STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Green Knoll	875 Route 202-206 North Bridgewater, NJ 08807

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 20413 Based on interview, record review, and facility policy review, the facility failed to provide information on how to file an anonymous grievance for six of six residents (Residents (R) 18, R88, R94, R97, R95, and R128) reviewed for the grievance process of 40 sample residents. The failure had the potential to affect residents' ability to safely report concerns without fear of retaliation. Findings include: A resident group interview was conducted on 09/25/24 at 3:00 PM with six residents whom the facility identified as reliable historians. During the meeting, six of the six residents (R18, R88, R94, R97, R95, and R128) expressed that they did not know how to file an anonymous grievance. They stated that Nobody told us how to file one and We can go to the social worker to file a grievance, but not anonymous. Review of the Resident Council meeting minutes, dated 01/26/24 through 09/12/24, revealed no mention of making an anonymous grievance. During an interview on 09/25/2024 at 4:00 PM, Social Services (SS) stated that the residents could come to her to make a grievance. SS stated that she went around to most residents in the morning to see how things were going or if they had any grievances. However, she stated she never explained to the residents about filing a grievance anonymously. During an interview on 09/25/2024 at 4:10 PM, the Administrator stated that the residents could file a grievance. However, she stated she never explained to the residents about filing a grievance anonymously. She also stated there was no way to file an anonymous grievance in the facility. Review of the facility's undated policy titled, Grievance Policy and Procedure, revealed All residents, responsible parties, interested family members, and staff of [Facility Name] have the right to voice grievances that are free from interference, coercion, discrimination, or reprisal concerning: The care, treatment, and services that are or fail to be, furnished; the policies, procedures, physical condition of the facility; the behavior of other residents, responsible parties, interested family members, and staff. NJAC 8:39- 4.1(a)35 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-13.2(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20413 39540 42440 Based on record review, interviews, and policy review, the facility failed to provide written notice of their bed hold policy and the cost of a bed hold when residents were transferred to the hospital for five of five residents (Resident (R) 119, R87, R83, R29, and R67) reviewed for hospitalization of 40 sample residents. This failure had the potential to cause confusion or distress regarding the cost to hold a room and whether or not a resident would be able to return to the facility after hospitalization . Findings include: 1. Review of R119's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/24 and located in the MDS tab of the electronic medical record (EMR), revealed the resident was unable to complete a Brief Interview for Mental Status (BIMS) and the staff assessment for cognition indicated moderately impaired cognition. Review of R119's Prog Note tab of the EMR revealed a note, dated 01/20/24 at 2:26 PM, which documented R119 was sent to the hospital for a sudden change in her level of consciousness. An entry dated 01/29/24, revealed R119 had returned from the hospital. Review of R119's Prog Note tab of the EMR further revealed a note, dated 04/12/24 at 10:28 PM, which documented R119 was admitted to the hospital for aspiration pneumonia. Review of R119's Census tab of the EMR revealed that R119's payor source at the facility was private pay when she was discharged to the hospital on 01/20/24 and Medicare when she was discharged to the hospital on 04/12/24. Review of R119's EMR and hard chart revealed no evidence that a bed hold policy or bed hold letter was provided to the resident representative for the hospitalization s. Review of a facility provided binder of bed hold letters revealed an undated letter to R119's representative, which revealed R119 had discharged to the hospital on 01/20/24 for altered mental status. It stated the facility would hold her bed for ten days but did not state the cost after the ten days or whether R119 would be able to return to the facility. The binder did not include a letter for when R119 was admitted to the hospital on 04/12/24. Review of the facility provided copy of the undated bed hold letter for 04/12/24 revealed R119 was discharged to the hospital for lethargy. It revealed the facility would hold her bed for ten days but did not state the cost after the ten days or whether R119 would be able to return to the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/26/24 at 4:53 PM, the Business Office Manager (BOM) stated that R119's two discharges had no cost associated with them because she was Medicaid pending. 2. Review of R87's undated Face Sheet located under the Profile tab of the EMR, revealed R87 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Incident Reporting Application (initial reporting), dated 04/09/24 and located under the Progress Notes tab of the EMR, revealed Received report [R87] noted with physical aggression towards resident . [R87] was later sent to the hospital for further evaluation and treatment. Review of R87's EMR revealed no documented evidence that the facility provided written information regarding the facility's bed hold policy to the resident and the resident's responsible party at the time of transfer. Review of a facility provided binder of bed hold letters revealed an undated letter that did not contain the cost associated with the bed hold. 3. Review of R83's undated Face Sheet located under the Profile tab of the EMR, revealed R83 was admitted to the facility on [DATE]. Review of R83s Progress Notes, dated 05/20/24 and located in the Progress Notes tab of the EMR, revealed R83 was discharged to the hospital on 05/20/24. Review of R83's EMR revealed no documented evidence that the facility provided written information regarding the facility's bed hold policy to the resident and the resident's responsible party at the time of transfer. Review of a facility provided binder of bed hold letters revealed an undated letter that did not contain the cost associated with the bed hold. 4. Review of R29's undated Face Sheet located under the Profile tab of the EMR, revealed R29 was admitted to the facility on [DATE]. Review of R29s Progress Notes, dated 05/17/23 and located in the Progress Notes tab of the EMR, revealed R29 was sent to the hospital on 05/17/23. Review of R29's EMR revealed no documented evidence that the facility provided written information regarding the facility's bed hold policy to the resident and the resident's responsible party at the time of transfer. Review of a facility provided binder of bed hold letters revealed an undated letter that did not contain the cost associated with the bed hold. During an interview on 09/25/24 at 8:48 AM Social Services Director (SSD) stated, I have nothing to do with the bed hold notice transfer. The receptionist sends out the notice the next day. SSD reviewed the facility bed hold notice upon transfer and stated was familiar with the policy, but did not realize the written notice did not include the bed hold payment portion. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/25/24 at 8:55 AM the Administrative Receptionist (AdmRec) stated, When I come in the morning, I will run the resident census to see what residents have been transferred to the hospital and then I will send out the facility bed hold policy to the family or responsible party. The AdmRec further stated that she was not familiar with the official policy; she just sent it out. 5. Review of R67's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] and readmission on 06/05/24 with medical diagnoses that included diabetes mellitus and end stage renal failure (ESRD). Review of R67's EMR documented R67 was emergently hospitalized on [DATE], 03/02/24, 04/08/24, and 05/29/24. Review of the EMR and paper chart lacked documentation the resident representative was notified in writing the cost-if any to hold the bed. During an interview on 09/26/24 3:57 PM, the AdmRec explained the process of notification to the family about a resident discharge. She stated each morning the Receptionist checked the census for discharges and clarified each with the Director of Nursing (DON). She stated they checked the census tab in the EMR to confirm payment status and informed the Business Office Manager (BOM) to clarify if payment for bed hold was required. She stated a copy of the facility bed hold policy was not included in the mailing to the resident representative address. The Receptionist stated she was unaware if the documentation about the bed hold notice being placed into the resident's medical record. During an interview on 09/26/24 at 4:12 PM, the BOM explained the Receptionist checked with the BOM to verify amount of payment for Medicare and private pay residents. The BOM stated they provided the amount and followed up with a call to the resident representative to confirm the bed hold. The BOM was unsure if the documentation about the bed hold and cost to hold the bed was placed in the resident's medical record. Review of the facility's policy titled, Bed Hold Notice Upon Discharge, updated 01/15/24, revealed Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: The duration of the state bed-hold policy, if any, during which the resident is permitted io return and resume residence in the nursing facility. The reserve bed payment policy in the slate plan policy, if any .The facility policies regarding bed-hold periods to include following a resident to return to the next available bed .Conditions upon which the resident would return to the facility: In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies. NJAC 8:39-4.1(a)32

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, record review, interview, and facility policy review, the facility failed to ensure a resident's safety during transport to an outside appointment when the resident was dropped off at his personal residence instead of a safe facility return for one of three residents (Resident (R) 298) and the facility failed to ensure safe resident transfers with use of a gait belt for two of three residents (R119 and R121) reviewed for accident hazards of 40 sample residents. This had the potential to place all residents who are dependent on the facility at risk. Findings include: 1. Review of R298's Face Sheet, located in the Profile tab of the electronic medical record (EMR), revealed R38 was admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD), muscle weakness, dysphagia, and difficulty in walking. Review of R298's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/23 located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) of three out of 15 which indicated the resident was severely cognitively impaired. Further review revealed the resident used a wheelchair for mobility and was an extensive assist of one staff with transfers. Review of R298's Care Plan located under the Care Plan tab of the EMR and dated 07/26/23, revealed the resident had impaired cognitive function. Review of R298's Patient Appointment, (hardcopy) dated 07/25/23 and provided by the facility, revealed appointment time was 1:30 PM. The pickup time was at 12:10 PM and the return time was 6:00 PM. It was noted under transport . R298 was dropped off at his home and the address of the resident's home was listed. During an interview on 09/25/24 at 4:32 PM, RN2 said R298 had a cardiologist appointment on 07/25/23 but the transportation company took the resident to his personal residence. She was unsure who notified the facility but thought someone called the transportation company and they said the personal address was the one on file as the drop-off location. She thought the facility requested that the transportation company to go back and pick up the resident and bring him to the facility, but she could not remember anything specifically. During an interview on 09/26/24 at 10:24 AM, Medical Records (MR) stated she spoke with the transport company, and they stated back on 07/25/23 the facility contacted the transportation company at 6:50 PM after the R298 did not return from his appointment. She stated the facility was informed the resident was dropped off at his personal residence. MR stated the previous staff who was the unit clerk/medical records at that time accidentally provided the transportation company with R298's personal address listed on the face sheet instead of the facility address as the drop off location. She said it was the previous unit clerk's error. During an interview on 09/26/24 at 2:25 PM, the Director of Nursing (DON) stated it was a previous Administrator and DON at the time the incident occurred, and she was unaware of what happened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R119's Admission Record located in the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the right, dominant, side. Review of R119's quarterly MDS with an ARD of 06/28/24 and located in the MDS tab of the EMR, revealed the resident was unable to complete a BIMS and the staff assessment for cognition indicated moderately impaired cognition. R119 required substantial/maximal assistance (helper provided more than half the effort) when moving from seated position to standing and during chair/bed-to-chair transfers. Review of R119's Care Plan, last reviewed 08/05/24 and located in the Care Plan tab of the EMR, revealed no information on how R119 transferred. It directed staff to: use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, date initiated 05/09/23. During an observation on 09/25/24 from 10:45 AM to 10:57 AM, Certified Nurse Aide (CNA) 3 and CNA8 transferred R119 from her wheelchair to bed. CNA3 stood on R119's left and CNA8 on the right. Each CNA put an arm under R119's arms and grabbed the back of R119's pants at the waist with the other hand. Pulling on R119's pants and using their arms to steady R119, the CNAs stood R119 and pivoted her to sit on the edge of the bed before they assisted her to lay down for incontinence cares. Following cares, CNA3 and CNA8 then transferred R119 back to the wheelchair using the same technique and no gait belt. During an interview on 09/26/24 at 9:36 AM, CNA2 stated R119 required two staff to assist with transfers. During an interview on 09/26/24 at 9:51 AM, CNA7 reported R119 needed two staff to transfer. CNA7 stated the floor had no gait belts, but she thought one floor still used them. CNA7 stated if any changes occurred in how residents transferred, the therapy department showed the staff how to do the transfer. 3. Review of R121's Admission Record located in the Profile tab of the EMR revealed she was admitted to the facility on [DATE]. Review of R121's quarterly MDS with an ARD of 06/20/24 and located in the MDS tab of the EMR, revealed a BIMS score of zero out of 15 which indicated the resident had severely impaired cognition. R121 required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs, but provided less than half the effort) for transfers. Review of R121's Care Plan, last reviewed 08/05/24 and located in the Care Plan tab of the EMR, revealed an intervention, dated 12/20/2023, that R121 required the assistance of one staff for transfers. During an observation on 09/26/24 at 9:29 AM, CNA2 transferred R121 from wheelchair to bed. Without locking the wheelchair's brakes, CNA2 faced R121, placed both arms under the resident's arms, counted to three, and moved R121 from the wheelchair to the bed. CNA2 did not use a gait belt. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 9:36 AM, CNA2 stated R121 required one person to transfer. She reported she had no gait belt and was unsure if there were any gait belts on the floor she worked. During an interview on 09/26/24 at 10:12 AM, Licensed Practical Nurse (LPN) 3 stated they did not use gait belts. LPN3 stated they let the residents know what they were doing and asked them to help. During an interview on 09/26/24 at 10:31 AM, LPN5 stated the facility did not use gait belts. She stated therapy used them for training. LPN5 was unsure why the facility did not use gait belts. It's not common practice at any facility I've been at. During an interview on 09/26/24 at 11:15 AM, the Director of Nursing (DON) reported the facility did not typically use gait belts for transfers, unless therapy approved them. She thought therapy had not approved one person for gait belt use. During an interview on 09/26/24 at 11:56 AM, the Rehabilitation Director stated that when therapy had recommendations for transferring a resident, they verbally told the charge nurse to update the care plan and Kardex. The Rehabilitation Director stated when a resident had a change in how they transferred, therapy provided an in-service to the CNAs. The rehabilitation director stated unless a resident transferred with contact guard assist and responded well to verbal cues (or used a mechanical lift), she expected staff to use a gait belt for transfers. Review of the facility's undated policy titled, Safe Resident Handling revealed: The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status .Resident lifting and transferring will be performed according to the resident's individual plan of care. NJAC 8:39-33.1(d) 42440

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review and interviews, the facility failed to ensure residents received alternative measures and informed consent with explained risks and benefits was obtained prior to installation for one of one resident (Resident (R) 30) reviewed for side rails of 40 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment. Findings include: Review of R30's undated Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE]. Diagnoses included vascular dementia, depression, bipolar disease, muscle weakness, and anxiety. Review of R30's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/14/24 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident had intact cognition. Review of R30's Care Plan, initiated 08/11/24, located under the Care Plan tab of the EMR, revealed R30 had 1/4 rails to bed for turning and repositioning. Review of R30's Order Summary Report located under the Orders tab of the EMR, revealed an order, dated 02/07/24, 1/4 side rails as an enabler for turning and repositioning in bed. Review of R30's Side Rail Assessment Screening located under the Assessments tab of the EMR, dated 07/15/24, revealed no documented evidence of any alternative measures prior to installation, and no documented evidence of obtained consent for side rail usage. During an interview on 09/26/24 at 10:59 AM, Licensed Practical Nurse (LPN) 4 stated they did not try alternatives prior to side rail use for R30. She stated staff did obtain informed consent and reviewed risks vs benefits and that it would be documented in the resident's hard chart. She reviewed the hard chart and found two forms titled informed consent for use of side rails but neither were filled out or signed. During an interview on 09/26/24 at 1:42 PM, LPN2 stated when staff were assessing residents for side rail use, they asked basic questions and asked about gaps between the side rail and mattress. LPN2 stated he was unsure what alternates would have been used and stated they did not look at alternates. He stated it's either a yes, they use side rails or a no, they did not use them. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 2:16 PM, the Director of Nursing (DON) stated prior to a resident using side rails staff should obtain a consent form that was completed on admission. She stated staff explained the risks versus the benefits of using side rails and had them or their responsible party sign it. She stated they had a Quality Assurance and Performance Improvement (QAPI) that was implemented on 08/08/24 for side rail use. The DON stated they had identified they were not getting informed consents, and they were not being care planned. She stated they only obtained signed consents for the residents on the 100 halls but have not obtained signed consents from residents on the 200 and 300 halls. When she was asked why that was not completed in the last month and a half since the QAPI on side rails was implemented, she was unsure. She confirmed the QAPI did not address the facilities lack of exploring alternates prior to bed/side rail use. NJAC 8:39-27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and facility policy review, the facility failed to ensure medication containers were labeled specific to the resident for two of six medication carts reviewed for correct labeling of medications. As a result of this deficient practice the residents had the potential for residents to receive the wrong medication. Findings include: During an observation on 09/26/24 at 5:13 PM, medication cart one on second floor revealed a box of slow-release iron pills, 45 milligrams (mg) were stored in-between medication punch cards for the resident in 223 with only the room number (223) on the box and a box of slow-release iron 45 mg pills were stored in-between medication punch cards for the resident in 224 with only the room number (224) on the box. Both rooms [ROOM NUMBERS] had residents in bed A and B. The box only had the room number without the A or B designation. During an interview on 09/26/24 at 5:13 PM, Registered Nurse (RN) 4 explained the iron pills were slow-release and the iron pills in the regular floor stock were not slow release so a separate box was placed in with the medication punch cards for the residents in 223 and 224 so the residents would get the correct dose of iron during medication pass. RN4 confirmed the resident name was not on the box, only the room number and should have had the resident name on the box, not just the room number. During an observation on 09/26/24 at 5:13 PM, medication cart two on second floor revealed a bottle of Alaway eye drops (for allergies), located in the drawer with the topical medications, with room [ROOM NUMBER]B written on the box with no resident name. During an interview on 09/26/24 at 5:13 PM, Licensed Practical Nurse (LPN) 6 confirmed the eye drops had only the resident room number and no name. LPN6 was not sure if the eye drops needed a name because they were an over the counter (OTC) medication. During an interview on 09/26/24 at 5:58 PM, the LPN4 confirmed medications with only a room number were not in compliance, including house stock OTC medications. She stated when an OTC was specific for a resident, a resident sticker (located in the front of the paper chart), should be put on the medication/or box to clearly identify the medication was for a specific resident to avoid giving a medication to the wrong resident. During an interview on 09/26/24 at 6:04 PM, the Director of Nursing (DON) confirmed all medications, including OTC, for a specific resident, should have been labeled with the specific resident name, not just the room number. Review of the facility policy titled Labeling of Medication Containers, updated 01/2024, revealed, Labels for over-the-counter drugs shall include all necessary information, such as: a. The original label, b. The resident's name, and the expiration date when applicable . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315134	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Green Knoll	875 Route 202-206 North Bridgewater, NJ 08807

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-29.2 NJAC 8:39-29.4 NJAC 8:39-44.2

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42440 Based on observation, interview, and facility policy review, the facility failed to ensure food prepared by the facility was served at a palatable temperature for five of six residents (Resident (R) 97, R18, R88, R94, and R128) reviewed for palatability of 40 sample residents. As a result of this deficient practice the residents had the potential for poor nutrition and weight loss. Findings include: 1. Review of R97's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/11/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. During an interview on 09/23/24 at 2:12 PM, R97 stated the food was always cold. 2. Review of R18's quarterly MDS assessment with an ARD of 06/16/24, revealed a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. 3. Review of R88's quarterly MDS assessment with an ARD of 09/02/24, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. 4. Review of R94's quarterly MDS assessment with an ARD of 08/26/24, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. 5. Review of R128's quarterly MDS assessment with an ARD of 06/26/24, revealed a BIMS score of six out of 15 which indicated the resident was severely cognitively impaired. During a resident group meeting on 09/25/24 at 3:20 PM, five residents (R18, R88, R94, R97, and R128) of the six residents expressed concerns that the food was cold and tasteless for most meals. They stated they had complained at the monthly council meetings as the issues had been going on for quite a while, but they saw no changes. During an observation on 09/25/24 at 11:22 AM, Dietary Staff (Dietary) 1 checked the temperatures of the food on the steam table. The readings of the main meal included: chicken 153.2 degrees Fahrenheit (F), boiled potatoes 183 degrees F, and broccoli 184 degrees F. Dietary1 then began to plate the food. Dietary staff did not check food temperatures throughout the meal service. During an observation on 09/25/24 at 1:06 PM, Dietary1 finished plating the last resident tray and then plated a test tray of the main meal and provided a facility thermometer to check the temperatures of the food on the test tray. During an observation on 09/25/24 at 1:12 PM, dietary staff brought the wheeled, enclosed cart to the second floor, which included the test tray, and left the cart to return to the kitchen in the basement. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/25/24 at 1:22 PM, as staff passed the last two trays to residents, the temperatures of the food on the test tray were: chicken 130.3 degrees F, potatoes 113.3 degrees F, and broccoli 112.8 degrees F. Human Resources (HR) verified the temperature readings and tasted the food for palatability, spitting out the chicken. During an interview on 09/25/24 at 1:23 PM, HR described the food on the test tray as room temperature and stated it could definitely be warmer. During an interview on 09/25/24 at 1:36 PM, the Regional Dietary Director (RDD) stated the facility needed to do audits to determine why the food temperatures dropped. During an interview on 09/25/24 at 1:41 PM, the Dietary Manager (DM) reported the temperature drops were significant. The DM expected the temperatures to be equivalent to the temperatures displayed on an undated, untitled paper which listed desired temperatures of food by category, hot entrees, starches, and vegetables had a desired temperature range of 140-165 degrees F. The DM stated the facility used heated pellets, which held temperatures for up to 20 minutes. Review of the facility's policy titled, Food Temperature Policy, revised 08/23, revealed All hot food items must be . held and served at a temperature of at least 135 [degrees] F. Take temperatures often to monitor for safe food holding temperature ranges . at or above 135 [degrees] F for hot foods .Temperatures should be taken periodically to assure hot foods stay above 135 [degrees] F . during the portioning, transporting and delivery process until received by the individual recipient .Foods sent to the units for distribution (such as meals, .) will be transported and delivered to maintain temperatures . at or above 135 [degrees] F for hot foods. NJAC 8:39-17.4(a)