on top of the resident's table without disinfecting the table. During an eye examination, S#1 observed the Physician interchange the two pieces of equipment on top of the table without disinfecting the entire equipment. There was a personal belonging on top of the resident's table near the equipment. After the examination, the Physician discarded the used gloves in the garbage receptacle near the sink, put back the equipment inside the luggage bag, exited the resident's room without disinfecting the table, and did not perform hand hygiene. Outside the resident's room, S#1 interviewed the Physician. The surveyor asked the physician what she did inside the room and the physician stated that she examined the resident's eye with the use of a custom refractor (white equipment) which was used for measuring refraction of glasses and black equipment was the fundus camera. The surveyor asked the Physician why she did not perform hand hygiene after she doffed off her gloves and when she left the room. The Physician stated that when she grabbed all her stuff, it did not make any sense for her to perform hand hygiene even when she exited the room. She acknowledged that after she removed gloves inside the room, she did not perform hand hygiene. In the nursing station, S#1 asked the Physician if she was aware of the posted sign for EBP (enhanced barrier precautions; an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission MDROs [multidrug-resistant organism]) in room [ROOM NUMBER] and what was the EBP for, and the Physician responded that she did not know. Immediately, S#1 notified the IPN of the concerns that the Physician did not perform hand hygiene and did not disinfect the table used for putting the equipment. The IPN stated that staff, visitors, and vendors should perform hand hygiene before and after gloves use and follow the posted sign and she stated that she would talk to the Physician about it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24 at 9:50 AM, S#1 and Surveyor #2 (S#2) interviewed the IPN. S#1 asked the IPN about Standard Precaution or Universal Precaution, and the IPN responded that it applied to everyone (all staff, visitors, and vendors) and that gloves, after use, should be discarded and perform hand hygiene and that was basic. S#2 asked the IPN if the facility provided disinfecting wipes or PPE to the Physicians and vendors when they come to provide services. The IPN stated that she had to check first and would get back to the surveyors. S#1 asked if the facility provided education or information to the Physician about the facility's practice and policy about EBP or other infection control guidance that the facility followed, and the IPN responded that she was unsure. S#2 asked the IPN if that was something she should know as part of infection control. The IPN stated that she started in April this year and unsure if that was provided to the Physician before her starting in the facility as IPN. On 12/17/24 at 12:22 PM, S#1 and S#2 met with the Regional Director of Nursing #1 (RDON#1) and LNHA. The surveyor notified the LNHA and RDON#1 of the above concerns with the Physician. S#1 asked what the facility's practice was about disseminating information to providers and vendors with regard to the facility's policy and practice with EBP and other infection control practices. RDON#1 stated that she knew that the Physicians of the facility especially the Medical Director and the Infectious Disease Doctor were aware of the facility's practice and protocol with regard to infection control and was unsure about the other providers and vendors. RDON#1 acknowledged that the facility had the responsibility to notify the vendors and providers about it. RDON#1 further stated that hand hygiene should be done before gloves and after gloves use, disinfect the area to be used and used for treatment and examination. On 12/17/24 at 2:00 PM, the survey team met with the Co-President and the owner of the company (vendor) where the Physician who provided an eye examination to Resident #241. The vendor informed S#1 that it was not part of their protocol and policy to disinfect the table where the Physician placed our equipment. The vendor further stated that the Physician certainly for this day, removed her gloves and did not wash her hands. On 12/18/24 at 11:14 AM, the survey team met with the LNHA and the Director or Nursing (DON). S#1 notified the LNHA and the DON of the above findings and concerns regarding the RA and the Physician. On 12/19/24 at 01:48 PM, the survey team met with the LNHA, DON, RDON#1 and RDON#2, Co-President, and Assistant DON (ADON) for an exit conference. The facility did not provide additional information. 46049 3. On 12/15/24 at 10:40 AM, the surveyor observed Housekeeper #1 (HK #1) exit a resident room (Resident #5 and Resident #84), remove their gloves while standing in front of their cart outside the room door. HK #1 disposed their gloves in a garbage bin on the cart and retrieved cleaning supplies from the cart. The HK returned inside the room without performing hand hygiene. The surveyor observed HK #1 inside the resident room apply gloves and cleaned inside the room. On 12/15/24 at 10:43 AM, the surveyor observed HK #1 exit the resident's room, removed their gloves while going to their cart located at the door. HK #1 disposed of their gloves in the garbage bin on the cart, went into their cart for more cleaning supplies, and returned inside the room. The surveyor observed the HK did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/15/24 at 10:45 AM, the surveyor interviewed HK #1 about hand hygiene upon their exit from the resident's room. HK #1 stated that hand hygiene should be performed when entering a resident room, when finished cleaning up, and when putting on gloves, when removing gloves, and in between changing gloves. The surveyor informed HK #1 of the above observations. The HK acknowledged she did not wash her hands between changing gloves and stated it was supposed to be done. On 12/15/24 at 1:46 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) about hand hygiene. The RN/UM stated hand hygiene should be performed between changing gloves and when exiting rooms. The surveyor informed the RN/UM of the above observations of HK #1. The RN/UM acknowledged she should have washed her hands in between changing gloves and when exiting the room. The RN/UM stated she would follow up with the HK to provide re-education. On 12/18/24 at 11:14 AM, the surveyor informed the LNHA and the DON of the observed concern of HK #1 not performing hand hygiene during changing of gloves. On 12/19/24 at 11:38 AM, the LNHA, DON, Co-President, ADON, RDON#1 and RDON#2 met with the survey team. The LNHA stated in-service education was provided to HK #1. 4. On 12/18/24 at 11:32 AM, the surveyor observed Dietary Staff (DS) #1 (DS#1) with gloves on for the start of tray line service of the lunch meal. DS#2 moved a wet floor sign to the hallway area between the food prep and dishwashing area. DS #2 removed their gloves, disposed of gloves, and put on a new pair of gloves. The surveyor observed DS #2 did not perform hand hygiene. The surveyor asked the Regional Food Service Director (RFSD) present in the kitchen about hand hygiene. The RFSD stated hands should be washed when changing gloves. The surveyor informed the RFSD of the above observation of DS #2 and stated states hands should be washed when changing gloves. The RFSD instructed the staff to remove their gloves and perform hand hygiene, and re-educated DS #2 that hand hygiene should be performed when gloves were changed. On 12/18/24 at 11:45 AM, during tray line the surveyor observed DS #3 while serving the food, removed their gloves and placed new gloves without washing their hands. The surveyor informed the RFSD of the observation. The RFSD and FSD instructed DS #3 to remove their gloves and wash their hands. On 12/18/24 at 12:41 PM, the surveyor informed the DON and LNHA of the hand hygiene concerns observed during tray line in the kitchen. There was no additional information provided by the facility. A review of the facility's Handwashing/Hand Hygiene Policy, last reviewed in May 2024 revealed: Under Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Under Policy Interpretation and Implementation: 5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions .u. after removing gloves . 6. If hands are not visibly soiled, use an alcohol-based hand rub containing at least 70% ethanol or isopropanol for all of the following situations .j. After removing gloves . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Hand hygiene is always the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing/hand hygiene. N.J.A.C. 8:39-19.4(a)(1,2),(l,n)