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	04/22/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding. This deficient practice was identified for 3 of 3 shower rooms in the long term care units. The deficient practice was evidenced by the following: On 4/16/26 at 9:32 AM, Surveyor #1 (S #1) toured the A side nursing unit shower room that was near the nursing station, and observed in the middle cubicle a shower chair with ripped back cover, below was two broken floor tiles, and the heater grills with heavy accumulation of brownish, rusty like substances. On 4/16/26 at 9:35 AM, S #1 went to B side nursing unit shower room near the nursing station, and observed the ceiling vent just above the sink with accumulation of grayish substances and below was the heater grills with heavy accumulation of rusty like substances brownish in color. S #1 also observed in the shower cubicle wall with an open wire outlet next to the hoyer lift battery and the weighing scale. The next cubicle was observed with broken and missing tiles on the lower wall. On 4/16/26 at 9:38 AM, outside the B side shower room, S #1 observed the Registered Nurse/Unit Manager (RN/UM), and the surveyor asked the RN/UM to accompany S #1 with the tour. At that same time, inside the shower room of B side nursing unit, S #1 showed the RN/UM the above concern with the ceiling vent which she said would ask housekeeping to clean it. S #1 also notified the RN/UM and showed concern with the lower heater, the wall with an open electrical outlet, and the broken tiles. The RN/UM had no response when asked why the wall outlet was left uncovered. On 4/16/26 at 9:41 AM, both S #1 and the RN/UM went to A side nursing unit shower room and observed the broken tiles. The RN/UM stated that there should be no broken tiles because bacteria could grow in that area. S #1 asked if there would also be a safety concern with use of wheelchair and shower chair when there were broken floor tiles, and she acknowledged the concern of the surveyor. S #1 also showed the ripped back cover of the shower chair in the same cubicle in the shower room, and she did not have a response as to why it was ripped (damaged). The RN/UM stated that the ripped back cover of the shower chair should have been changed. S #1 also showed the lower heater, and she stated she did not know if that was rust or what. On 4/17/26 at 10:00 AM, S #1 observed the A side nursing unit shower room and the broken floor tiles were not replaced or fixed. On 4/20/26 at 12:14 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and S #1 notified them of the above findings and concerns. On 4/21/26 at 10:13 AM, S #1 observed there was a posted sign outside B side nursing unit shower room outside door [NAME] our appearance . that the shower room work in progress and not to use. Inside the room, the surveyor observed the middle cubicle (second cubicle shower area) still with missing and broken tiles. On that same date and time, S #1 also observed the same posted sign outside A side nursing unit shower room outside door. Inside the room the middle (2nd cubicle shower area) still with broken tiles on the floor. On 4/21/26 at 10:24 AM, S #1 interviewed the RN/UM who informed the surveyor that due to broken tiles, both A and B side nursing units shower rooms were closed and would be renovated. The RN/UM also stated that there was one shower room at the other end of B side nursing unit that residents would be using for shower. S #1, Surveyor #2 (S #2), (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the RN/UM went to the end of B side nursing unit shower room and observed one shower cubicle, and there was a strong smell of urine. The RN/UM acknowledged the strong smell of urine and stated that she would ask housekeeping to clean it. On 4/21/26 at 11:59 AM, the survey team met with the LNHA, DON, Regional DON #1 (RDON1) and Regional DON #2 (RDON2), and there was no response with above concerns with the environment. A review of the facility's Quality of Life-Homelike Environment Policy that was provided by the LNHA, with reviewed date of 10/2025, reflected a policy statement, residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation .2. These characteristics include: a. Cleanliness and order .e. Pleasant, neutral scents . On 4/21/26 at 1:27 PM, during the exit conference with the survey team, DON, RDON1, RDON2, the LNHA did not provide additional information. NJAC 8:39-31.4(a)(f)

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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. Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to a.) follow the physicians' orders with regard to behavior and side effects monitoring for 5 of 5 residents (Residents #3, #7, #8, #9, and #89) reviewed for unnecessary medications and b.) clarify the physician's order according to the standard of clinical practice and facility's policies.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 4/16/26 at 10:25 AM, Surveyor #1 (S #1) observed Resident #3 participating in activities in the recreation area with a group of residents. On 4/16/26 at 10:45 AM, S #1 interviewed Licensed Practical Nurse #1 (LPN #1) who reported that the resident has improved during the residents stay at the facility and was currently using a walker for ambulation. S #1 reviewed the medical record for Resident #3, and revealed: A review of the admission Record (AR) or face sheet (an admission summary) revealed the resident had diagnoses which included, but were not limited to; cerebral infarction, atrial fibrillation, encephalopathy, diabetes mellitus, epilepsy, and depression. A review of the resident's comprehensive Minimum Data Set (cMDS) (an assessment tool used to facilitate the management of care), with an assessment reference date (ARD) of 3/8/26, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the cMDS revealed the resident required behavioral monitoring related to mood and antidepressant medication (med) use. A review of the resident's comprehensive care plan (CP), dated 2/2026, included a focus area that the resident uses antidepressant med related to depression. Interventions included administering antidepressant medications (meds) as ordered, monitoring and documenting side effects (s/e) and effectiveness each shift, and monitoring and documenting behavioral symptoms (SX). A review of the Order Summary Report (OSR), dated as of 4/16/26, included the following physician orders (PO): (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PO, dated 2/15/26, Behavior Monitoring: Anti Depressant Med (Specify behavior) i.e. Sadness, Crying, Withdrawn, Irritability/Anger, Isolation, Appetite change, Neglecting Self-care, Sleep disruption, Lost motivation. Then, record the corresponding Non-Pharmacological intervention(s): 1. Encouragement 2. Listen/Document Feelings 3. Psychotherapy 4. Activities of Interest 5. Communication family/friends 7. Pastoral Care and if (E) Effective (IE) Ineffective every shift for Behavior Monitoring: Anti-Depressant Med A PO, dated 3/13/26, Behavior Monitoring: catatonia (slow movement, mute, staring, or refusing to eat or drink, agitations). Record the number of times resident exhibited this behavior during the shift. Then, record the corresponding Non-Pharm intervention(s): 1. give fluids, 2. offer food, 3. redirect, 4. return to room, 5. (Specify), 6. (Specify), 7. (Specify). Document E if intervention Effective; Document N if intervention Not Effective. every shift A PO, dated 4/2/26, Behavior Monitoring: sitting in the radiator. Record the number of times resident exhibited this behavior during the shift. Then, record the corresponding Non-Pharm intervention(s): 1. give fluids, 2. offer food, 3. redirect, 4. return to room, 5. (Specify), 6. (Specify), 7. (Specify). Document E if intervention Effective; Document N if intervention Not Effective. every shift A review of the electronic Medication Administration Record (eMAR), dated from 4/1/26 - 4/30/26, revealed inconsistent documentation of behavioral monitoring: For the PO dated 2/15/26, staff documented E, not applicable, and 0. The PO did not include definitions for 0 or not applicable, and documentation of E was entered without corresponding intervention codes. For the PO dated 3/13/26, staff documented N to indicate no behavior was observed; however, the PO did not include a code for documenting absence of behaviors. Additional entries of 0 were also observed without defined meaning. For the PO dated 4/2/26, staff documented check marks (√) and X instead of recording the number of behaviors and corresponding interventions as required by the PO. On 4/17/26 at 10:58 AM, S #1 interviewed LPN #1, who stated, the behavior monitoring system is very confusing and each one is different. LPN #1 further stated she used E, not applicable, or check marks to indicate no behaviors were present because she was unsure how to document correctly. On 4/17/26 at 11:20 AM, S #1 interviewed the Director of Nursing (DON), who stated that the PO for behavior monitoring were fuzzy and that the coding system was inconsistent, making it difficult for nursing staff to document appropriately. On 4/17/26 at 11:39 AM, S #1 interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the PO should be more specific and clearer to follow. On 4/21/26 at 11:59 AM, the LNHA in the presence of the survey team, acknowledged that PO required revision and that staff education was completed to address concerns related to behavioral monitoring and documentation. A review of the facility's Psychoactive Drug Use Policy, dated/reviewed 2/2026, which included that the resident's behavior is monitored. It goes on to state, the specific behavioral problems are tracked (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and documented as to the number of episodes or number of hours (if for pacing, yelling, or screaming) as determined by the interdisciplinary team care plan . 2. On 4/16/26 at 9:46 AM, Surveyor #2 (S #2) observed Resident #7 in the activity room sitting in the wheelchair (w/c). Resident #7 was unable to participate in an interview. A review of Resident #7's electronic medical record (eMR) revealed that the resident was admitted with diagnoses including dementia (decline in memory, thinking and daily function severe enough to affect everyday life), psychosis (difficulty distinguishing what's real from what isn't), depression and anxiety disorder. A review of the quarterly MDS (qMDS), with an ARD of 3/1/26, indicated a BIMS score of 0 out of 15, reflecting that the resident was severely cognitively impaired. A review of the OSR dated 2/22/26-4/17/26, revealed: A PO dated 2/25/26, antipsychotic medication (med): Observe s/e: dry mouth, constipation, blurry vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, N&V (nausea & vomiting), lethargy, drooling, EPS (extrapyramidal symptoms) (tremors, gait issues, agitation, restlessness, involuntary movement of mouth/tongue). Document Y if s/e present; document N is s/e absent. If Y also document s/e in progress notes (PN). Every shift for routine monitoring. A PO dated 2/25/26, behavior monitoring antipsychotic med: (specify Behavior (#) exhibited/noted): 1. Itching, 2. Picking at skin, 3. Restlessness/agitation, 4. Hitting, 5. Increase in complaints, 6. Biting, 7. Kicking. Record intervention code. Document in PN if intervention ineffective. Every shift code the corresponding Non-Pharm intervention: 1. Distraction 2. Calm/Quiet environment 3. Redirect 4. Return to room.; Document: Effective (E) or (N) Not effective; (#) episodes every shift. A review of the April 2026 eMAR revealed that the PO for antipsychotic med: Observe s/e did not have a Y or N documented. April 1st through April 16th had a check mark with the Nurses initials documented. The PO for behavior monitoring antipsychotic med did not have a corresponding number or a E or N documented. April 1st through April 16th had a check mark with the Nurses initials documented. On 4/17/26 at 9:29 AM, S #2 interviewed Licensed Practical Nurse #2 (LPN #2) regarding antipsychotic med and monitoring residents for s/e and behaviors. LPN #2 stated that the documentation for monitoring s/e and behaviors was in the eMAR. LPN #2 stated that they would document in the eMAR if there were any s/e and/or behaviors and what interventions were done. In the presence of S #2 LPN #2 reviewed eMAR for Resident #7. LPN #2 acknowledged that the PO should have been followed. LPN #2 stated the nurse should have entered the number to correspond with the behavior. LPN #2 acknowledged there were no numbers documented on the eMAR, just a check mark and initials. LPN #2 stated to documented s/e, the nurse should have entered the Y if present or N if not present. LPN #2 acknowledged that it was not documented on the eMAR. LPN #2 stated that it was important to document behaviors so treatments could have been adjusted as needed. LPN #2 further added it was important to document s/e because the dose could have been too high or too low. On 4/21/26 at 9:47 AM, S #2 interviewed the Registered Nurse/Unit Manager (RN/UM), who stated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that the behavior and s/e should be monitored and documented to know if the med dose was appropriate. dose. S #2 and the RN/UM reviewed eMAR record together. She acknowledged that the PO was not followed, and the documentation was incorrect. I missed fixing it I updated others but not this one. I do not know why some have it and some do not have it. The RN/UM corrected both orders in the presence of S #2. On 4/21/26 at 11:59 AM, The survey team met with the LNHA, DON, Regional DON #1 (RDON1), and Regional DON #2 (RDON2). The DON stated that they reviewed all orders for monitoring s/e and behaviors and made updates after surveyors' inquiry. The facility did not have a policy regarding following PO. 2.On 4/15/26 at 10:56 AM, Surveyor #2 (S #3) observed a posted sign outside Resident #8's door for EBP (Enhanced Barrier Precautions). Inside the room, the resident was observed seated in the bed with oxygen in use. S #3 reviewed the medical records of Resident #8, and revealed: A review of the AR or face sheet revealed that Resident #8 was admitted to the facility with diagnosis that included but were not limited to; displaced trimalleolar fracture (a severe, unstable ankle injury where all three bony prominences (malleoli) break: the lateral (fibula), medial (tibia), and posterior (back of the tibia) malleolus) of right lower leg, subsequent encounter for closed fracture with routine healing, unspecified fall, subsequent encounter, muscle weakness, unspecified atrial fibrillation (afib), and chronic kidney disease, stage 4 (severe). A review of the cMDS, with an ARD of 3/19/26, reflected in Section C-Cognitive Patterns that the resident had a BIMS score of 15 out of 15, which indicated that the resident had an intact cognition. Section N-Medications (meds) reflected that the resident received antianxiety, antidepressant, anticoagulant, and diuretic meds. A review of the OSR revealed the following PO that included but were not limited to: - Lexapro oral tablet (tab) 5 mg (milligram), give 3 tablets (tabs) by mouth at bedtime (HS) for depression/anxiety; 3 tabs=15 mg-Start Date 4/7/26-Hold Date from 4/9/26 to 4/10/26-Hold Date from 4/13/26 to 4/13/26. - Eliquis tab 2.5 mg, give 1 tab by mouth two times a day for Afib. Observe for bleeding/bruising, dark urine, black tarry stools.-Start Date 3/13/26-Hold Date from 4/9/26 to 4/10/26. - oxybutynin chloride oral tab 5 mg, give 1 tab by mouth one time a day for OAB (over active bladder) observe for anticholinergic s/e-Start Date 3/14/26-Hold Date from 4/9/26 to 4/10/26. - Alprazolam tab 0.25 mg, give 1 tab by mouth every 8 hours as needed (PRN) for anxiety for 14 days, observe for CNS (central nervous system) depression-Start Date 3/30/26. - Antianxiety med-Observe for s/e: drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior. Document Y if s/e are present; document N if s/e are absent. If Y is documented also in the PN. every shift for routine monitoring-Start Date 3/15/26-Hold Date from 4/9/26 to 4/10/26-Hold Date from 4/13/26 to 4/13/26. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The antianxiety med order above was signed by nurses from 4/1/26 to 4/15/26, except on 4/9/26 evening shift (coded as 6=hospitalized) and 4/12/26 night shift (blank) with check mark code and the PO was not followed to document a Y or an N. -Anticoagulant med: Observe for s/e: discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB (shortness of breath), nosebleeds. Document Y if s/e are present; document N if s/e are absent. If Y is documented also document in PN every shift for routine monitoring-Start Date 3/13/26-Hold Date from 4/9/26 to 4/10/26-Hold Date from 4/13/26 to 4/13/26. The anticoagulant med order above was signed by nurses from 4/1/26 to 4/15/26, except on 4/9/26 evening shift (coded as 6) and 4/12/26 night shift (blank) with check mark code and the PO was not followed to document a Y or an N. -Antidepressant med-Observe for s/e: GI (gastrointestinal) upset, insomnia, fatigue, dizziness, dry mouth, headache. Document Y if s/e are present; document N if s/e are absent. If Y is documented also document in the PN. every shift for routine monitoring-Start Date 3/14/26-Hold Date from 4/9/26 to 4/10/26-Hold Date from 4/13/26 to 4/13/26. The antidepressant med order above was signed by nurses from 4/1/26 to 4/15/26, except on 4/9/26 evening shift (coded as 6) and 4/12/26 night shift (blank) with check mark code and the PO was not followed to document a Y or an N. -Behavior Monitoring-AntiAnxiety med: constant calling causing distress to self-record the number (#) of times resident exhibited this behavior during the shift. Then, record the corresponding Non-Pharm intervention(s)(NPI): 1. give fluids, 2. offer food, 3. redirect, 4. return to room, 5. allow time to verbalize feelings, 6. (Specify), 7. (Specify). Document E if intervention Effective; Document N if intervention Not Effective. every shift for behavior monitoring-Start Date 3/30/26-Hold Date from 4/9/26 to 4/10/26-Hold Date from 4/13/26 to 4/13/26. The behavior monitoring for antianxiety med order above was signed by nurses from 4/1/26 to 4/15/26, except on 4/12/26 night shift (blank) and 5 out of 53 shifts the were coded incorrectly and did not follow the PO that if resident exhibited behavior during the shift, then record the corresponding NPI (1, 2, 3, 4, 5, 6 (specify), and 7 (specify), to document E if intervention effective and N if the intervention not effective. -s/e Monitoring: Anticholinergic s/e: Observe for s/e: dry mouth, blurred vision, tachycardia, urinary retention, constipation, confusion, delirium or hallucination. Document Y if s/e are present; document N if s/e are absent. If Y is documented also in the PN. every shift for routine monitoring- on Oxybutynin-Start Date 3/13/26-Hold Date from 4/9/26 to 4/10/26. The s/e monitoring for anticholinergic med order above was signed by nurses from 4/1/26 to 4/15/26, except on 4/9/26 evening shift (coded as 6) with check mark code and the PO was not followed to document a Y or an N. On 4/17/26 at 12:22 PM, S #3 interviewed the RN/UM regarding behavior and s/e monitoring, and she said the PO should be followed, if the PO was to document Y or N it should be documented. She further stated that if there was a documented behavior there should be a NPI in the PO that also should be followed, but if no behavior observed, then there should no NPI documented in the eMAR. S (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A PO, dated 3/27/26, behavior monitoring: anti depressant med (Specify behavior)i.e. Sadness, Crying, Withdrawn, Irritability/Anger, Isolation, Appetite change, Neglecting Self-care, Sleep disruption, Lost motivation. Then, record the corresponding Non-Pharmacological intervention(s): 1. Encouragement 2. Listen/Document Feelings 3. Psychotherapy 4.Activities of Interest 5.Communication family/friends 7. Pastoral Care and if (E) Effective (IE) Ineffective. Directions: every shift for Behavior Monitoring: Anti-Depressant Med. -A PO, dated 4/16/26, s/e monitoring: anticholinergic s/e: Observe for s/e: dry mouth, blurred vision, tachycardia, urinary retention, constipation, confusion, delirium or hallucination. Document Y if s/e are present; document N if s/e are absent. If Y is documented also document in the PN. Directions: every shift for routine monitoring. A review of the April 2026 eMAR revealed the following: -The PO for Anticoagulant Med: Observe for s/e did not have a Y or N documented. 4/9/26 through 4/20/26 had a check mark with the nurses' initials documented. -The PO for Antidepressant Med - Observe for s/e did not have a Y or N documented. 4/9/26 through 4/20/26 had a check mark with the nurses' initials documented. -The PO for Antipsychotic Med: Observe for s/e did not have a Y or N documented. 4/9/26 through 4/20/26 had a check mark with the nurses' initials documented. -The PO for Behavior Monitoring Antipsychotic Med did not have a corresponding number or an E or N documented. 4/9/26 through 4/20/26 had a check mark with the nurses' initials documented. -The PO for Behavior Monitoring: Anti Depressant Med did not have a corresponding number to the non-pharmacological intervention or an E or IE documented. 4/1/26 through 4/7/26 had either 0 or NA documented instead of E or IE. Moreover, 4/1/26 through 4/7/26 had NA documented for the non-pharmacologic intervention instead of a corresponding number. -The PO for s/e Monitoring: Anticholinergic s/e did not have a Y or N documented. 4/16/26 through 4/20/26 had a check mark with the nurses' initials documented. On 4/20/26 at 12:33 PM, S #4 discussed the above concerns with the LNHA and the DON. On 4/21/26 at 11:00 AM, S #4 interviewed the DON who stated the expectation was that the eMAR needs to show a yes or no for s/e, specify the behaviors exhibited, code the corresponding non-pharmacological interventions, and document the effectiveness or ineffectiveness of the interventions. A review of the facility's Administering Meds Using Electronic System Policy, revised 4/2010, revealed that as required or indicated for a med, the individual administering the med will record in the resident's medical record any complaints or symptoms for which the drug was administered, and any results achieved and when those results were observed. 5. On 4/15/26 at 11:43 AM, Surveyor #5 (S #5) observed Resident #89 seated in a w/c in the dayroom waiting for lunch to be served. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/26 at 10:31 AM, S #5 reviewed Resident #89 medical record. A review of Resident #89's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to dementia (a decline in mental ability—such as memory, language, problem-solving, and thinking—severe enough to interfere with daily life) and anxiety (a common mental health condition characterized by excessive, uncontrollable fear or worry that interferes with daily life). A review of Resident #89's most recent cMDS, with an ARD of 3/3/26, reflected that the resident had a BIMS score of 00 out of 15, which indicated the resident's cognition was severely impaired. A review of Resident #89's April 2026 eMAR revealed the following order: Antianxiety med - Observe for s/e: drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior. Document Y if s/e are present; document N if side effects are absent. If Y is documented also document in the PN. every shift for routine monitoring with a start date of 3/18/2026. The nurses were documenting with check marks and not the Y and N. On 4/17/26 at 12:18 PM, S #5 interviewed the Registered Nurse (RN) who stated that for s/e monitoring it should follow the order and put a y or n. S #4 notified the RN about Resident #89's order. The RN stated that there was something in the electronic system to click to have the yes or no status and that we would fix it. On 4/20/26 at 12:16 PM, S #5 notified the LNHA and DON the concern that Resident #89's s/e monitoring order was not being followed as ordered. On 4/21/26 at 12:19 PM, in the presence of the DON, RDON1 and RDON2, the LNHA stated that the order was updated and staff were educated. NJAC 8:39-11.2(b)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, it was determined that the facility failed to ensure that the resident's medical record included documentation that indicated, at a minimum, that the resident or resident's representative was provided education regarding the benefits and potential side effects of the influenza and pneumococcal immunization for 3 of 5 residents reviewed for immunizations (Residents #6, #7, and #89). This deficient practice was evidenced by the following: 1.On 4/16/26 at 10:46 AM, Surveyor #1 (S #1) reviewed the medical record for Resident #6. A review of the admission Record (AR) or face sheet (an admission summary) for Resident #6, revealed diagnoses which included, but were not limited to; multiple sclerosis, sepsis, extended spectrum beta-lactamase resistance, acute kidney failure, and depression. A review of the comprehensive Minimum Data Set (cMDS) (an assessment tool used to facilitate the management of care), with an assessment reference date (ARD) of 3/13/26, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. The cMDS included that the resident was assessed for pneumococcal and influenza vaccination status and it was refused. A review of the immunization record revealed: Pneumococcal vaccine (Prevnar 20), dated 3/6/26, was documented as refused, with education provided documented as No. Influenza vaccine was documented as refused, despite the resident having a documented allergy to the influenza vaccine. On 4/17/26 at 8:30 AM, S #1 interviewed the Infection Preventionist Nurse (IPN), who stated that, education should be provided when a resident refuses a vaccine. After reviewing the documentation and speaking with nurse, the IPN further stated that, the nurse reported education was provided but was not documented. During the same interview, the IPN stated that the resident had an allergy to the influenza vaccine; however, the nurse documented the vaccine as Refused instead of indicating the resident was not eligible due to contraindication. On 4/21/26 at 12:00 PM, the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team, acknowledged that education for the pneumococcal vaccine refusal was not documented correctly and that staff were re-educated regarding pneumonia and Influenza vaccine documentation. A review of the facility's Pneumococcal and Influenza Vaccination Policies reviewed 10/2025, which included, If a resident declines vaccination, education regarding the benefits and risks of the vaccine will be provided and documented in the medical record. The policies go on the say, Documentation will include whether the vaccine was administered, refused, or not indicated. 2.On 4/16/26 at 9:46 AM, Surveyor #2 (S #2) observed Resident #7 in the activity room sitting in the wheelchair. Resident #7 was unable to participate in an interview. A review of Resident #7's electronic medical record (eMR) revealed that the resident was admitted with diagnoses including dementia (decline in memory, thinking and daily function severe enough to (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	affect everyday life), psychosis (difficulty distinguishing what's real from what isn't), depression and anxiety disorder. A review of the quarterly MDS (qMDS), with an ARD of 3/1/26, indicated a BIMS score of 0 out of 15, reflecting that the resident was severely cognitively impaired. A review of the immunizations records in the eMR, revealed that there was no documentation for offered, administered or refusal of flu and pneumonia immunizations. There was no documented evidence that the resident's representative (RR) was educated regarding the benefits and potential side effects (s/e) of influenza and pneumococcal immunization. On 4/17/26 at 11:47 AM, S #2 interviewed the IPN who stated they did not have a tracking system in place for tracking immunizations status for the residents. She further stated that the information for the immunizations for the residents was in the eMR. The IPN stated that when the residents were admitted to the facility, she documented their immunizations in her notebook. The IPN could not provide any other information including documented evidence that the RR was educated regarding the benefits and potential s/e of influenza and pneumococcal immunization. On 4/17/26 at 1:07 PM, S #2 requested immunization information for Resident #7. The IPN and S #2 reviewed the eMR together and the IPN confirmed that the information regarding immunizations was not available. The IPN stated she would look at the nursing notes. There was no further information provided by the IPN. On 4/21/26 at 11:59 AM, the survey team met with the LNHA, DON, Regional DON #1 (RDON1) and Regional DON #2 (RDON), and there was no further information provided regarding the immunization information for Resident #7. 3.On 4/15/26 at 11:43 AM, Surveyor #3 (S #3) observed Resident #89 seated in a wheelchair in the dayroom waiting for lunch to be served. On 4/16/26 at 10:31 AM, S #3 reviewed Resident #89 medical record. A review of Resident #89's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to dementia (a decline in mental ability—such as memory, language, problem-solving, and thinking—severe enough to interfere with daily life) and anxiety (a common mental health condition characterized by excessive, uncontrollable fear or worry that interferes with daily life). A review of Resident #89's most recent cMDS, with an ARD of 3/3/26, reflected that the resident had a BIMS score of 00 out of 15, which indicated the resident's cognition was severely impaired. Further review of the cMDS reflected that the resident received the influenza vaccine in the facility for the current year's season on 1/31/25. The date administered was not in the current year's season. A review of Resident #89's eMR under immunization tab reflected that the last documented influenza vaccine was given to the resident was 1/31/25. There was no documented evidence that the influenza vaccination was offered, given or refused for the most recent influenza vaccination season. Further review reflected that other vaccinations were offered and refused by the RR and education was provided. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/26 at 9:46 AM, S #3 interviewed the IPN regarding Resident #89's influenza vaccination. The IPN viewed the eMR and confirmed that Resident #89's last influenza vaccination was given on 1/31/25, The IPN then reviewed the resident's electronic Medication Administration Records (eMAR) from September 2025-March 2026 (most current influenza vaccination season) and confirmed that an influenza vaccination was not ordered/given. The IPN stated that the vaccination was offered through a mass email system that it sent each month to the representatives. The surveyor asked the IPN if the offer or refusal and education should be documented in the resident's medical record. The IPN stated again, we do it through mass email system. On 4/17/26 at 10:19 AM, the IPN provided a copy of a mass email (multiple email addresses were listed) that was delivered to Resident #89's representative which was dated 3/9/26. The surveyor asked the IPN why the other vaccinations were listed in the eMR as refused but not the influenza. The IPN stated that she did not have an answer right now. On 4/20/26 at 12:16 PM, the surveyor notified the LNHA and DON the concern that Resident #89's was not offered the influenza vaccination or any documented evidence that it was offered and refused and education was provided. On 4/21/26 at 12:19 PM, in the presence of the DON, RDON1 and RDON2, the LNHA stated that an email was sent to the RR through a mass email system to offer the vaccination. A review of the facility's Influenza Vaccine Policy, reviewed 10/25, under Policy, to protect the health and safety of all residents in the facility, the influenza vaccine will be offered to all residents annually between October 1st to March 31st . Under procedures: 1. Yearly determination between October 1st to March 31st should be made on all residents concerning the offering of influenza vaccine.5) Document at the time of vaccine administration must be recorded on the Medication Administration Record, Resident's Immunization Record and/or progress notes.7) The administration of the influenza vaccine will be in accordance with the CDC recommendations. A review of the facility's Resident Vaccination for Pneumonia Policy dated 9/2022, Purpose: The facility will offer pneumococcal vaccination for residents to aid in preventing pneumococcal infections or disease (e.g. pneumonia) in the lungs and the blood stream caused by Streptococcus pnuemoniae. The facility will offer vaccination as currently recommended by the Center for Disease Control and Prevention (CDC) .Procedure: 1. All newly admitted , readmitted and current residents are to be offered a pneumococcal vaccine unless the immunization is medically contraindicated or the resident has already been immunized. 1. Ensure that the resident or RR is provided education regarding the benefits, risks and potential side effects associated with the vaccine. The resident or RR has the opportunity to accept or refuse the pneumococcal vaccine, and change their decision. The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or RR was provided education regarding the benefits and potential risks associated with pneumococcal vaccine. Consent for administration of the pneumococcal vaccine. Date of the pneumococcal vaccination, type of the pneumococcal vaccination, including lot number, (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expiration date, administering provider, and the site of vaccination. If the resident did not receive pneumococcal vaccine due to medical contraindications (e.g. allergy) or refusal. The LNHA did not provide any additional information. N.J.A.C. 8:39-19.4 (i)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to ensure an as needed psychotropic (affecting the brain and nervous system, altering mood, thoughts, perception, and behavior) medication ordered was limited to 14 days, unless the attending physician/prescribing practitioner documents a rationale to extend the medication for 1 of 2 residents reviewed for hospice (Residents #75). This deficient practice was evidenced by the following: On 4/15/26 at 10:20 AM, the surveyor observed Resident #75 asleep in bed. On 4/16/26 at 11:51 AM, the surveyor reviewed Resident #75's medical record. A review of Resident #75's admission Record or face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to anorexia (a serious, potentially life-threatening eating disorder characterized by an intense fear of gaining weight, self-starvation, and a distorted body image) and dementia (a decline in mental ability-such as memory, language, problem-solving, and thinking-severe enough to interfere with daily life). A review of Resident #75's most recent Significant change in status assessment Minimum Data Set (sMDS) (an assessment tool used to facilitate the management of care) with an Assessment Reference Date of 3/30/26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident's cognition was severely impaired. A review of Resident #75's April 2026 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) included the following order:Lorazepam oral concentrate 2 mg/ml (milligrams/milliliters) *Controlled Drug* give 0.25 ml by mouth every 4 hours as needed (PRN) for anxiety with an order date of 3/18/26.The order was not limited to 14 days. On 4/16/26 at 12:19 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that lorazepam PRN was ordered for 14 days and then reevaluated by the physician. On 4/16/26 at 12:23 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that for lorazepam PRN was initially ordered for 14 days and then if still needed would be ordered for 30 days. On 4/20/26 at 9:44 AM, the surveyor interviewed the Director of Nursing (DON) who stated that lorazepam PRN was initially ordered for 14 days and then renewed. On 4/20/26 at 12:19 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #75's lorazepam PRN order was not limited to 14 days and that there was no documentation of a rationale to extend the medication (med). On 4/21/26 at 12:21 PM, in the presence of the DON, Regional DON #1 (RDON1) and RDON #2 (RDON2), the LNHA stated that the staff were educated on the 14 days. A review of the facility's Psychotropic Drug Use Policy with an update reviewed date of 10/2024, included under H.2. Anxiolytics:.3. PRN order is for 14 days and MD will review when med is still needed. The LNHA did not provide any additional information. N.J.A.C. 8:39-27.1

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on the interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to provide the Resident or Resident Representative with a written notification of the facility's bed hold policy that included the reserve payment information for 2 of 2 residents (Residents #1 and #14) reviewed for hospitalizations.This deficient practice was evidenced by the following: 1.On 4/17/26 at 9:44 AM, Surveyor #1 (S #1) interviewed the Licensed Practical Nurse (LPN) who stated that he was the assigned nurse of Resident #14. The LPN informed S #1 that the resident was cognitively impaired, required total assistance with care, with pressure ulcer (PU), and had been in and out of the hospital where PU worsened. S #1 reviewed the medical records of Resident #14, and revealed the following: The admission Record (AR) or face sheet(an admission summary) reflected that the resident was admitted to the facility with diagnosis that included but were not limited to; PU of sacral region, stage 4, muscle weakness (generalized), difficulty in walking, not elsewhere classified, and unspecified protein-calorie malnutrition. A review of the resident's Discharge Return Anticipated Minimum Data Set (DRAMDS) revealed in Section A-Identification Information, the resident had an unplanned transfer to hospital in August 2025, October 2025, and December 2025. A review of the electronic medical records (eMR) revealed a Notification of Bed Hold Policies (NBHP) dated for 8/8/25 and 12/9/25. The NBHP had a red bold instruction to Print and give resident a copy prior to transfer out of the center. The NBHP did not include information about reserve payment and there were no responses to questions in the NBHP document. On 4/20/26 at 11:30 AM, the Licensed Nursing Home Administrator (LNHA) provided a black binder and red folder, and he said that the black binder was the 2026 LTCO (Long-Term Care Ombudsman; is a trained advocate who investigates complaints, resolves disputes, and protects the rights of residents in nursing homes, assisted living, and other residential care facilities) notification and the red folder was for the 2025 LTCO notification. The LNHA further stated that he would get back to S #1 for the bed hold notice/notification. On 4/20/26 at 1:15 PM, S #1 followed up with the LNHA the bed hold notices, and he stated that it was with the admission Director (AD). At that same time, S #1, Surveyor #2 (S #2), and the LNHA went to the AD who was in her computer with a binder, and stated that she would still need five minutes because she was checking if everything was okay. On 4/20/26 at 1:28 PM, the AD provided S #1 the binder for bed hold notices. The AD informed S #1 and S #2 the process that when the resident was transferred to the hospital, nurses handed the resident or Resident Representative (RR) with bed hold paper, then the RR would give me a call if they wanted to hold the bed or not because the insurance would not cover the bed hold. She further stated that it was an out of pocket expense, it was the nurse to give the bed hold paper, it would be in the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment of the nurses in the eMR the information, and then I go to my own bed hold and sent it out or I call. The AD also stated that the amount was $420 per night, the price was for all residents, and it did not matter if the resident was LTC (Long Term Care) or subacute residents. She added that for Medicaid residents we have 10 days to hold the bed. In the office of the AD, both S #1 and S #2 reviewed the eMR where the AD showed the bed hold notices versus what was provided in the printed binder. The computer list of bed hold policies (or notices) were from 6/3/25 to 1/26/26 for messages sent to residents, families, employees, or prospective families. While reviewing, the AD confirmed in the presence of the LNHA that the 12/9/25 Bed Hold Policies notification was for another resident and was not for Resident #14, there were no bed hold policies notices for dates 8/8/25 and 10/22/25. The AD also confirmed that the only bed hold notice that was in the binder was for 8/8/25. At that same time, the AD confirmed it was the nurse's responsibility in the Assessment tab in the eMR to document that the bed hold policies notices were given to the resident or RR. The AD also confirmed with the LNHA that there was no 10/22/25 and 8/8/25 bed hold notices in the computer and the printed information in the binder was for 8/8/25 that did not include reserve payment. Later on, S #1, S #2, and the LNHA went to the nursing unit to review the resident's chart and did not see the bed hold notices. The Unit Clerk claimed it should be in the chart or in the miscellaneous tab of resident's medical record in the computer. On 4/20/26 at 2:11 PM, the Registered Nurse/Unit Manager (RN/UM) informed S #1 in the presence of S #2 that when the resident was transferred to the hospital, the nurse would document in the assessment tab the bed hold notice, print it out and attached it to the discharge papers that goes to the hospital, and usually unable to ask the resident or RR to sign because of emergent transfer. The RN/UM also stated that there was no printed copy except the one in the computer, and then it will be followed up by the AD. The RN/UM also confirmed that the amount of bed hold will be discussed by the AD and she could not recall if there was a reserve payment in the bed hold notice in the assessment nor she was aware of the amount. The surveyor then asked the RN/UM for copy of bed hold notices in the assessment tab. On 4/20/26 at 2:19 PM, the RN/UM provided a printed copy of bed hold notices for 8/8/25 and 12/19/25. The RN/UM was not able to provide a copy for 10/22/25, and she said she would get back to S #1 as to why there was none for 10/22/25. S #1 reviewed with the RN/UM the printed bed hold notices and asked the RN/UM if there was a reserve payment in the notice paper, and she responded there were none. The LNHA came and stated that there were bed hold notices for Resident #14, and S #1 asked the LNHA if there were reserve payment documented, and he responded none. The LNHA further stated that they will do better next time. He also acknowledged that it should be in bed hold notices the reserve payment. 2. Surveyor #2 (S #2) reviewed the medical records of Resident #1, which revealed the following: The AR reflected that the resident was admitted to the facility with diagnoses that included, but were not limited to; bronchopneumonia (a type of pneumonia that causes inflammation in the airways, or bronchioles, and small air sacs, or alveoli, of the lungs), unspecified organism, anemia (a condition that develops when the blood produced a lower-than-normal amount of healthy red blood cells), unspecified, muscle weakness (generalized), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1's DRAMDS revealed in Section A-Identification Information, the resident had an unplanned transfer to hospital in March 2026. A review of the eMR revealed an NBHP dated 3/18/26. The NBHP had a red bold instruction to Print and give resident a copy prior to transfer out of the center. The NBHP did not include information about reserve payment and there were no responses to questions in the NBHP document. A review of the eMR revealed a document, Bed Hold Policy, which was a notice of emergency transfer and confirmed that on 3/18/26, Resident #1 was sent to the hospital. It did not include reserve payment. A review of the facility's Bed Hold Policy that was provided by the LNHA, with a reviewed date of 1/2026, did not include information about reserve payment. On 4/21/26 at 1:27 PM, the survey team met with the LNHA, Director of Nursing (DON), Regional DON #1 and Regional DON #2 for exit conference, and there was no additional information provided by the LNHA. On 4/21/26 at 2:01 PM, RDON2 informed S #1 in the presence of the survey team that the carefeed was only a supplemental information, and the facility should follow up with resident and/or RR. N.J.A.C. 8:39-4.1(a)(31);5.1 (a)(b)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interviews and record review, it was determined that the facility failed to complete and transmit the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within 14 days as required, for 1 of 2 residents, (Resident #120), reviewed for facility task-resident assessment, in accordance with federal guidelines. This deficient practice was evidenced by the following:According to the Resident Assessment Instrument (RAI) Manual, dated October 2025, RAI-required Assessment Summary:-The admission (Comprehensive) assessment, the MDS completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The CAA(s) (Care Area Assessment) Completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The Care Plan Completion date is no later than CAA(s) Completion date + 7 calendar days. The Transmission date is no later than Care Plan Completion date + 14 calendar days.-The Discharge MDS assessment return not anticipated (DRNA), the MDS completion date is the discharge date + 14 calendar Days. The Transmission date is MDS Completion date + 14calendar days. On 4/17/26 at 8:40 AM, the surveyor reviewed Resident #120's MDS in the electronic medical records, and revealed: 1.Resident #120's comprehensive MDS assessment with an ARD of 12/12/25, admission date of 12/1/25, completed date was on 12/15/25, care plan (CP) completed 12/15/25, and was lock/accepted (or transmitted) on 12/16/25. The comprehensive MDS CP and completion date were completed late, after 15 days, which should have been completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). The CAA(s) (Care Area Assessment) Completion date no later than 14th calendar day of the resident's admission (admission date + 13 calendar days). 2. Resident #120's DRNA with an ARD of 2/17/26, was completed on 2/23/26, and was transmitted on 4/15/26. The DRNA MDS was transmitted late, after 37 days, which should have been transmitted MDS Completion date + 14 calendar days. Further review of the above MDS revealed that the 12/15/25 completion and CP were in red. The 4/15/26 transmission date for DRNA MDS was also in red. On 4/20/26 at 12:14 PM, during meeting with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor notified them of the above findings and concerns about late completion and transmission of MDS for Resident #120. On 4/21/26 at 11:10 AM, the surveyor interviewed the Regional MDS Coordinator (RMDSC) who informed the surveyor that if the completion, CP, and lock/accepted (transmission) boxes in the MDS were in red it means it was late. He further stated that for the comprehensive MDS, completion date should be within 14 days of admission date, and transmission date should be within 14 days from completion date. He added that the same with discharge MDS, transmission date should be within 14 days from completion date. He informed the surveyor that we follow the RAI Manual as our policy. On 4/21/26 at 11:59 AM, the survey team met with the DON, Regional DON #1 (RDON1), Regional DON #2 (RDON2), and the LNHA stated that for Residents #120, we provided education to the MDS Coordinators. A review of the facility's MDS Completion and Submission Timeframes Policy that was provided by the DON, with a revision date of October 2025, reflected in the policy statement, the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Policy Interpretation and Implementation: 1. The assessment coordinator or designee is responsible for ensuring resident assessments are submitted to CMS' Internet Quality Improvement Evaluation System (iQIES) in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the RAI Manual . On 4/21/26 at 1:27 PM, the survey team met with the LNHA, DON, RDON1, and RDON2 for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39 - 11.1

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 5 of 27 residents, (Residents #7, #8, #13, #14, and #89), reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1.On 4/17/26 at 9:00 AM, Surveyor #1 (S #1) reviewed the electronic medical record (eMR) of Resident #7 and revealed: A review of the immunization record reflected that there was no documentation for offered, administered or refusal of flu and pneumonia vaccines. A review of the MDS revealed under section O0250, that C. If influenza vaccine not received, state reason: the code entered in the assessment was 1. Resident not in this facility during this year's influenza vaccination season. Further review of the MDS section O0300 revealed that A. Is the resident's Pneumococcal vaccination up to date? the code entered in the assessment was 0. No B.the code entered in the assessment was 2. Resident offered and declined. On 4/17/26 at 10:44 AM, S #1 interviewed the Licensed Practical Nurse/MDS Coordinator (LPN/MDSC), who stated that she obtained the flu and pneumonia vaccination information from the immunization tab in the eMR, admission Record (AR), and hospital records. S #1 reviewed the information that was coded in the MDS section O with the LPN/MDSC who stated that she would have reviewed the coding again and followed up with S #1. On 4/17/26 at 12:01 PM, the LPN/MDSC stated that the assessment was modified. She further stated that Resident #7 received the pneumonia vaccine in 2020 based on eligibility status of Medicare and provided a document. A review of the document titled Eligibility Response Screen revealed Pneumococcal Conjugate dated 6/24/20. On 4/18/25 at 10:00 AM, S #1 reviewed the MDS which reflected to be modified. Review of section O0250 revealed that C. If influenza vaccine not received, state reason: the code entered in the assessment was 9. None of the above. A review of the MDS section O0300 revealed that section A. Is the resident's Pneumococcal vaccination up to date? the code entered in the assessment was 1. Yes. A review of the facility's MDS Accuracy Policy, revised October 2023, included Policy Statement: Our facility will conduct resident assessments in accordance with the current Resident Assessment Instrument .Policy Interpretation and Implementation: 1. The assessment coordinator or designee will complete MDS Assessments per accordance to the Resident Assessment Instrument and per CMS guidelines and regulations. 2.On 4/15/26 at 10:45 AM, Surveyor #2 (S #2) observed Resident #13 in the rehabilitation room participating in Physical Therapy (PT) and Occupational Therapy (OT) while seated in a wheelchair (w/c). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/26 at 10:52 AM, S #2 reviewed the medical record for Resident #13. A review of the AR revealed the resident had diagnoses which included, but were not limited to; Parkinson's disease, diabetes mellitus, chronic kidney disease, and dementia. A review of the resident's quarterly MDS (qMDS), with an assessment reference date (ARD) of 4/6/26, included the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed Section O (O0390 – Therapy Services) was coded No for physical therapy. A review of the resident's comprehensive care plan (CP) included a focus area that the resident required rehabilitation services to improve functional mobility. Interventions included participation in PT and OT services. A review of the Order Report (OSR), dated as of 4/17/26, included the following physician orders (PO): A PO, dated 4/4/25, for PT evaluation and treatment as indicated. A PO, dated 4/2/26, for PT three times per week for therapeutic exercise, therapeutic activities, neuromuscular reeducation, and gait training. A review of the progress notes (PN) included therapy documentation, dated 3/31/26 and 4/1/26, which indicated the resident received PT services within the 7-day look-back period of the MDS assessment. Further review of the above medical records revealed that the active PO at the time of the quarterly MDS assessment, which indicated the resident was receiving rehab services. However, the MDS did not reflect that the resident received therapy services during the 7-day look-back period. On 4/17/26 at 11:40 AM, S #2 interviewed the PT Regional Rehabilitation (Rehab) Coordinator who stated the resident had been receiving therapy services for approximately two months and was working toward returning to prior level of function. The therapist further stated the resident was discharged from therapy on 4/15/26 after reaching highest potential. On 4/17/26 at 12:20 PM, S #2 interviewed the Regional Rehab representative who stated the resident was receiving rehab services on and prior to 4/12/26. On 4/17/26 at 12:55 AM, S #2 interviewed the LPN/MDSC, who stated, it appears the quarterly MDS did not capture that the resident was receiving physical therapy during the 7-day look-back period. On 4/18/26 at 9:55 AM, S #2 reviewed again the resident's MDS and revealed that the MDS was modified to reflect that the resident received PT services. On 4/21/26 at 11:59 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team, Director of Nursing (DON), Regional DON 1 (RDON1), and Regional DON 2 (RDON2) acknowledged that the MDS assessment was inaccurate and required correction. The LNHA stated that education provided to MDS coordinator and the MDS was fixed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's MDS Accuracy Policy and MDS Error Correction Policy, dated/revised October 2025, which included, the assessment coordinator or designee will complete MDS assessments per directions in the Resident Assessment Instrument Manual and per CMS (Centers for Medicare and Medicaid Services) guidelines and regulations.The policy goes on the state .A significant error inaccurately reflects the resident's clinical status and/or may result in an inappropriate plan of care. 3. On 4/15/26 at 10:56 AM, Surveyor #3 (S #3) observed a posted sign outside Resident #8's door for EBP (Enhanced Barrier Precautions). Inside the room, the resident was observed seated in the bed with oxygen in use. S #3 reviewed the medical records of Resident #8, and revealed: A review of the AR revealed that Resident #8 was admitted to the facility with diagnosis that included but were not limited to; displaced trimalleolar fracture (a severe, unstable ankle injury where all three bony prominences (malleoli) break: the lateral (fibula), medial (tibia), and posterior (back of the tibia) malleolus) of right lower leg, subsequent encounter for closed fracture with routine healing, unspecified fall, subsequent encounter, muscle weakness, unspecified atrial fibrillation, and chronic kidney disease, stage 4 (severe). A review of the comprehensive MDS (cMDS), with an ARD of 3/19/26, reflected in Section C-Cognitive Patterns that Resident #8 had a BIMS score of 15, which indicated that the resident had an intact cognition. Section O- Special Treatments, Procedures, and Programs were coded as follows: -influenza vaccination was received outside facility; -pneumococcal vaccine was offered and declined; and -COVID-19 vaccine was not up to date. A review of the immunization tab in the eMR revealed that there was no documentation to reflect information about influenza, pneumococcal, and COVID-19 vaccinations. A review of the Nursing Admission-readmission Screening dated 3/13/26, under B. Vital Signs/Immunizations/Allergies revealed: #5. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? was coded 2 (no, offered). 5a. Date of influenza vaccine. [was blank] 5b. If influenza vaccine not received, state reason: was coded 2 (received outside of this facility) 6. Is the resident's Pneumococcal vaccination up to date? was coded 2 (no, offered) 6a. Date of pneumococcal vaccine. [was blank] 6b. If pneumococcal vaccination not received, state reason. [was blank]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the choices: 1. not eligible and 2. offered and declined Further review of the medical records revealed no documented evidence that the resident was offered and declined COVID-19 vaccine(s), nor the resident was asked about their history of COVID-19 in the 3/13/26 assessment. Furthermore, there was no documented evidence that the resident had offered and declined the pneumococcal vaccine and COVID-19 vaccinations were up to date as reflected in the comprehensive MDS with an ARD of 3/19/26. On 4/16/26 at 11:24 AM, the Infection Preventionist Nurse (IPN) informed S #3 that after reviewing Resident #8's medical records, she confirmed that there were no information of resident's immunization, flu, pneumonia, and COVID in the immunization tab of the eMR. She also stated that there were information that the vaccination history of the resident was asked in the admission on [DATE] of the resident by the nurse, and no information about COVID-19. At that same time, the IPN provided a copy of the PN that she documented dated 4/16/26 at 10:24 AM, after surveyor's inquiry with a Note Text called and spoke with resident's emergency contact 1.for vaccination records.the Resident Representative (RR) said the RR will look for the record as the VA (Veterans Affair) nurse is coming tomorrow. The surveyor then asked the IPN, should the PN and information was asked to the resident or RR prior to surveyor's inquiry, and the IPN did not respond. On 4/17/26 at 10:46 AM, S #3 interviewed the LPN/MDSC regarding the MDS immunizations in Section O, and she stated that she gathered information from the immunization tab in the eMR, if not there, in the admission record, and hospital records of the resident. S #3 notified the LPNMDSC about the MDS concern for ARD 3/19/26, that the pneumococcal immunization was coded offered and declined when there was no documentation that it was offered and declined. S #3 also notified the LPN/MDSC of the concern that COVID-19 was coded not up to date when there was no documented evidence of such record, not until yesterday when the surveyor's inquiry. She said she would get back to S #3. S #3 asked whether that should be considered inaccurate MDS if there were no information about it, and she did not respond. On 4/17/26 at 11:59 AM, the LPNMDSC informed S #3 that she modified Resident #8's MDS to reflect the accurate information for resident's vaccination status on 3/19/26. 4.S #3 reviewed the medical records of Resident #14, and revealed: A review of the AR revealed that the resident was admitted to the facility with diagnosis that included but were not limited to; pressure ulcer (PU) of sacral region, stage 4, muscle weakness (generalized), difficulty in walking, not elsewhere classified, and unspecified protein-calorie malnutrition. A review of the Assessment tab in the eMR revealed an admission assessment dated [DATE], reflected in the skin evaluation that the resident had a sacrum stage 4 (a severe, full-thickness wound with extensive tissue loss, exposing muscle, tendon, ligament, cartilage, or bone) and right buttock DTI (deep tissue injury; often rapidly evolving pressure injury where soft tissue is damaged under intact skin due to prolonged pressure or shear). A review of the re-admission assessment dated [DATE] at 10:52 PM, revealed that the resident had sacral, right buttock, and left buttocks PU. The skin evaluation did not include further description of the wound to indicate the staging of the wounds (the classification of pressure injuries (bedsores) based on their depth and severity, ranging from Stage 1 (skin intact) to Stage 4 (deep tissue (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exposure) except for the measurements. A review of the PN, created by the Physician Assistant (PA) with an effective date of 7/28/25 at 10:00 AM, for a wound initial consult reflected that the resident had a stage 4 PU in the sacrum. A review of the PN, type: Skilled Note, with an effective date of 7/30/25 at 9:50 PM, created by the Registered Nurse (RN), with a text note that the resident with sacral wounds unstageable, peri buttocks MASD (Moisture-Associated Skin Damage, a condition where prolonged exposure to moisture leads to inflammation and erosion of the skin), right buttocks with DTI, and with no s/sx (signs/symptoms) of infection noted. Further review of the PN, type: Skilled Note, with an effective date of 7/31/25 at 2:55 PM, created by a Licensed Practical Nurse (LPN), with a note text that the resident with sacral wounds unstageable, peri buttocks MASD, right buttocks with DTI, and with no s/sx of infection noted. A review of the modified cMDS, with an ARD of 7/31/25, reflected in Section M-Skin Conditions that the resident had one stage 4 and one unstageable DTI PU that both were present on admission. A review of the qMDS with an ARD of 2/25/26, reflected that the resident had severely impaired cognition. Section M reflected that the resident had one stage 4 PU that was present on admission. Further review of the medical records revealed that Resident #14's MASD that were documented by the LPN (7/31/25) and the RN (7/30/25) were not identified in the resident's comprehensive MDS on ARD 7/31/25. There was no documented evidence as to why it was not captured in the MDS. On 4/17/26 at 9:28 AM, S #3 interviewed the LPN/MDSC in the nursing station of LTC unit regarding the MDS. The LPN/MDSC informed S #3 that the facility followed the RAI (Resident Assessment Instrument) manual when doing MDS, she was responsible for Sections A, B, some part of C with Social Worker (SW), J, L, M, N, O some part with Rehab department, P, and Section V. She also stated that for Section M-wounds in the MDS, she gather the information from the resident's medical records including the nursing notes, physician and the wound consultation notes. At that same time, S #3 notified the LPN/MDSC of the above concern with Resident #14's MASD documentations by the LPN and an RN were not reflected in the coding of the MDS specifically in the ARD 7/31/25. S #3 then asked the LPN/MDSC if that would consider an inaccurate MDS coding if the MDS did not reflect the current condition and assessment of the resident, and the LPN/MDSC stated she would review the record and would get back to S #3. On 4/17/26 at 1:30 PM, the survey team met with the LNHA and DON informed S #2 that it was the responsibility of the wound nurse (contracted) to stage the wound of the resident, and the Wound Nurse (also known as the PA) was in the facility at least once or twice a week. The DON was unable to state the specific days the PA was at the facility. The DON further stated that when a resident was admitted or readmitted at the facility, on the day of admission, the nurse describe the wound, and the second or following day, an RN would stage the wound. S #3 then notified the LNHA and DON of the above findings and concerns with Resident #14's inaccurate coding for the MDS. On 4/20/26 at 10:24 AM, the RN/MDS Coordinator (RN/MDSC) informed S #3 that they go by the PA assessment on 7/28/25, that there was no MASD that was why the MDS was not coded with MASD. She also stated that there were no documentation that the assessment of an RN on 7/30/25 was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clarified that there was no MASD. S #3 then asked the RN/MDSC if part of her MDS assessment was to observe and assess resident if there was an MASD, and she responded, I do not physically look. On 4/20/26 at 10:29 AM, the DON stated that she was not familiar with MDS and unable to speak about it. She further stated that the RN who documented on 7/30/25 resigned and was not an employee of the facility anymore. On 4/21/26 at 11:59 AM, the survey team met with the DON, RDON1, RDON2, and the LNHA stated that for Residents #8 and #14, we provided education to the MDS Coordinators. 5. On 4/15/26 at 11:43 AM, S #4 observed Resident #89 seated in a w/c in the dayroom waiting for lunch to be served. On 4/16/26 at 10:31 AM, S #4 reviewed Resident #89 medical record. A review of Resident #89's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to dementia (a decline in mental ability—such as memory, language, problem-solving, and thinking—severe enough to interfere with daily life) and anxiety (a common mental health condition characterized by excessive, uncontrollable fear or worry that interferes with daily life). A review of Resident #89's most recent cMDS, with an ARD of 3/3/26, reflected that the resident had a BIMS score of 00 out of 15, which indicated the resident's cognition was severely impaired. Further review of the cMDS reflected that the resident received the influenza vaccine in the facility for the current year's season on 1/31/25. The date administered was not in the current year's season. The cMDS was not coded accurately. A review of Resident #89's most recent qMDS, with an ARD of 12/3/25, reflected that the resident received the influenza vaccine in the facility for the current year's season on 1/31/25. The date administered was not in the current year's season. The qMDS was not coded accurately. A review of Resident #89's eMR under immunization tab reflected that the last documented influenza vaccine was given to the resident was 1/31/25. There was no documented evidence that the influenza vaccination was offered, given or refused for the most recent influenza vaccination season. On 4/17/26 at 10:40 AM, S #4 interviewed the LPN/MDSC regarding the influenza vaccination coding, and the LPN/MDSC stated that it was coded by when the season started and the email mass notification system started. S #4 asked LPN/MDSC if Resident #89's most recent aMDS and qMDS were accurate for the influenza vaccination. She stated that she would have to check. On 4/20/26 at 12:16 PM, S #4 notified the LNHA and DON the concern that Resident #89's most recent aMDS and qMDS were not accurate for the influenza vaccination status. On 4/21/26 at 12:19 PM, in the presence of the DON, RDON1 and RDON2, the LNHA stated that staff were education on accuracy. On 4/21/26 at 1:27 PM, the survey team met with the LNHA, DON, RDON1 and RDON2 for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-33.2 (d)

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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. Based on interviews and record review and review of pertinent facility documentation, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice that meet each resident's physical, mental and psychosocial needs, specifically a.) ensuring a consent was obtained and signage posted for video monitoring for 1 of 2 residents reviewed for falls (Resident #16) and b.) ensuring hospice recommendations that were not followed were clarified with the physician and medications discontinued that a hospice resident was refusing to take for 1 of 2 residents reviewed for hospice (Resident #75).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 4/15/26 at 11:25 AM, the surveyor observed Resident #16 seated in a wheelchair in their room. The surveyor observed a video monitoring camera on the dresser. There was no signage on the door of the room or inside the room to indicate video monitoring was in the process. A review of Resident #16's admission Record (AR) or face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to hemiplegia and hemiparesis following cerebral infarction (total paralysis and weakness on one side of the body which are consequences of a stroke or cerebral infarction due to damaged brain tissue) and encephalopathy (a broad, non-specific term for any disease, damage, or dysfunction that alters brain function or structure). A review of Resident #16's most recent Discharge Return Anticipated Minimum Data Set (DRAMDS), with an Assessment Reference Date of 3/17/26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. Further review reflected the resident had a fall with major injury. A review of Resident #16's comprehensive care plan (CP) included a focus area of at risk for falls and actual falls related to impaired mobility and poor safety awareness which included but was not limited to the following intervention added 3/23/26 of video monitor at all times for safety. A review of Resident #16's April 2026 electronic Treatment Administration Record (eTAR) included the following order:Video monitor at all times, check for placement every shift. A review of Resident #16's Progress Notes (PN) included the following note dated 3/23/26:IDT (interdisciplinary team) met to discuss the fall incident that occurred on 3/17/26 around 4:45 PM. Resident was sent to ER (emergency room) and was admitted with Rt (right) thigh Hematoma. Resident returned to facility on 3/23/26, noted with five staples to scalp Rt temporal post laceration . Rt thigh hematoma, findings may reflect hematoma in the setting of recent trauma. Team recommended to apply video monitor at all times. Resident continues to be fall risk due to poor safety awareness despite of current interventions. Further review of the PN did not include any documentation that the resident representative (RR) was notified or gave permission for the video monitoring. A review of the resident's hybrid (electronic and paper) medical record did not contain a written consent from the RR for the video monitoring. On 4/17/26 at 9:57 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1) who stated that the resident had a recent and had a fall when the resident was located on the other unit. LPN #1 stated that the resident liked to get up in the room and that there was a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	video monitor in the room. LPN #1 stated that when the resident had returned from the hospital, the resident was moved to a room by the nurse station and that the resident was in an activity now. On 4/20/26 at 12:51 PM, the surveyor interviewed LPN #2 who stated that Resident #16 had video monitoring especially at night and when in the room by themselves. LPN #2 stated that the resident suffered a stroke and was very impulsive and did not make good decisions. The surveyor asked LPN #2 if there was signage for the video monitoring. LPN #2 confirmed that there was no signage for the video monitoring in Resident #16's room or door. The surveyor asked LPN #2 if there was a written consent for the video monitoring. LPN #2 stated that they had obtained verbal consent from the RR and that the RR was in agreement with the video monitoring. The surveyor, in the presence of LPN #2 reviewed Resident #16's paper medical record and did not see a written consent for video monitoring. LPN #2 confirmed that there was not a written consent for the video monitoring. The surveyor observed the monitor for Resident #16 was sitting on the counter of the nurses station. The resident was not currently in their room. On 4/20/26 at 1:01 PM, the surveyor interviewed the Director of Nursing (DON) regarding video monitoring. The DON stated that it was ok if in a private room and that if in a two-person room would have to get consent. The DON stated that if a resident was a high fall risk, then one of the interventions they used was for video monitoring if the RR was agreeable. She added that they would get written consent or verbal consent. The surveyor asked if the verbal consent would be documented. The DON stated that it would be expected to be documented. The surveyor asked the DON if there should be signage about the video monitoring that was occurring. The DON stated, something to be considered. On 4/20/26 at 1:06 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #16 had video monitoring and there was no documented evidence that a consent was obtained and that there was no signage alerting that the room was being video monitored. On 4/21/26 at 12:27 PM, in the presence of the DON, Regional DON #1 (RDON1) and RDON #2 (RDON2), the LNHA stated that the staff were educated about consent and signage for video monitoring. A review of the facility's Photography/Videography Policy with a reviewed date of 3/2026, included the following:3. Room video monitoring devices to monitor resident safety use audio/video transmitter that stays in the room, while a handheld monitor is held by staff.4. If a video monitoring device is installed in a resident's room, a sign will be posted at the room entrance to inform all residents, visitors, employees, etc., of the use of this device. The staff shall obtain signed consent from the resident's roommate or authorized representative before video monitoring starts.5. Staff must obtain written consent from the resident or resident's legal representative to have video camera in the room.6. Residents' privacy rights and dignity should always be maintained. Video monitor will be turned off when staff are providing care. Attached was an example of the Resident Video Monitoring Consent Form. The LNHA did not provide any additional information. 2. On 4/15/26 at 10:20 AM, the surveyor observed Resident #75 asleep in bed. On 4/16/26 at 11:51 AM, the surveyor reviewed Resident #75's medical record. A review of Resident #75's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to anorexia (a serious, potentially life-threatening eating disorder characterized by an intense fear of gaining weight, self-starvation, and a distorted body image) and dementia (a decline in mental ability-such as memory, language, problem-solving, and thinking-severe enough to interfere with daily life). A review of Resident #75's most recent comprehensive MDS with an ARD of 3/30/26, reflected that the resident had a BIMS score of 00 out of 15, which indicated the resident's cognition was severely impaired. Further review reflected the resident received hospice services. A review of Resident #75's Hospice recommendations dated 3/18/26 included the following:D/C (discontinue) Memantine, Eliquis, Vitamin D3, Multivitamin, Cyanocobalamin, Ascorbic Acid, Methenamine, Omega.Start Memantine 5 mg (milligram) 1 tablet (tab) daily for 7 days and then DC. A review of Resident #75's March 2026 electronic Medication Administration Record (eMAR) reflected that after 3/18/26 the resident refused Ascorbic acid 8 out of 13 days; Methenamine 2 of 13 days; Multivitamin 7 of 13 days; Vitamin D 8 of 13 days. Further review reflected that Cyanocobalamin, Omega-3, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Losartan and Eliquis were discontinued (d/c'd) on 3/20/26. A review of Resident #75's April 2026 eMAR reflected that the resident refused Ascorbic acid 13 out of 16 days; Methenamine 4 of 16 days; Multivitamin 13 of 16 days; Vitamin D 14 of 16 days. A review of the physician note dated 3/20/26 included the following:Hospice then 10 words that were illegible. d/c 1 illegible word & Eliquis. Family wants to keep Namenda & 1 illegible word. 3 illegible words. It did not appear that all the medications (meds) that were recommended to be d/c'd were addressed in the note. A review of the physician note dated 4/14/26 was illegible. A review of Resident #75's Progress Notes (PN) included the following note:3/18/26 16:41 PN -Note Text: Resident evaluated today by Hospice with RR at bedside. admitted to hospice with Dx of Anorexia. Recommendations given, and PMD (primary medical doctor) made aware. PMD ordered to d/c Eliquis.New orders:Morphine 20 mg/ml (milligrams/milliliters) - 5 mg SL (sublingual) Q4H (every 4 hours) PRN (as needed) for pain/SOB (shortness of breath)Lorazepam 2 mg/ml - 0.5 mg SL Q4H PRN for anxiety/restlessness.Hyoscyamine 0.125 mg/0.25 ml - 0.125 mg SL Q6H PRN for secretions.Acetaminophen 650 mg Supp (suppository) - 1 Supp Q 6H (every 6 hours) PRN for fever.Bisacodyl 10 mg Supp - 1 Supp Daily PRN for constipationPMD stated she will talk with family.Endorsed. Further review of the PN reflected that resident refused to take meds and became agitated on additional attempts to administer meds on 3/25/26, 4/7/26, 4/14/26, 4/18/26 and 4/19/26. On 4/16/26 at 12:19 PM, the surveyor interviewed LPN #3 who stated that usually the meds were d/c'd that hospice recommends. The surveyor asked LPN #3 who checked the recommendations and LPN #3 stated that she would have to get back to the surveyor on that. She added not the nurse but that maybe it was the Unit Manager or Assistant DON. On 4/16/26 at 12:23 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that for they called the primary physician with the hospice recommendations to see what should be started or discontinued. She added that sometimes the physician did not agree and that it should be documented somewhere. On 4/17/2026 at 9:16 AM, the surveyor interviewed the Registered Nurse (RN) who stated that she had shown the hospice recommendations to the physician and that the physician would follow up with the RR. The surveyor asked the RN about the multiple refusals of the meds. The RN stated that the physician was aware that the resident refused but that the physician wanted us to try. On 4/17/26 at 9:32 AM, the surveyor asked the RN/UM to read the physician notes. The RN/UM stated that she was unsure what some of the words that were written were and that she would call the physician. On 4/20/26 at 10:00 AM, the RN/UM stated that she spoke with the physician and that she wanted to continue the medicine because the RR wanted it. The RN/UM stated that she did not ask the physician what her note specifically was but that she read each med to her. An additional review of Resident #75's PN included the following note dated 4/17/26: LATE ENTRY Spoke to PMD regarding the recommendations to d/c meds, per PMD the RR still wanted to continue Namenda and vitamin. Will continue to monitor. The clarification was done after surveyor inquiry. On 4/20/26 at 9:45 AM, the surveyor interviewed the DON who stated that when hospice makes recommendations that they notify the physician and carry them out if the physician is in agreement and the RR was involved. The surveyor asked the DON what was done if the resident refused the meds. The DON stated that she would have to check. On 4/20/26 at 12:19 PM, the surveyor notified the LNHA and DON the concern that Resident #75's hospice recommendations were not followed and the facility did not clarify the physician's documentation as to which recommendations were to be followed and that the Eliquis was d/c'd but the various supplements were not and the resident was refusing and became agitated when nurses made several attempts to administer the meds. On 4/21/26 at 12:21 PM, in the presence of the DON, RDON1 and RDON2, the LNHA stated that the physician only d/c'd the eliquis and that the physician spoke with the RR. He added that they called the doctor to confirm. The surveyor asked if the physician documentation should have been clarified prior to surveyor inquiry. The DON stated that it should have been clarified. She added that the RR requested to try to administer the meds. The LNHA stated that staff were educated. A review of the facility's Hospice Program Policy with a reviewed date of 10/2025, included (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following:5. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The CP shall be revised and updated as necessary to reflect the resident's current status. The LNHA did not provide any additional information. N.J.A.C. 8:39-27.1 (a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) an air mattress was set according to the resident's weight and b.) the medication administration record was signed in accordance with professional standards of nursing practice for 1 of 2 residents reviewed for pressure ulcer (PU) (Resident #11).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 4/15/26 at 10:27 AM, the surveyor observed Resident #11 asleep in bed. The Registered Nurse/Unit Manager (RN/UM) informed the surveyor that the resident had a facility acquired PU. On 4/16/26 at 9:00 AM, the surveyor interviewed Resident #11 who stated that they received an antibiotic for the wound (PU) they had. A review of Resident #11's admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to cerebral infarction (or ischemic stroke, occurs when blood flow to the brain is blocked, starving brain tissue of oxygen and causing cell death) and moderate protein-calorie malnutrition (a condition marked by inadequate intake of protein and calories, resulting in 10-20% weight loss, reduced muscle mass, and exhaustion). A review of Resident #11's most recent quarterly Minimum Data Set (qMDS) with an Assessment Reference Date (ARD) of 3/31/26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the qMDS revealed that the resident had one Stage 3 PU that was not present upon admission/entry or reentry. A Review of Resident #11's April 2026 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) included the following orders:Vancomycin HCl (hydrochloride) Intravenous Solution Reconstituted 1 gm (gram), use 1 vial intravenously one time a day for Wound infection. for 21 Days until finished with a start date of 4/8/26. The order was plotted to be administered at 6:45 AM. There was a blank for 4/9/26 and 4/13/26. The medication (med) was not marked as administered or held. Device: Mattress-Air, check for placement and functioning every shift with a start date of 5/28/25. The order did not indicate to check the setting of the air mattress. A review of Resident #11's weight was 126 pounds on 4/2/26. On 4/16/26 at 10:40 AM, the surveyor observed Resident #11's PU treatment that was performed by Licensed Practical Nurse #1 (LPN #1) and LPN #2. Following the wound treatment, the surveyor observed that Resident #11's air mattress was set at 260. The surveyor observed the resident who was not 260 pounds. LPN #1 and LPN #2 confirmed that the setting was 260. On 4/16/26 at 11:23 AM, the surveyor interviewed LPN #1 who stated that she was not really sure but that a resident's weight was taken into consideration and that she would check. On 4/17/26 at 9:12 AM, LPN #1 stated that she was not sure why the setting was up but that maybe someone touched it and that now it was set by the weight. On 4/17/26 at 9:35 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding Resident #11's antibiotic order. The RNUM stated that there should not be blanks and that if something was not administered it should have documentation as to why. She added that maybe if a trough was done they were holding it until the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result. The surveyor asked if there should have been documentation for that. She stated that she would have to check. The surveyor then asked the RN/UM about air mattress process. The RN/UM stated that every shift the air mattress was checked that it was in place, functioning and set according to weight. The surveyor showed the RN/UM the picture of Resident #11's air mattress setting from the prior day. The RN/UM stated that the air mattress should have been set to the weight. On 4/20/26 at 9:42 AM, the surveyor interviewed the Director of Nursing (DON) regarding air mattress process. The DON stated that the air mattress was set on static by weight [of resident] and that the nurses were expected to check the setting every shift. The surveyor then asked the DON if a resident's eMAR should have blanks. The DON stated that unless there was a hold. The surveyor asked if there should be a code for a hold. The DON stated that there should be a code. On 4/20/26 at 12:16 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #11's air mattress was not set according to the resident's weight and that there were two blanks for the Vancomycin order. On 4/21/26 at 12:19 PM, in the presence of the DON, Regional DON #1 (RDON1) and Regional DON #2 (RDON2), the LNHA stated that all staff were educated on the air mattress and that the order was changed to include check the settings. The LNHA added that maybe it was not checked yet that shift. The LNHA stated that he received a statement from the nurse that she gave the med and that it was blank. The email statement provided was dated 4/20/26 The LNHA did not provide any additional information. A review of the facility's Manufacturer's Use Instructions for the air mattress included the following:Step 6 Determine the patient's weight and set the control knob to that weight setting on the control unit. A review of the facility's Administering Medications Using Electronic System Policy with a reviewed date of 11/2025, included the following:Charting Withholding/Refusal of Medications on the eMAR16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the med shall document following the appropriate key guide in the eMAR space provided for that drug and dose. N.J.A.C. 8:39-27.1

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, 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 resident that was receiving oxygen according to the standard of clinical practice and the facility's policy and procedure. This deficient practice was identified for 1 of 1 resident, Resident #8, reviewed for respiratory care, and was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual 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 4/15/26 at 10:56 AM, the surveyor observed a posted sign outside Resident #8's door for EBP (Enhanced Barrier Precautions). Inside the room, the resident was observed seated on the bed with oxygen (O2) in use. S #3 reviewed the medical records of Resident #8, and revealed:A review of the admission Record or face sheet (an admission summary) revealed that Resident #8 was admitted to the facility with diagnosis that included but were not limited to; displaced trimalleolar fracture (a severe, unstable ankle injury where all three bony prominences (malleoli) break: the lateral (fibula), medial (tibia), and posterior (back of the tibia) malleolus) of right lower leg, subsequent encounter for closed fracture with routine healing, unspecified fall, subsequent encounter, muscle weakness, unspecified atrial fibrillation (afib), and chronic kidney disease, stage 4 (severe). A review of the comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 3/19/26, reflected in Section C-Cognitive Patterns that the resident had a BIMS score of 15 out of 15, which indicated that the resident had an intact cognition. The MDS also included that the resident received O2. A review of the Order Summary Report (OSR) revealed the following physician's order (PO) that included but were not limited to:-Check O2 saturation (sats) every shift-Start Date 3/14/26-Hold Date from 4/9/26 to 4/10/26-Hold Date from 4/13/26 to 4/13/26. The above PO to check O2 sats was signed by nurses every shift except on 4/12/26 at night shift. The 4/12/26 had no documentation of O2 sats and initials of the nurse. -Transmission Based Precautions: EBP for suprapubic catheter every shift-Start Date 3/13/26-Hold Date from 4/9/26 to 4/10/26. -Administer O2 at 3 L/Min (liters/minute) via NC (nasal cannula) as needed (PRN) for SOB/SPO2 (shortness of breath/Peripheral Oxygen Saturation) below 90-Start Date 3/25/26-Hold Date from 4/9/26 to 4/10/26-Hold Date from 4/13/26 to 4/13/26. A review of the above PO for O2 at 3 L/min, there were no documentation or signature of nurse(s) to indicate that the resident was administered with O2 nor was the sats obtained. A review of the Progress Note (PN) with an effective date of 4/14/26 at 10:00 PM, that was electronically signed by Licensed Practical Nurse #1 (LPN #1), with a note text that the resident was received alert and oriented at approximately 3:00 PM, seated in a wheelchair with O2 via NC.Care plan on going. A review of the PN, with an effective date of 4/15/26 at 2:06 PM, that was electronically signed by Licensed Practical Nurse #2 (LPN #2) with a note text that Resident #8 was anxious and complained of SOB; constantly pushing call bell for minor details; with disruptive behavior. New order for IV (intravenous) furosemide (diuretic) 40 mg (milligram) was ordered. Resident in bed, accompanied by the resident representative (RR). Further review of the medical records revealed that the PO for PRN 3 L/min O2 was not followed, there was no documentation that (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was administered on 4/14/26 when LPN #1 documented in her PN that O2 via NC was in used. There was no documentation that the O2 was administered on 4/15/26 when the resident complained of SOB, LPN #2 did not follow the PO to administer the 3 L/min O2 for PRN SOB. On 4/16/26 at 9:53 AM, the surveyor observed Licensed Practical Nurse #3 (LPN #3) inside the resident's room while the resident seated on their bed with O2 via NC. LPN #3 informed the surveyor that the resident was on continuous O2 at 2 L/min while checking the O2 concentrator at 3 L/min (set), and LPN #3 stated that it will drop to 2 liters later. On 4/16/26 at 10:05 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that she was covering for the other RN/UM. The surveyor notified the RN/UM of the concern that for two days of observation that the resident was on O2 via NC and that the electronic Medication Administration Record (eMAR) was not signed for PO of PRN O2. The RN/UM confirmed that the O2 eMAR and electronic Treatment Administration Record (eTAR) should have been signed. Later on, during the interview of the surveyor with the RN/UM, Licensed Practical Nurse #4 (LPN #4) informed the surveyor Resident #8 was on continuous O2 and the records should have been signed that it was administered. The surveyor also notified the RN/UM and LPN #4 the concern that there was no order for continuous O2 and only PRN which was not signed. On 4/16/26 at 10:31 AM, the surveyor interviewed LPN #2 who informed the surveyor that she was the assigned nurse of the resident yesterday (4/15/26) at 7-3 shift, and that the resident was on continuous O2 via NC at 3 L/min. She further stated that when she came in yesterday at 7:00 AM, the resident was on O2 already. On that same date and time, LPN #2 stated that she was a per diem nurse, had worked four times at the facility, and a floater. She indicated that the resident was on continuous O2 because the resident's O2 sats without O2 was on 88%. She was unaware that there was no standing order for O2, and that the order was a PRN. She had no response when asked why she did not sign the eMAR when O2 was used by the resident yesterday. On 4/20/26 at 12:14 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns with regard to Resident #8's O2. On 4/21/26 at 11:59 AM, the survey team met with the DON, Regional DON #1 (RDON1), Regional DON #2 (RDON2), and the LNHA stated that for Residents #120, we provided education to all staff. A review of the facility's Oxygen/Nebulizer Care Policy that was provided by the DON, with a reviewed date of 10/2025, reflected in the policy, to administer O2 for the treatment of certain diseases or conditions. Policy Explanation and Procedures: 1. Care of the resident: a. obtain PO for the rate of flow and route of administration of O2 (mask, NC, etc.). On 4/21/26 at 1:27 PM, the survey team met with the LNHA, DON, Regional DON #1 (RDON1) and Regional DON #2 (RDON2) for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-11.2(a)(b); 27.1(a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interviews and review of other facility documentation, the facility failed to ensure that the physician must include an evaluation of the resident's condition and total program of care and a decision about the continued appropriateness of the resident's current medical regimen. The primary physician's history and physical and succeeding visit notes did not reflect resident's skin impairment and pressure ulcer. This deficient practice was identified for 1 of 27 residents, (Resident #14), reviewed for physician services.This deficient practice was evidenced by the following: On 4/17/26 at 8:34 AM, the surveyor reviewed the medical records of Resident #14, and revealed the following: The admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included but were not limited to; pressure ulcer (PU) of sacral region, stage 4 (a severe, full-thickness wound involving extensive destruction, tissue necrosis, and damage to muscle, bone, or supporting structures), muscle weakness (generalized), difficulty in walking, not elsewhere classified, and unspecified protein-calorie malnutrition. A review of the modified comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/31/25, revealed that Resident #14 had one stage 4 and unstageable PUs (pressure ulcers) that were present on admission. A review of the comprehensive MDS with an ARD of 11/25/25, revealed that the resident had one unstageable PU that was present on admission. A review of the quarterly MDS with an ARD of 2/25/26, revealed that the resident had one stage 4 PU that was present on admission. A review of the Care Plan that was revised on 8/11/25, reflected that the resident had a right buttock DTI (deep tissue injury; is a serious pressure injury characterized by localized, persistent, non-blanchable deep red, maroon, or purple discoloration of intact or non-intact skin) and stage 4 sacral PU. A review of the assessment tab in electronic medical record revealed the following skin evaluation:-7/24/25, admission assessment, reflected a sacrum stage 4 and right buttock DTI. -11/12/25, readmission assessment, reflected a sacrum right and left buttocks unstageable. -12/12/25, readmission assessment, reflected a sacrum, right and left buttocks skin impairment with no staging. A review of the 2/10/26 Weekly Skin Condition revealed stage 4 sacral and bilateral buttocks mycosis (a disease or infection caused by a fungus that invades human tissues). A review of the Progress Notes (PN) with an effective date of 7/30/25 at 9:50 PM, that was electronically signed by the Registered Nurse (RN), revealed that Resident #14 with sacral wounds unstageable, peri buttocks MASD (Moisture Associated Skin Damage is the general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage), right buttocks with DTI, bilateral thigh with wounds, no s/sx (signs/symptoms) of infection noted. Further review of the PN with an effective date of 7/31/25 at 2:55 PM, that was electronically signed by Licensed Practical Nurse #1 (LPN #1) revealed that Resident #14 with sacral wounds unstageable, peri buttocks MASD right buttocks with DTI, bilateral thigh with wounds, no s/sx of infection noted. On 4/17/26 at 9:39 AM, the surveyor reviewed the paper chart of the resident and revealed that the resident's primary physician had a handwritten History and Physical (H&P) dated 7/24/25, documented in the physical findings skin no lesions. The succeeding visit notes dated 8/1, 8/4, 8/27 documented PUs were absent and skin no rashes, lesions, ulcers. The follow up visit notes 10/4/25, 10/24/25, 11/4/25, 11/15/25, 12/4/25, 12/18/25, 1/4/26, 1/18/26, 2/4/26, 2/15/26, 3/4/26, 3/18/26, and 4/3/26 did not identify any skin impairments. There was one visit note with handwritten information after 4/3/26, with no date and was already signed by the primary physician. Further review of the paper chart included a UTF (Universal Transfer Form) dated 12/9/25, transfer from the facility going to the hospital with a reason for transfer: failure to thrive, malnutrition, and unstageable sacral wound. The UTF was signed by the RN/Unit Manager (RN/UM). On 4/17/26 at 9:44 AM, the surveyor interviewed Licensed Practical Nurse #2 (LPN #2) who stated that he was the assigned nurse of Resident #14. LPN #2 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated that the resident was cognitively impaired, required total assistance with care, with PU, and had been in and out of the hospital where PU worsened. At that same time, both the surveyor and LPN #2 reviewed the paper chart of the resident and LPN #2 confirmed that the primary physician did not identify any skin impairment or PU in the visit notes. LPN #2 had no response as to why the primary physician did not identify in their visit notes resident's skin impairment and PU. On 4/17/26 at 9:47 AM, the surveyor notified the RN/UM of the above findings and concern regarding the physician's H&P and succeeding visit notes did not reflect resident's skin impairment and PUs. The RN/UM checked and reviewed the resident's paper chart and stated that she did not know why the physician did not document the PU and skin impairment. She further stated that it was an expectation that the visit notes should include the resident's information about wounds in the physician notes. The surveyor asked the RN/UM who was responsibility to check the physician's visit notes, and she did not respond. On 4/17/26 at 10:19 AM, the RN/UM informed the surveyor that she called the primary physician about the surveyor's concerns regarding the visit notes, and the physician stated that even though he did not document that the resident had wounds, it did not mean that the resident had no wounds, it was just missed. The RN/UM then provided the surveyor with the phone number of the physician. Afterward, the surveyor called the physician twice and the surveyor was unable to reach the physician because the voicemail was full and unable to leave a message. On 4/17/26 at 10:26 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) that the surveyor was unable to reach the primary physician for an interview. On 4/20/26 at 12:14 PM, the survey team met with the LNHA and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns with regard to physician's H&P and succeeding visit notes did not reflect the resident's PU and skin impairments. On 4/21/26 at 11:59 AM, the survey team met with the DON, Regional DON #1 (RDON1), Regional DON #2 (RDON2), and the LNHA did not provide additional information. A review of the facility's Physician Services Policy that was provided by the LNHA, with a revised date of 10/2025, reflected under policy statement, the medical care of each resident is under the supervision of a Licensed Physician. Policy Interpretation and Implementation.3. Physician orders and PN shall be maintained in accordance with current.regulations and facility policy.6. The attending physician shall also be responsible for initial and ongoing medical evaluations as follows.b. The physician PN shall be maintained in accordance with acceptable professional standards and practices as necessitated by the medical beneficiary's and medical condition. On 4/21/26 at 1:27 PM, the survey team met with the LNHA, DON, RDON1 and Regional DON2 for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-23.2(b); 35.2(d)(8, 5, 6)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) ensure the consultant pharmacist identified and reported irregularities in the medication regimen, b.) ensure duplicate and conflicting physician orders were clarified, and c.) ensure that as needed and routine orders were not duplicative or clinically appropriate. This deficient practice was identified for 1 of 27 residents (Resident #6) reviewed for orders.The deficient practice was evidenced by the following: On 4/16/26 at 10:10 AM, the surveyor observed Resident #6 in the resident's room lying in bed. The resident was alert and oriented, with the call bell within reach. The surveyor reviewed the medical record for Resident #6. A review of the admission Record or face sheet (an admission summary), revealed diagnoses which included, but were not limited to; multiple sclerosis, sepsis, extended spectrum beta-lactamase resistance, acute kidney failure, and depression. A review of the comprehensive Minimum Data Set (MDS) (an assessment tool used to facilitate the management of care), with an assessment reference date (ARD) of 4/2/26, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. A review of the resident's comprehensive care plan (CP) revealed no interventions addressing duplicate or conflicting physician orders (PO) related to skin treatments or medication (med) monitoring. A review of the Order Summary Report (OSR), dated as of 4/16/26, included concerns with the following PO:Order #1: apply cornstarch to BL (bilateral) groin q (every) shift and PRN (as needed) every shift for protection Start Date: 3/6/26. Order #2: MASD (moisture associated skin damage), intergluteal cleft- cleanse with NS (normal saline), apply Silvadene 1% cream and cover with alginate BID (twice a day) and PRN every day and evening shift for masd Start Date: 3/7/26. Order #3: Apply cornstarch to BL breast folds, abdominal [NAME], BL groin and buttocks q shift and PRN every shift for protection for redness Start Date: 3/6/26. Order #4: Intergluteal cleft- cleanse with NS, apply alginate, change BID and PRN every day and evening shift for masd Start Date: 3/7/26. Further review revealed that the above PO included: Duplicate cornstarch orders for overlapping anatomical areas (groin, breast folds, pannus, buttocks), Overlapping wound care orders for the same anatomical site (intergluteal cleft), including multiple orders for alginate and Silvadene, and routine and PRN orders for the same treatments without clear differentiation. There was no documented evidence that the above duplicate orders were clarified. A review of the monthly medication regimen review (MMR) dated 3/12/26 documentation revealed that the Consultant Pharmacist did not identify or report these irregularities, including duplicate and conflicting PO. On 4/17/26 at 9:51 AM, the surveyor interviewed the Director of Nursing (DON), who stated she would review the documentation and follow up regarding the identified concerns. On 4/20/26 at 12:30 PM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON and survey team, acknowledged that the duplicate and conflicting PO were not identified during the monthly MRR. The DON confirmed that duplicate and conflicting PO should be identified and clarified and that the consultant pharmacist was responsible for identifying irregularities during the MRR. On 4/21/26 at 12:00 PM, the LNHA stated that the irregular orders were fixed following surveyor inquiry. A review of the facility's Pharmacy Services - Role of the Consultant Pharmacist Policy, dated/reviewed 8/2025, which included that the Consultant Pharmacist is responsible for conducting a documented monthly MRR for each resident . The policy further included that the Consultant Pharmacist is to communicate potential or actual problems related to medications, including medication irregularities, to prescribers and facility leadership . NJAC 8:39-29.3

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** REPEAT DEFICIENCYBased on observation, interview, and review of other pertinent facility documentation, it was determined that the facility failed to; a.) follow appropriate hand hygiene, use of personal protective equipment (PPE), and disinfect equipment for 1 of 4 nurses during medication pass observation, b.) perform hand hygiene and follow enhanced barrier precautions (EBP) for 1 of 1 staff (Housekeeper), and c.) track the extent to which staff were following the facility's policy and procedures to control infections and communicable diseases for all residents with regard to vaccinations, failed to follow appropriate infection control practices to prevent the spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy. This deficient practice was evidenced by the following: According to the CDC Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, revealed, EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. While this guidance focuses on gown and glove use, prevention of MDRO transmission in nursing homes requires much more than just proper use of PPE. Adherence to other recommended infection prevention practices including performing hand hygiene, cleaning and disinfection of environmental surfaces and resident care equipment, proper handling of indwelling medical devices, and care of wounds is also critical. CDC and health departments continue to identify gaps in recommended infection prevention practices as part of on-site infection control assessments in nursing homes. Examples include lack of access to alcohol-based hand sanitizer in resident rooms and other care areas; lack of access to EPA-registered disinfectants at the point of use; and failure to clean and disinfect shared resident care equipment after each use. 1.On 4/15/26 at 10:58 AM, Surveyor #1 (S #1) interviewed Licensed Practical Nurse #1 (LPN #1) who informed S #1 that residents with posted sign for EBP were those residents with tube feeding (TF), wounds, and catheters. She further stated that staff must follow the posted sign instructions for EBP. On 4/20/26 at 8:41 AM, S #1 observed the Housekeeper (HK) inside room [ROOM NUMBER] (R70), in the toilet room, kneeling while picking up garbage with gloves, stood up, left the toilet room, did not perform hand hygiene, exited the room with same gloves, walked in the hallway, and discarded the garbage and used gloves in one of two compartment bins with note for garbage. At that same time, S #1 observed the HK walked away from the two compartment bins, knocked in room [ROOM NUMBER] (R64) without performing hand hygiene, and entered the room. R64 door had a posted sign for EBP. S #1 asked HK for an interview outside R64. During an interview, the HK acknowledged and stated that he came out from one of the room where he picked up garbage. He continued to state that he left the room without removing used gloves, did not perform hand hygiene, and went to the two compartment bins to dispose of the garbage and used gloves. He further stated that he went to R64 with posted sign for EBP. After the interview, the surveyor did not observe HK performed hand hygiene and continued to walk away. On 4/20/26 at 8:44 AM, S #1 notified the Registered Nurse/Unit Manager (RN/UM) of the above findings and concerns with regard to HK's hand hygiene and use of gloves in the hallway. The RN/UM stated she would talk to the HK. She further stated that the HK should have removed gloves inside the room and performed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/20/26 at 8:46 AM, S #1 interviewed Licensed Practical Nurse #2 (LPN #2) who informed S #1 that the resident in R64 had a posted sign for EBP due to presence of foley catheter and wound. 2. On 4/15/26 at 10:56 AM, S #1 observed a posted sign outside Resident #8's door for EBP. Inside the room, the resident was observed seated in the bed with oxygen in use. S #1 reviewed the medical records of Resident #8, and revealed: A review of the admission Record (AR) or face sheet (an admission summary) revealed that Resident #8 was admitted to the facility with diagnosis that included but were not limited to; displaced trimalleolar fracture (a severe, unstable ankle injury where all three bony prominences (malleoli) break: the lateral (fibula), medial (tibia), and posterior (back of the tibia) malleolus) of right lower leg, subsequent encounter for closed fracture with routine healing, unspecified fall, subsequent encounter, muscle weakness, unspecified atrial fibrillation (afib), and chronic kidney disease, stage 4 (severe). A review of the comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 3/19/26, reflected in Section C-Cognitive Patterns that the resident had a BIMS score of 15, which indicated that the resident had an intact cognition. The MDS also reflected that influenza vaccine was received outside the facility, the pneumococcal vaccine was offered and declined, and the COVID-19 vaccinations were not up to date. A review of the immunization tab in the electronic medical records (eMR) was blank. Further review of the eMR revealed that there was no documented evidence that the resident or Resident Representative (RR) was provided an opportunity in writing to accept or decline the COVID-19 vaccine. A review of the paper chart revealed that there was no consent forms for influenza, pneumococcal, and COVID-19 vaccines that the resident or RR signed. On 4/16/26 at 10:05 AM, S #1 interviewed the RN/UM who stated that it was the nurse's responsibility to obtain consent for vaccinations of the resident, and it should be documented in the immunization tab of the eMR, or if not in the progress notes (PN). S #1 notified the RN/UM of the above concern that Resident #8 had no consent obtained for s in the immunization tab. The RN/UM checked eMR and stated that she did not see also that consent was obtained. On 4/16/26 at 10:11 AM, S #1 interviewed the Infection Preventionist Nurse (IPN) in the presence of LPN #2 and the RN/UM regarding immunization records. The IPN informed S #1 that it should be obtained and document it in the immunization tab of eMR, and there were no paper consent forms anymore, it was being done electronically. S #1 then notified the IPN of the concern and asked how the resident's immunization were being tracked. The IPN stated that she would get back to S #1. On 4/16/26 at 11:24 AM, the IPN informed S #1 that after reviewing Resident #8's medical records, there was no information of resident's immunization for COVID-19. She further stated that the information for influenza and pneumococcal vaccines were asked and documented in the admission of resident on 3/13/26. At that same time, the IPN provided a copy of the resident's PN dated 4/16/25 at 10:24 AM, after surveyor's inquiry, with a note text that the IPN called the RR for vaccination records. S #1 then asked the IPN, should the PN and information was asked to the RR prior to surveyor's inquiry, and the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IPN did not respond. The surveyor also asked how she was able to track the immunization of the residents in the facility and who was responsible for tracking, and she responded that some she was responsible, and that she would get back to S #1 to show her notebook. On 4/16/26 at 11:54 AM, the IPN provided a copy of the printed NJ (New Jersey) Immunization Information System Patient Immunizations Administered Report for Resident #8, which was printed on 4/16/26 at 11:51 AM, by the IPN, which was obtained after surveyor's inquiry. On 4/16/26 at 12:14 PM, the IPN provided and showed the three notebooks that she claimed her tracking for immunization of residents in the facility. The IPN informed S #1 that there were no record in her three notebooks that Resident #8 was checked or tracked for vaccinations, it was missed. The IPN stated that the three notebooks were for two facilities that she covered as an IPN. Both S #1 and the IPN reviewed the three notebooks, and S #1 asked the IPN why the three notebooks were incomplete, inconsistently documented, and missed other residents. The IPN responded that the notebook was not a tracking record for immunizations, it was for state reports. Furthermore, S #1 asked how she was able to track the immunizations of residents in the facility, and she did not provide a direct response, and stated that it was also the Director of Nursing (DON) who tracked the immunization records since she was only at the facility part time, two times a week at the facility, which was every Thursday and Friday. The IPN was unable to state where the tracking was documented. On 4/16/26 at 12:23 PM, S #1 in the presence of the Licensed Nursing Home Administrator (LNHA), Regional DON #1 (RDON1) and Regional DON #2 (RDON2) asked the DON if she was tracking immunizations of residents, and the DON was unable to answer. S #1 asked who was responsible for tracking immunizations of residents and RDON1 stated that it was the IPN who was responsible for tracking. At that same time, RDON2 stated to the IPN that she should have the tracking in excel spreadsheet of residents' immunization records, and the IPN responded that she did not have an excel spreadsheet for residents, but she had for staff. On 4/20/26 at 12:14 PM, the survey team met with the LNHA and the DON, and S #1 notified them of the above findings and concerns with regard to immunization records tracking. On 4/21/26 at 1:27 PM, the survey team met with the LNHA, DON, RDON1, and RDON2 for exit conference, and there was no additional information provided by the LNHA. 3. On 4/20/26 at 10:32 AM, Surveyor #2 (S #2) observed the following during medication (med) administration: -Licensed Practical Nurse #3 (LPN #3) did not perform hand hygiene before entering Resident #90's room to administer medications (meds), including Allegra, as well as Ipratropium-Albuterol Solution via nebulizer, and to use devices on the resident, including a stethoscope (a medical instrument used for listening to sounds inside the heart, lungs, intestines, and blood vessels) and pulse oximeter (a device usually placed on a fingertip that estimates the amount of oxygen in the blood). -LPN #3 did not sanitize the stethoscope or pulse oximeter before or after use on Resident #90. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN #3 washed their hands for 14 seconds before exiting Resident #90's room. -LPN #3 used the same paper towel to turn off the faucet as they used to dry their hands. On 4/20/26 at 10:38 AM, S #2 interviewed LPN#3 who stated they did not perform hand hygiene before entering Resident #90's room to administer medications (meds) and use devices on the resident. Moreover, LPN #3 stated they did not sanitize the stethoscope or pulse oximeter before or after use on Resident #90. LPN #3 stated the expectation was to sanitize the stethoscope and pulse oximeter before and after use. He also stated the expectation was to wash their hands for at least 20 seconds and that it was best practice to turn off the faucet with a new, unused paper towel. On 4/20/26 at 12:33 PM, S #2 discussed the concerns with the LNHA and the DON. On 4/21/26 at 12:35 PM, S #2 interviewed the LNHA and the DON. The LNHA stated equipment should be cleaned after each use. The DON stated that handwashing should be performed for at least 20 seconds, and a clean, separate paper towel should be used to turn off the faucet. A review of the AR revealed Resident #90 had diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), Unspecified (a chronic lung disease that prevents airflow to the lungs, causing breathing problems). A review of the Order Summary revealed orders for Resident #90 included, but were not limited to, the following: -Allegra Oral Tablet (tab)180 milligrams (MG), ordered 4/14/26, with directions to give 1 tab by mouth one time a day for post nasal drip. -Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3 milliliters (ML), ordered 10/20/25, with directions to inhale 3 ML orally via nebulizer two times a day for COPD. Supplementary Documentation Codes: Pre & Post Treatment Lung Sounds - C = Clear, O = Other (see progress note) Pre & Post Treatment – P (pulse), R (respiratory), and Oxygen Saturation results. A review of the quarterly MDS, with an ARD of 3/27/26, revealed that Resident #90 had a BIMS score of 13 out of 15, which indicated intact cognition. A review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment Policy, revised 10/2022, revealed resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected. Reusable resident care equipment i.e.; stethoscopes, blood pressure cuffs, glucometer machine, will be decontaminated between residents use according to manufacturers' instructions. A review of the facility's Handwashing/Hand Hygiene Policy, revised 4/2010, revealed the following: -Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions, including but not limited to, before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). -If hands are not visibly soiled, use an alcohol-based hand run containing at least 70% ethanol or isopropanol for the following situations, including, but not limited to, before and after direct contact (continued on next page)

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	315129	A. Building B. Wing	04/22/2026

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with residents; before preparing or handling meds. -Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. A review of the facility's Administering Meds Using Electronic System Policy, revised 4/2010, revealed staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of meds. NJAC 8:39-19.4(a)(1,2,4)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure all residents and/or resident representatives must be educated on the COVID-19 vaccine the facility offered, in a manner they could understand for 2 of 5 residents reviewed for immunizations (Residents #6 and #7). This deficient practice was evidenced by the following: 1.On 4/16/26 at 10:46 AM, Surveyor #1 (S #1) reviewed the medical record for Resident #6. A review of the admission Record (AR) or face sheet (an admission summary) for Resident #6, revealed diagnoses which included, but were not limited to; multiple sclerosis, sepsis, extended spectrum beta-lactamase resistance, acute kidney failure, and depression. A review of the comprehensive Minimum Data Set (MDS) (an assessment tool used to facilitate the management of care), with an assessment reference date (ARD) of 3/13/26, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. A review of the immunization record for Resident #6 revealed the last documented COVID-19 vaccine was administered on 10/5/23, with no documented evidence that the vaccine was offered, accepted, refused, or that education was provided after that date. On 4/17/26 at 8:30 AM, S #1 interviewed the Infection Preventionist Nurse (IPN), who stated that COVID-19 vaccines were offered through a system called Care Feed and that notifications were sent to the resident or Resident Representative (RR) monthly. The IPN further stated that if the resident or RR wanted the vaccine, they would respond to the notification. On 4/17/26 at 10:40 AM, S #1 interviewed the Director of Nursing (DON), who stated that the facility considered the Care Feed notifications as documentation that the vaccine was offered. On 4/21/26 at 12:00 PM, the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team, stated that the COVID-19 vaccine was offered through the Care Feed system and that general education was provided through postings in the facility; however, documentation of the resident's response and education was not maintained in the medical record. A review of the facility's Resident Vaccination for COVID-19 Protocol, reviewed 10/2025, which indicated, The resident's medical record includes documentation that indicates, at a minimum. consent for each COVID-19 vaccine and/or booster, and date of each dose of COVID-19 vaccine and/or booster administered. The policy goes on to say the facility shall, Ensure that the resident or RR is provided with education regarding the benefits, risks and potential side effects associated with the vaccine or booster. 2.On 4/16/26 at 9:46 AM, Surveyor #2 (S #2) observed Resident #7 in the activity room sitting in the wheelchair. Resident #7 was unable to participate in an interview. A review of Resident #7's electronic medical record (eMR) revealed that the resident was admitted (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with diagnoses including dementia (decline in memory, thinking and daily function severe enough to affect everyday life), psychosis (difficulty distinguishing what's real from what isn't), depression and anxiety disorder. A review of the quarterly MDS, with an ARD of 3/1/26, indicated a BIMS score of 0 out of 15, reflecting that the resident was severely cognitively impaired. A review of the immunizations records in the eMR, revealed COVID-19 booster history of administration on 10/21/21. There was no recent documentation for offered, administered or refusal of COVID-19 immunizations. There was no documented evidence that the RR was educated regarding the benefits and potential side effects of COVID-19 immunizations. On 4/17/26 at 11:47 AM, S #2 interviewed the IPN who stated they did not have a tracking system in place for tracking immunizations status for the residents. She further stated that the information for the immunizations for the residents was in the eMR. The IPN stated that when the residents were admitted to the facility, she documented their immunizations in her notebook. The IPN could not provide any other information including documented evidence that the RR was educated regarding the benefits and potential side effects of COVID-19 immunizations. On 4/17/26 at 1:07 PM, S #2 requested immunization information for Resident #7. The IPN and surveyor reviewed the eMR together and the IPN confirmed that the information regarding immunizations was not available. The IPN stated she would look at the nursing notes. There was no further information provided. On 4/21/26 at 11:59 AM, The survey team met with the LNHA, DON, Regional DON #1 (RDON1), and Regional DON #2 (RDON2), there was no further information provided regarding the immunization information for Resident #7. A review of the facility's Resident Vaccination for COVID-19 Protocol Policy, updated 4/2026, Purpose: The facility will offer vaccination for COVID-19 for residents according to CMS QSO-21-19-NH, including education of resident or RR regarding the benefits and potential side effects associated with the COVID-19 vaccine. The facility will offer vaccination and as currently associated with the COVID-19 vaccine. The facility will offer vaccination and as currently recommended by the Centers for Disease Control and Prevention (CDC) and by the New Jersey Department of Health (NJ DOH). Procedure: All newly admitted , readmitted and current residents are to be offered a pneumococcal vaccine unless the immunization is medically contraindicated or the resident has already been immunized. Screening residents prior to offering the vaccination for prior immunization, medical precautions and contraindications is necessary for determining whether they are appropriate candidates for vaccination at any given time. If the resident has already been immunized, ensure that all vaccination information, are documented in the resident's medical record. Ensure that the resident or RR is provided education regarding the benefits, risks and potential side (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effects associated with the vaccine or booster. The resident or RR has the opportunity to accept or refuse the pneumococcal vaccine, and change their decision. The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or RR was provided education regarding the benefits and potential risks associated with COVID-19 vaccine. Consent for each COVID-19 vaccine. Date of each dose of the COVID-19 vaccine and/or booster administered to the resident. If the resident did not receive COVID-19 vaccine due to medical contraindications (e.g. allergy) or refusal. NJAC 8:39-5.1(a)