STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, NJ 07054

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48423 Based on observations, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that the resident's call light was readily accessible within reach. The deficient practice was identified for 1 of 3 residents, Resident #79, reviewed for accommodation of needs and limited range of motion (ROM). This deficient practice was evidenced by the following: On 11/18/24 at 10:43 AM, the surveyor observed Resident #79 resting in bed and their right arm was elevated on the pillow. The surveyor greeted the resident, and the resident elevated their head of bed with the controller. The resident was unable to speak much at the time of observation. The surveyor observed resident's call bell wrapped around the side rails on resident's right side of bed. The resident was unable to reach it. On 11/20/24 at 11:42 AM, the surveyor observed the resident in their bed and the call bell was wrapped around the right side and the end of the call bell was hung on the right side of the bed. Resident #79's right arm was elevated on the pillow. The surveyor asked the resident if they were able to reach the call bell and resident shook their head sideways indicating No. On 11/20/24 at 12:11 PM, during an interview with the surveyor, the Certified Nursing Assistant (CNA) stated if the resident has a weakness on right side, she would make sure the resident was able to reach the call bell, tv (television) remote and water. The CNA further stated that she would clip the call bell on resident's gown so that resident could use the call bell if in case of emergency or if they needed help. At that time, both the surveyor and the CNA went into the resident's room to observe the call bell. The CNA confirmed the call bell wrapped and hung down from the right sided side rail and that it should be placed within resident's reach. The CNA placed the call light within the resident's reach. On 11/20/24 at 02:39 PM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM) stated if the resident had a right sided weakness. the call bell should be placed on resident's left side otherwise the resident would not be able to use the call bell. The surveyor reviewed the medical records of Resident #79 and revealed: (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Admission Record (admission summary), Resident #79 was admitted to the facility with diagnoses which included but were not limited to, hemiplegia (paralysis/weakness on one side of the body) unspecified affecting right dominant side, aphasia (a language disorder that affects your ability to speak and understand what others say), hypertension (high blood pressure), and type 2 diabetes mellitus. A review of Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 10/11/24, indicated the resident had limitations and impairment on one side of upper extremities (limbs). Further review of MDS, in section I - Active diagnoses indicated Resident #79 was coded for Cerebrovascular Accident (CVA [stroke; sometimes called a brain attack, occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts]), transient ischemic attack (TIA), or stroke and hemiplegia or hemiparesis (is a condition with one-sided muscle weakness). A review of care plan (CP) dated 8/26/22 with a focus that reflected that the resident requires assistance for mobility related to body weakness dx (diagnosis) CVA, right hemiplegia. The CP did not include an intervention to accommodate the needs of the resident due to limited ROM specifically the use of call bell. On 11/21/24 at 12:44 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Assistant Director of Nursing (ADON), the Regional Compliance Advisor (RCA) and Market President of Special Project (MPSP). The surveyor notified the facility management of the above concerns. The ADON acknowledged that the resident should have call bell on their unaffected side. A review of facility's policy, Call Lights, revised on 02/01/23, included that all [company name] patients will have a call light or alternative communication device within their reach at all times when unattended. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing (DON), ADON, Market Clinical Lead and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-27.1 (a)

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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** 38327 Complaint #: NJ#171636 Based on observation, interview, and review of other facility documentation, the facility failed to ensure the facility was maintained in a safe, clean, and homelike environment. This deficient practice was identified for 2 of 4 units, (Unit 1 and Unit 3), and 2 of the common areas, (lobby and Unit 3 tub room). This deficient practice was evidenced by the following: 1. During the initial tour of Unit 1 on 11/18/2024 at 11:18 AM, the surveyor observed Resident #80's room with a posted sign of EBP (Enhanced Barrier Precautions; an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes). There was a strong smell of urine in front of the resident's door. Inside the room, the surveyor observed the resident lying on a specialized air mattress, with an indwelling catheter covered with a privacy bag, and the resident was dry and clean. The resident informed the surveyor that they were not wet and were changed by an aide today. On that same date and time, the surveyor observed the resident's nightstand table with dried whitish substances on top next to the nebulizer machine, the side of the table with dried whitish substances, and the floor with an accumulation of dust and dried brownish substances. Inside the toilet room, the air vent with accumulation of dust and was grayish to blackish. The windows with accumulation of dust inside and outside and with cobwebs. On 11/19/24 at 8:48 AM, the surveyor asked the Assistant Director of Nursing (ADON) and the Regulatory Compliance Advisor (RCA) to go with the surveyor inside the resident's room. Inside the resident's room, there was a strong smell of urine. The surveyor observed the nightstand table, ceiling tiles, and floor the same as it was observed on 11/18/24. The RCA with gloves brushed off the light on top of the resident's bed and there were reddish stains on RCA's gloves and some dust. The toilet room vent was the same with an accumulation of dust. Later, the Director of Maintenance (DM) came and was notified by the ADON and RCA of the concerns with ceiling tiles. The DM stated that the brownish stains on the ceiling tiles were water drip and should have been changed. Outside the resident's room, the surveyor interviewed the RCA and the ADON. The surveyor asked what the strong smell in the resident's room was, the RCA responded that it was an old urine smell. The ADON stated it was urine. The surveyor also asked why the resident's room had multiple brownish stains on the ceiling tiles, there was an accumulation of dust in the night lights, and floors, stains on the nightstand table and toilet room, and the resident's room stains, and both RCA and ADON had no answer. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 12:08 PM, the surveyor interviewed Housekeeper #1 (HK#1), who informed the surveyor that he was aware of the concerns about room [ROOM NUMBER] environment and cleanliness. HK#1 further stated that room [ROOM NUMBER] was cleaned yesterday (11/19/24) after the surveyor's inquiry. On that same date and time, both the surveyor and HK#1 went to room [ROOM NUMBER]. The surveyor and HK#1 observed the floor was clean and with no odor. Inside the toilet room, the air vent was the same when it was observed from day 1 and day 2. The surveyor asked HK#1 how often the vent was being cleaned, and HK#1 responded that usually it was being cleaned by the housekeeper once a week. The windows were not cleaned, it was the same as it was observed from day 1 and day 2. HK#1 stated he would ask the housekeeper to clean it and he acknowledged that if the room was cleaned yesterday, the windows should have also been cleaned. At that same time, the surveyor observed the resident on 113 bed B (near the window) with gauze used as a light string. Outside the room, the surveyor asked HK#1 if it was appropriate for the gauze to be used as a string for the light, and HK#1 did not respond. On 11/21/24 at 12:44 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), ADON, RCA, and Market President Special Project (MPSP). The surveyor notified the facility management of the above concerns about the environment tour from day 1 to 3rd day for room [ROOM NUMBER] where Resident#80 resided. 2. On 11/19/24 at 8:43 AM, the surveyor observed Resident #57 in the atrium during breakfast seated in a wheelchair (w/c). Resident # 57's bilateral w/c armrests with cracks and some areas were covered with white tape. 3. On 11/19/24 at 11:07 AM, the surveyor toured the lobby area (reception area) and the Receptionist was at the desk, there were scattered 20 ceiling tiles with dried brownish discoloration and some with fading brownish colors. The Receptionist stated that the facility was an old facility and Bear with us, we are in the process of painting the walls. The surveyor then asked the DM to meet the surveyors in the lobby area for some inquiries. Later on, the DM came, and the surveyor asked the DM what were those dried brownish and fading brownish discoloration on the ceiling tiles. The DM informed the surveyors that those were from the water leak and that some fading colors were from the spray paint that he used to cover the leak. The surveyor then asked the DM why it was being painted instead of correcting the main problem which was the leak considering the 20 ceiling tiles in the lobby area. The surveyor also notified the concern about room [ROOM NUMBER]'s ceiling tiles. The DM stated that the leak was serviced. 4. On 11/19/24 at 01:39 PM, the surveyor reviewed the last three months' resident council meeting minutes that were provided by the LNHA and revealed: -8/15/24: Housekeeping: fruit flies in room [ROOM NUMBER] -9/16/24: residents would like to know who was responsible for cleaning the outside of the windows and when will it be started. -10/21/24: residents voiced concerns with cleaning outside of residents' windows. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 10:32 AM, the surveyor met with five residents for the resident council meeting. Five out of five residents stated that the windows were not cleaned and acknowledged that it was reported in previous meetings. 5. On 11/20/24 at 11:50 AM, the surveyor and Licensed Practical Nurse (LPN) from unit 3 observed room [ROOM NUMBER] for an environment tour. The residents were not inside the room. Both the surveyor and the LPN observed the windows. The LPN informed the surveyor that the windows with accumulation of dust and some cobwebs. Both the surveyor and the LPN observed the blinds in the windows were blackish due to accumulation of dust and the LPN stated that they should have been cleaned. The surveyor then asked the LPN to check the overhead light and the LPN asked why she had to check it if the windows were dirty and acknowledged that the light fixture would also be dirty. Inside toilet room [ROOM NUMBER], both the surveyor and the LPN observed one missing tile and one broken tile, and the LPN stated that she would report it to the DM. The surveyor asked why there was no toilet paper inside the room, and the LPN responded that she would ask the housekeeper. On 11/20/24 at 11:56 AM, the surveyor and the LPN went to room [ROOM NUMBER]. The residents were not inside the room. The LPN confirmed the five ceiling tiles with dried brownish discoloration and the LPN stated that she was unsure what the discoloration on the ceiling tiles was. The LPN observed grayish and blackish substances in the windows and the LPN stated and acknowledged those were dust and cobwebs. The LPN further stated that should have been cleaned. The surveyor also asked the LPN why there was no privacy curtain in bed A and the LPN had no answer. The surveyor and the LPN exited the room, and both observed brownish stains on the floor and the carpet near the door of room [ROOM NUMBER]. The LPN stated that she was unsure what was the stain between the door and the carpet. 6. On 11/20/24 at 12:14 PM, the surveyor asked HK#1 if the facility had a common shower room. HK#1 immediately accompanied the surveyor to Unit 3 tub room. The surveyor observed the tub room (also known as the shower room) dark and not well-lit, and the air vent above the sink had an accumulation of blackish-grayish substances. The surveyor asked HK#1 to please open the light and he responded that the lights were on already and the reason it was a little dark was because the light on top of the sink was broken. The surveyor asked HK#1 what those blackish-grayish substances on the vent and he were would not respond. On 11/20/24 at 12:27 PM, the surveyor interviewed the LNHA about the room cleaning and environment of the residents in the facility. The LNHA informed the surveyor that the protocol and practice was to clean daily and schedule for deep cleaning and the schedule was posted in the nursing station. The LNHA further stated that my expectation was that the contracted housekeeping company would provide services and maintain the clean environment of the facility. She stated the ceiling tiles should have been replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On that same date and time, the surveyor notified the LNHA of the concern regarding the continuation of the environment tour from day 1 (11/18/24), day 2 (11/19/24) surveyor with the RCA and ADON in room [ROOM NUMBER], and today (11/20/24) with the LPN from unit 3. The surveyor asked the LNHA if it was appropriate to use the gauze in replacement of the light string for Resident #49 in room [ROOM NUMBER], and the LNHA responded that it should be replaced with the better one. The surveyor asked who was responsible for windows inside and outside the room about cleaning, the LNHA responded that it was the responsibility of the contracted housekeeping department as part of their contracts with the facility and that they should be aware of it. The surveyor notified the LNHA of the concern that during the environment tour, HK#1 and HK#2 both stated that it was the housekeeper's responsibility to clean the windows from the inside and that it was the outside vendor's responsibility to clean the outside windows. The surveyor notified the LNHA of the above findings, observations, and concerns in rooms 113, 304, 314, Unit 3 hallway, lobby, and Unit 3 tub room. The LNHA stated that it should not be like that, it should be replaced and repaired. The surveyor showed the picture of the unit 3 tub room, the LNHA confirmed that the tub room vent was not clean and acknowledged that there was an accumulation of dust a grayish substance. On 11/22/24 at 02:24 PM, the survey team met with the LNHA, ADON, RCA, and MPSP. The LNHA stated that the concerns of the surveyor with room [ROOM NUMBER] were corrected and were resolved after the surveyor's inquiry. The MPSP stated that we had scheduled duct cleaning, and we would give you copies of all the documents we explained today including work orders for duct cleaning. The MPSP stated that it should be the contracted housekeeping company's responsibility to clean the windows of residents in the facility both inside and outside. She further stated that as far as the facility knew it was done in August 2024 the window cleaning, but the facility should have checked when it was cleaned. A review of the facility's Resident Rights Under Federal Law Policy with a revision date of 02/01/23 that was provided by the LNHA revealed: Purpose: To treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their self-esteem and self-worth A review of Resident Rights Under Federal Law dated 11/28/16 that was provided by the LNHA included that on #9 Safe Environment: The resident has the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety. The facility must provide: 9.1. A safe, clean, comfortable, and homelike environment, allowing the resident to use their personal belongings to the extent possible . 9.2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 9.3. Clean bed and bath linens that are in good condition . 9.5. Adequate and comfortable lighting levels in all areas . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Detail Cleaning Policy with a revision date of 3/01/24 that was provided by the LNHA revealed: Purpose: To ensure an optimal level of cleanliness of patient rooms and to enhance the overall appearance of their environment . A review of the Patient/Resident Transport Wheelchair Cleaning Policy with an effective date of 3/01/24 that was provided by the LNHA included Process: #4. Perform an inspection of the transport wheelchair for any loose, broken, or damaged areas. Remove damaged wheelchairs from service until repairs are completed. Inspect the following: 4.3. side supports and armrests . On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-31.4(a)

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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. 38327 Based on observation, interview, and review of facility documentation, it was determined that the facility failed to follow its Grievance/Concern policy and procedure by failing to a.) conduct a formal investigation of a grievance filed by a resident, (Resident #42) and followed through, b.) persisted for 4 of 4 resident council meetings regarding laundry services of the facility, and c.) conduct a formal investigation of a grievance filed by a resident to another resident to determine if abuse had occurred for 1 of 1 resident (Resident #45). This deficient practice was evidenced by the following: On 11/18/24 at 10:04 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) for an Entrance Conference. The LNHA informed the surveyor that the facility's census (total number of residents) was 97. 1. On 11/19/24 at 01:39 PM, the surveyor reviewed the last three months resident council minutes that were provided by the LNHA and revealed: -8/15/24: Council Members in Attendance: 10 Compliments/Ideas/Preferences/Concerns/Suggestions: Laundry: residents wanted to know who to contact with missing clothes. The Infection Preventionist Nurse (IPN) checked with the LNHA and told the residents if items were missing, inform any staff member and they will fill out a grievance form, be sure to list the specifics of each item missing. -9/16/24: Council Members in Attendance: 7 Discussion of Old/Unfinished Business (include resolution of previous concerns) *There was no response for the last month 8/15/24 concerning laundry issues. Reviewed laundry details and what shift was assigned to take the dirty laundry out of the room and what shift was assigned to bring in clean clothes. -10/21/24: Council Members in Attendance: 11 Discussion of Old/Unfinished Business (include resolution of previous concerns) (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The missing baseball hat was not located but the resident purchased a new one. Compliments/Ideas/Preferences/Concerns/Suggestions: -no one assumes responsibility for laundry concerns and passes it off to other depts (departments). -The resident council voted to write a petition to the corporate office to reinstate laundry in the building due to the many unresolved issues and concerns they have and the cleanliness of their clothes. -The new Grievance Officer (GO) reiterated that a resident can ask any staff member to assist in completing a grievance, it was not just filled out by the GO. -The 11:00 PM-7:00 AM (11-7) shift was still not taking dirty laundry out to the bins. Further review of the above resident council meeting minutes revealed that the typewritten report was not signed by facility representatives or the resident council members. On 11/20/24 at 10:32 AM, the surveyor met with five residents for the resident council meeting. Resident #27 informed the surveyor that the concern with laundry services continued, we were not aware of where to go when there were laundry concerns, and no go-to person. Five out of Five residents confirmed the ongoing laundry services problem with missing clothes, not receiving their own clothing, mixed matches, and dirty clothes. All residents stated that the residents in the facility had sent out a petition to the corporate office to have the in-house laundry back due to continued problems with laundry services. Resident #54 stated that they had the same problem before, although right now had no issues because they were currently at Skilled Occupational Therapy (OT) wherein their laundry was being done in therapy as part of their treatment. Resident #54 acknowledged that after the OT sessions, they would not be able to do laundry in the therapy room anymore and would go back to offsite laundry services. Resident#52 stated that a couple of times reported that they were missing clothes and Resident #60 reported two pairs of socks a few months back and the facility did not respond to resident updates on missing items. On that same date and time, Resident#42 stated a month ago no clothes to put on, and the 7:00 AM to 3:00 PM (7-3) nurse in Unit 3 was notified of the concerns and helped the resident to find clothes to wear to be able to get up of bed. Residents #52 and Resident #27 confirmed the allegation that Resident #42 had no clothes to put on due to laundry concerns and the nurse at that time was upset and had to find Resident #42 pants to wear. (continued on next page)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the facility-provided resident council meeting minutes revealed that there was no resolution or follow-through with the above concerns on the 8/15/24 grievance voiced by the complainant. On 11/19/24 at 01:54 PM, the surveyor asked the LNHA about the 8/15/24 Resident Council Minutes that reported to Nursing about the complainant's concerns. The surveyor asked if the grievance was filed and the incident was investigated, and the LNHA stated that she would get back to the surveyor. On 11/20/24 at 8:32 AM, the LNHA stated that the incident on 8/15/24 about the complainant was not a thorough investigation and was not resolved. The LNHA stated that still in the process of investigation after the surveyor's inquiry. The LNHA stated that the residents in the concerns were Resident # 45 (the complainant), Resident # 52 (roommate), and Resident #150. The surveyor asked what the facility's policy and process for grievance was. The LNHA stated that she had to check their policy. The LNHA stated that as the standard of practice if it was a questionable abuse, it should be investigated immediately. On 11/21/24 at 12:44 PM, the survey team met with the LNHA, Assistant Director of Nursing (ADON), Regional Compliance Advisor (RCA), and Market President Special Project (MPSP). The surveyor notified the facility management of the above findings about Resident Council Meeting concerns with laundry, missing clothes, and the complainant's concerns. The surveyor asked if there should be a grievance for Resident#54 about clothes, and the LNHA and RCA stated that there should be a grievance. The surveyor notified them that when the surveyor reviewed the provided Grievance binder from January through November 2024, there was no grievance filed when Resident #54 and Resident #45 voiced concerns. On 11/22/24 at 02:24 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The LNHA stated that the grievances of five residents' concerns with no resolutions, we had an emergency resident council meeting today with the presence of the contracted laundry company representative and discussed the concerns. At that same time, the RCA informed the surveyor that the facility conducted the facility wide investigation and interviews of residents and reached out to families as well with regard to the concerns with laundry services and missing clothes. The ADON was unable to identify the exact date of the grievance voiced by Resident #54. The facility management confirmed that there was no grievance initiated by the RN for resident#54 and the RN should have initiated the grievance to further investigate and resolve the concerns. The LNHA stated that education was done to all staff about grievance and reportable events abuse allegation. A review of the facility's Grievance/Concern Policy with a revision date of 10/15/24 that was provided by the LNHA revealed: Policy: All patients and/or their representatives may voice grievances/concerns and recommendations for changes. Service location leadership will investigate, document, and follow up on all concerns and grievances registered by any patient or patient representative. Social Services personnel will serve as patient advocates in the grievance/concern process. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process, including Civil Rights grievances/concerns, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, for example, the identity of the patient for those grievances submitted anonymously, issuing written grievance decisions to the patient, and coordinating with state and federal agencies, in consultation with the National Law Department, as necessary in light of specific allegations. Purpose: To assure prompt receipt and resolution of patient or representative grievances/concerns. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor, and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-4.1(a)5,11, 12; 13.2(c)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48423 Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure reference checks were completed for 2 out of 10 newly hired staff (Staff #2 and #6) prior to their start date of employment. This deficient practice was evidenced by the following: The surveyor reviewed ten randomly selected new employee files. The review for reference checks for 2 of the 10 new employees revealed the following: -Staff #2's file, a Licensed Nursing Home Administrator (LNHA) who was hired on 7/03/23, revealed no reference checks in their file. -Staff #6's file, a Nursing Assistant (NA) who was hired on 9/27/24, revealed no reference check in their file. On 11/25/24 at 12:20 PM, during an interview with the surveyor, the Staffing Coordinator (SC) stated minimum of 2 reference checks were required before the date of hire. SC further stated the recruiter was responsible to check the reference checks and then SC would double check the files. In the presence of the surveyor, the SC checked the employee files and acknowledged that the 2 newly hired staff did not have a reference check completed. On 11/25/24 at 01:12 PM, the survey team met with LNHA, Director of Nursing (DON), Assistant Director of Nursing (ADON), Regulatory Compliance Advisor (RCA), and Market Clinical Lead (MCL) The surveyor notified the facility management of the above concerns. There was no additional information provided by the facility. A review of facility's policy, Hiring, revised on 7/01/22, included, Process:1.2.2-Check at least two professional references. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, DON, ADON, MCL and the RCA for an exit conference. The facility management did not refute the findings. N.J.A.C 8:39-9.3 (b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38327 Based on the interview, record review, and review of other facility provided documents, it was determined that the facility failed to report an allegation of Abuse/Neglect to the New Jersey Department of Health (NJDOH) in the required timeframe for 1 of 4 sampled residents, Resident #45, reviewed for abuse. This deficient practice was evidenced by the following: On 11/19/24 at 01:39 PM, the surveyor reviewed the last three months' resident council minutes that were provided by the Licensed Nursing Home Administrator (LNHA) and revealed: -8/15/24: Council Members in Attendance: 10 Compliments/Ideas/Preferences/Concerns/Suggestions: Nursing: A resident awoke another resident and tried to get into their bed. The complainant resident asked the other resident to leave and would not. The complainant's roommate stayed with the complainant until nursing came, and not the first time the resident visited the complainant's room. Further review of the facility-provided resident council meeting minutes revealed that there was no resolution or follow-through with the above concerns on the 8/15/24 grievance voiced by the complainant. On 11/19/24 at 01:54 PM, the surveyor asked the LNHA about the 8/15/24 Resident Council Minutes that reported to Nursing about the complainant's concerns. The surveyor asked if the grievance was filed and the incident was investigated, and the LNHA stated that she would get back to the surveyor. The surveyor reviewed the medical records of Resident #45 and revealed: The Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to, unsteadiness of the feet, need for assistance with personal care, and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) with dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk), with fluctuations. The most recent quarterly Minimum Data Set (MDS) with an assessment reference date of 6/07/24 revealed that the section for cognition was not assessed or attempted. A Review of the Progress Notes, documented as a Late Entry Care Plan Meeting with an effective date of 6/20/24 was created on 6/24/24 by Social Services revealed that Resident #45 was alert and oriented with confusion, however, the resident was able to verbalize her needs and concerns. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 8:32 AM, the LNHA stated that the incident on 8/15/24 that was reported by the resident was not a thorough investigation and was not resolved. The LNHA stated that still in the process of investigation after the surveyor's inquiry. The surveyor asked what the facility's policy and process for grievance was. The LNHA stated that she had to check their policy. The LNHA stated that as the standard of practice if it was a questionable abuse, it should be investigated immediately. The LNHA confirmed that the incident was not reported to the NJDOH within two hours and should have been reported. She further stated that it was now reported to NJDOH after the surveyor's inquiry. On 11/21/24 at 12:44 PM, the survey team met with the LNHA, Assistant Director of Nursing (ADON), Regional Compliance Advisor (RCA), and Market President Special Project (MPSP). The surveyor notified the facility management of the above findings that Resident #45, who was cognitively impaired, and the reported incident was not reported timely to the NJDOH. On 11/22/24 at 02:24 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The LNHA stated that education was done to all staff about grievance and reportable events abuse allegation, facility management confirmed that it should be reported to the NJDOH within 2 hours for Resident #45. A review of the facility's Abuse Prohibition Policy with a revision and review date of 10/24/22 that was provided by the LNHA revealed: Policy: .Centers also strive to comply with the Elder Justice Act (EJA). Under the EJA, employees are designated as mandated reporters and are obligated to immediately report any reasonable suspicion of a crime against a patient . The Center will implement an abuse prohibition program through the following: -Identification of possible incidents or allegations which need investigation; -Investigation of incidents and allegations; -Protection of patients during investigations; and -Reporting of incidents, investigations, and Center response to the results of their investigations Process: 1. The Administrator, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property. The Center must ensure that all staff are aware of reporting requirements and must support an environment in which covered individuals report a reasonable suspicion of a crime . 7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following. 7.1. Enter allegation into the [electronic] risk management portal. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7.2 Report allegations involving abuse not later than 2 hours after the allegation is made . 9. The Administrator or designee will: 9.2 Report findings of all completed investigations within 5 working days to the Department of Health using the state on-line reporting system or state-approved forms. A review of Resident Rights Under Federal Law dated 11/28/16 that was provided by the LNHA included that on #10 Grievances: 10.4.4. Immediate reporting of alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the Administrator of the provider, and as required by state law; A review of the facility's Detail Cleaning Policy with a revision date of 3/01/24 that was provided by the LNHA revealed: A review of the facility's Grievance/Concern Policy with a revision date of 10/15/24 that was provided by the LNHA revealed: Policy: All patients and/or their representatives may voice grievances/concerns and recommendations for changes. Service location leadership will investigate, document, and follow up on all concerns and grievances registered by any patient or patient representative. Social Services personnel will serve as patient advocates in the grievance/concern process. The Administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process, including Civil Rights grievances/concerns, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, for example, the identity of the patient for those grievances submitted anonymously, issuing written grievance decisions to the patient, and coordinating with state and federal agencies, in consultation with the National Law Department, as necessary in light of specific allegations. Purpose: To assure prompt receipt and resolution of patient or representative grievances/concerns. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor, and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-9.4(f)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 46049 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 24 residents, (Residents #14, #45, #68, #79 and #81), reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: According to the CMS (Centers for Medicare & Medicaid Services) MDS 3.0 RAI (Resident Assessment Instrument) Manual of October 2023, Section C Cognitive Patterns, Coding Tips o Attempt to conduct the interview with ALL residents. This interview is conducted during the seven-day look-back period (the period over which the resident's condition or status is captured by the MDS assessment) of the Assessment Reference Date (ARD) . The latest version of the CMS - RAI 3.0 Manual (updated October 2023), Chapter 3-page C-2, under C0100 Coding Instructions read: .Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available . Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. 1. The surveyor reviewed the medical records of Resident #14 which revealed the following: The resident's Admission Record (AR; a summary of important information about the resident) revealed that Resident #14 had diagnoses that included, but were not limited to, chronic kidney disease, dementia, schizophrenia, and bell's palsy (sudden weakness in the muscles on one side of the face). A comprehensive Minimum Data Set (cMDS) with ARD of 10/07/24, under section B, B0700, Makes Self Understood and B0800, Ability to Understand Others it was coded that the resident 1. Usually understands. Under Section C- Cognitive Patterns, C0100, Should Brief Interview for Mental Status [BIMS] (C0200-C0500) be Conducted? it was coded 0. No (resident is rarely/never understood). A BIMS evaluation note written by a Licensed Practical Nurse (LPN) dated 10/07/24, indicated a BIMS was conducted with the resident. On 7/10/24 at 12:15 PM, the surveyor interviewed the Reimbursement Clinical Coordinator (RCC) about completing MDS assessments' section B and section C. The RCC stated that if a resident was coded as being able to sometimes understand in Section B, a BIMS should be attempted for a resident in Section C. The surveyor reviewed with the RCC Resident #138's MDS assessments. The surveyor discussed the concern of hospice care not being coded for the resident and the inconsistency of section B and section C coding for the resident. The RCC stated she would review and provide further information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/24 at 01:03 PM, the surveyor interviewed the RCC about completing MDS assessments' section B and section C. The surveyor asked the RCC if for a resident that was usually understood should a BIMS test be attempted. The RCC replied, yes. The surveyor discussed the concern for the inconsistency of section B and section C for the resident. On 11/22/24 at 02:24 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Assistant Director of Nursing (ADON), the Market President of Special Projects (MPSP), and the Regional Compliance Advisor (RCA) about the concern the coding of sections B and C of the MDS. On 11/25/24 at 01:12 PM, the LNHA, the Director of Nursing (DON), the ADON, and the RCA met with the survey team. The RCA stated the Regional MDS Coordinator provided education to staff. There was no additional information provided by the facility. 38327 2. The surveyor reviewed the medical records of Resident #45 and revealed: The AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to, unsteadiness of the feet, need for assistance with personal care, and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) with dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk), with fluctuations. The most recent quarterly Minimum Data Set (qMDS) with an ARD of 6/07/24 revealed that Section C for cognition was not assessed or attempted. Section C was electronically signed (was done) by the RCC on 6/21/24 at 10:41 PM, 14 days after the ARD. The most recent cMDS with an ARD of 9/07/24 revealed that Section C was not attempted, the RCC electronically signed on 9/18/24 at 10:44 AM, 11 days after the ARD. A Review of the Progress Notes (PN), documented as a Late Entry Care Plan Meeting (CPM) with an effective date of 6/20/24 was created on 6/24/24 by Social Services (SS) revealed that Resident #45 was alert and oriented with confusion, however, the resident was able to verbalize her needs and concerns. On 11/20/24 at 12:59 PM, the surveyor met with RCC. The RCC informed the surveyor that she was not responsible for answering Section C of the MDS, it was the responsibility of the Director of Social Services (DSS). The RSS stated that if the DSS was unavailable and the MDS was due for transmission, as an MDS Coordinator, she would sign Section C, and that was why her name was reflected in Section C. She further stated that the UDA (User Define Assessment) that was done in the electronic medical records of the resident would auto-populate to the MDS and that she would not verify the accuracy of the response in Section C, that would be the responsibility of who entered the information in UDA that auto-populated in the MDS that the RCC signed off in the absence of the DSS. The RCC acknowledged that a Section C interview should be attempted, and the interview done within the lookback period. She further stated that the facility had no separate policy for MDS and the facility followed the RAI Manual. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 01:14 PM, the surveyor interviewed the DSS, who informed the surveyor that she was responsible for answering the Sections C, D, E, Q, and Section V that populated in the CAA (Care Area Assessment) of the MDS. The surveyor asked about Resident #45 and the DSS responded that the resident was alert with confusion and able to verbalize needs. The surveyor asked the DSS why the MDS on 6/07/24 and 9/07/24 were coded as not assessed on Section C and were done after the ARD look-back period. The DSS stated that Section C should be attempted and not to code not assessed. The DSS stated she was unsure why it was coded as not assessed but it should be assessed. The DSS also stated that the UDA should have been done within the ARD lookback period and not after the ARD, which will auto-populate to the MDS. On 11/21/24 at 12:44 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The surveyor notified the facility management of the above findings that Resident #45's MDS was done after the ARD and was coded not assessed in Section C. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor (MCA), and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. 48423 3. On 11/18/24 at 10:30 AM, the surveyor observed Resident #68 awake while resting in their bed. The resident was watching television. The surveyor reviewed the medical records of Resident #68 and revealed: The AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to insomnia, need for assistance with personal care, and muscle weakness. A review of qMDS with an ARD of 8/08/24, under Section B0700. Makes Self Understood- Ability to express ideas and wants, consider both verbal and non-verbal expression- reflected Code 0 which indicated: 0.) Understood. Review of Section C - Cognitive Pattern did not reflect Resident #68's BIMS score. Further review of MDS question C0100: Should BIMS (C0200-C0500) be conducted? Reflected Code 0 which indicated No (resident is rarely/never understood) 'Skip to and complete C0700-C1000, Staff Assessment for Mental Status. Section C interview was not attempted and BIMS was not done. Further review of qMDS revealed that Section C was electronically signed by the SS on 8/21/24, 13 days after the ARD. A review of the PN titles as CPM dated 8/22/24, created by SS revealed that Resident #68 was alert and oriented. The Resident tried to verbalize their needs and concerns. The Resident sometimes understood and they understands. 4. On 11/18/24 at 10:43 AM, the surveyor observed Resident #79 resting in their bed. The surveyor greeted the resident, and the resident elevated their head of bed with the controller. The resident was not able to speak much at the time of observation. The surveyor reviewed the medical records of Resident #79 and revealed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The AR revealed that Resident #79 was admitted to the facility with diagnoses that included but were not limited to, hemiplegia (paralysis on one side of the body), hypertension (high blood pressure), and type 2 diabetes mellitus. A review of qMDS with an ARD of 10/11/24, under Section B0700. Makes Self Understood- Ability to express ideas and wants, consider both verbal and non-verbal expression- reflected Code 0 which indicated: 1.) Usually Understood- difficulty, communicating some words or finishing thoughts but is able to if prompted or given time. Review of Section C - Cognitive Pattern did not reflect Resident #79's BIMS score. Further review of qMDS question C0100: Should BIMS (C0200-C0500) be conducted? Reflected Code 0 which indicated No (resident is rarely/never understood) 'Skip to and complete C0700-C1000, Staff Assessment for Mental Status. Section C was not attempted and that BIMS interview was not conducted. Further review of MDS revealed that Section C was electronically signed (was done) by the SS on 10/24/24, 13 days after the ARD. A review of PN documented as a Late Entry N Adv- BIMS Evaluation with an effective date of 10/11/24 was created on 10/29/24 by SS revealed that BIMS should not be conducted. (Resident is rarely/never understood). Complete staff assessment for mental status. Resident was unable to complete BIMS. Seems or appears to recall after 5 minutes: Memory problems. Seems or appears to recall long past: Memory problem. None of the above recalled. 5. On 11/18/24 at 10:27 AM, the surveyor observed that Resident #81 was not in their. The Resident's bed was made. The surveyor reviewed the medical records of Resident #81 and revealed: The AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to, schizophrenia (a serious mental disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder, muscle weakness and hypertension (high blood pressure). A review of cMDS with an ARD of 10/22/24, under Section B0700. Makes Self Understood- Ability to express ideas and wants, consider both verbal and non-verbal expression- reflected Code 1 which indicated: 1.) Usually Understood- difficulty, communicating some words or finishing thoughts but is able to if prompted or given time. Review of Section C - Cognitive Pattern did not reflect Resident #81's BIMS score. Further review of qMDS question C0100: Should BIMS (C0200-C0500) be conducted? Reflected Code 0 which indicated No (resident is rarely/never understood) 'Skip to and complete C0700-C1000, Staff Assessment for Mental Status. Further review of MDS revealed that Section C was electronically signed by the RCC on 10/31/24, 9 days after the ARD. A review of PN documented as a Late Entry N Adv- BIMS Evaluation with an effective date of 10/16/24 was created on 10/20/24 by SS revealed that BIMS should not be conducted. (Resident is rarely/never understood). Complete staff assessment for mental status. Resident was able to complete BIMS. On 11/22/24 at 10:57 AM, during an interview with the surveyor, the RCC stated, Yes, BIMS would be attempted for everyone except if a resident is in coma. The surveyor discussed the concern for the inconsistency of section B and section C for Residents #68, #79, and #81 mentioned above. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/25/24 at 01:12 PM, the survey team met with LNHA, DON, ADON, RCA and MCL. The surveyor notified the facility management of the above findings for Resident #68, Resident #79, and Resident #81's MDS were done after the ARD and inaccuracy between Section B and C and Section C was not attempted. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, DON, ADON, MCA and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-11.1; 33.2 (d)

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Troy Hills Center	200 Reynolds Ave Parsippany, NJ 07054

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46049 REPEAT DEFICIENCY Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to a.) ensure accurate documentation of treatment administration and follow wound consultant recommendations for 1 of 1 resident, Resident #15, reviewed for pressure ulcer, b.) follow a PO with regard to vital signs for 1 of 24 residents, Resident #68, and c.) clarify the physician's order with regard to pain medication for 1 of 24 residents, Resident #80, according to the standard of clinical practice. 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 11/25/24 at 9:16 AM, the surveyor reviewed the paper and electronic medical record (EMR) of Resident #15. The Admission Record (AR; admission summary) documented that the resident had diagnoses that included but were not limited to, Alzheimer's disease, anxiety disorder, and pressure-induced deep tissue damage of left heel. The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 9/14/24, indicated the facility assessed the resident's cognition using a brief interview for mental status (BIMS) test. Resident #15 scored a 3 out of 15, which indicated the resident had severe cognitive impairment. In Section M-Skin Conditions of the MDS revealed the resident was coded as having an unstageable deep tissue injury (DTI). A physician's order (PO) dated 8/18/24 documented, left heel DTI wound care every day and evening shift to cleanse wound with NS [normal saline], pat dry, do not scrub or use excessive force, apply skin prep and LOTA [Leave open to air]. A PO dated 3/28/22 documented, skin check every Monday 7-3 shift on shower days. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO dated 6/16/24 documented, low air loss mattress while in bed; check every shift for function. A PO dated 02/24/24 documented, moisture barrier-apply every shift to peri-area buttocks. A PO dated 7/26/24 documented, zinc oxide external paste, apply to sacrum topically in the morning for wound care; cleanse wound with NS, pat dry, do not scrub or use excessive force, apply zinc oxide and LOTA. A review of the October 2024 electronic Treatment Administration Record (eTAR) revealed the nurse did not sign the eTAR to indicate the treatments were administered to the resident on the following days: 10/01/24 7:00 AM (7 AM)-3:00 PM (3 PM) (day) shift, 10/04/24 day shift, 10/19/24 3 PM- 11:00 PM (3 PM) (evening) shift, 10/28/24 day shift, 10/29/24 day shift, 10/30/24 day shift, and 10/31/24 day shift. A review of the November 2024 eTAR revealed the nurse did not sign the eTAR to indicate the treatments were administered to the resident on the following days: 11/02/24 day shift, 11/03/24 day shift, 11/04/24 day shift, and 11/06/24 day shift. On 11/25/24 at 8:54 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN) about Resident #15's wound care. The IPN stated that the resident's left heel wound had healed and the treatments the resident was receiving were preventive measures. The surveyor asked the IPN about documenting in the eTAR by the nurses. The IPN replied that it was expected for the nurses to document when a treatment was administered and when a treatment was not. She further acknowledged that entries on the eTAR should not be left blank. The surveyor discussed the above concerns found for the resident's eTAR. The IPN stated she would have to review to provide further information. On 11/25/24 at 01:41 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), the Regulatory Compliance Advisor (RCA), the Assistant Director of Nursing (ADON), and the Market Clinical Lead (MCL) about the above concern for multiple entries for Resident #15's October 2024 and November 2024 eTAR not signed by nurses. There was no additional information by the facility. A review of the facility's Medication Administration General Guidelines Policy, dated 01/2024. Under Procedure, Medication Administration it documented: 1. Medications are administered in accordance with written orders of the prescriber . A review of the facility's Skin Integrity and Wound Management Policy with a last revised date of 10/15/24. Under Practice Standards 6.13, it documented to implement special wound care treatments/techniques, as indicated, and ordered. The policy did not further address documentation in the TAR. 48423 2. On 11/18/24 at 10:30 AM, during the initial tour, the surveyor observed Resident #68 resting in their bed. The resident was awake and watching TV. The surveyor greeted the resident. Resident #68 was able to communicate with the surveyor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the medical records of Resident #68 and revealed: According to the AR, the resident was admitted to the facility with diagnoses which included but were not limited to insomnia, Multiple Sclerosis [MS] (is an autoimmune disorder, meaning that in MS the immune system-which normally protects us from viruses, bacteria, and other threats-mistakenly attacks healthy cells), need for assistance with personal care, and muscle weakness. A review of the Order Summary Report (OSR) revealed a PO: Vital signs (v/s; clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions) daily every evening shift for protocol with a start date 10/20/2024. The above PO was transcribed to the October 2024 electronic Medication Administration Record (eMAR) and signed by nurses as completed with a checkmark next to their initials without documented evidence that the v/s was obtained according to the PO. A review of the BP (blood pressure) Summary, from the Weights and v/s Summary tab, did not include v/s from October 20th to October 31st. November 2024 which reflected eight entries, out of which three were the same entries for 11/13/24 as follows: Dates Time BP Heart Rate Temperature Respirations 11/12/24 9:22 PM 144/94 73 98.2 No entry 11/13/24 8:25 PM 138/87 76 98.4 18 11/13/24 9:35 PM 138/87 76 98.4 17 11/13/24 9:36 PM 138/87 76 98.4 17 11/15/24 7:36 PM 123/78 69 97.0 18 11/17/24 8:11 PM 126/79 71 97.0 18 11/20/24 9:24 PM 128/76 74 97.5 18 11/21/24 9:04 PM 123/68 70 97.7 18 There was no documented evidence for v/s entries for 15 days out of 21 days until November 21st. On 11/20/24 at 02:45 PM, during an interview with the surveyor, Licensed Practical Nurse #1 (LPN#1) stated if there was a PO order to check v/s then she would check the v/s. The LPN further stated that the v/s were entered in eMAR and then would pop up in the v/s tab. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 11:22 AM, during an interview with the surveyor, the Registered Nurse (RN) explained if she saw a PO as v/s daily as per protocol that means we have to take v/s daily. The RN further stated that she would perform resident's v/s and entered them in eMAR, and v/s would show up in v/s section under Weight and v/s Summary tab. The surveyor reviewed Resident # 68's order in the eMAR in presence of the RN. The RN stated Since I have been here, the protocol has been different for Long-term care (LTC) than Short-term care (STC) and we do not do v/s daily in LTC. The RN further stated that she had modified the order on 10/20/24 to do v/s in the evening and explained the process to the surveyor that the staff performed v/s on B bed in the evenings. The RN further stated that after the modification, the evening shift should be able to enter the v/s now. On 11/21/24 at 12:00 PM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM) stated the nurses were expected to check resident's v/s if they saw a PO as mentioned above. The RN/UM further stated that if the nurses were not able to enter the v/s in eMAR then they should go into v/s tab and enter them separately. On 11/21/24 at 12:44 PM, the survey team met with the LNHA, ADON, RCA and the Market President Special Project (MPSP). The surveyor notified the facility management of the above concerns. The ADON acknowledged that the nurses should followed the PO. 38327 3. During the initial tour of Unit 1 on 11/18/2024 at 11:18 AM, the surveyor observed Resident #80's room with a posted sign of EBP (Enhanced Barrier Precautions; an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes). The surveyor observed the resident lying on a specialized air mattress, with an indwelling catheter covered with a privacy bag, and the resident was dry and clean. The surveyor reviewed the medical records of Resident #80 and revealed: The AR revealed that the resident was admitted to the facility with the following medical diagnoses that were not limited to abnormal posture, chronic obstructive pulmonary disease (COPD; a condition caused by damage to the airways or other parts of the lung), peripheral vascular disease (PVD; a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), and pressure ulcer of sacral region stage 4 (the largest and deepest of all bedsore stages). The most recent comprehensive MDS with an ARD of 9/29/24, under Section Cognitive Patterns revealed a BIMS score of 15 out of 15 which reflected that the resident had intact cognition. Section J Health Conditions reflected that the resident had mild occasional pain. A review of the November 2024 OSR revealed: -Oxycodone-Acetaminophen tablet (tab) 5-325 mg (milligram) Give 1 tab by mouth every 6 hours as needed (PRN) for severe pain medicate 30 minutes prior to wound care-Start Date 11/18/2024. -Oxycodone-Acetaminophen Tab 5-325 mg Give 1 tab by mouth one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) for 30 minutes prior to wound care-Start Date 11/20/2024 The above two orders for Oxycodone-Acetaminophen were transcribed in the November 2024 eMAR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 8:48 AM, the surveyor asked the ADON for the November 2024 OSR and eMAR copies. The ADON stated that she would get back to the surveyor. On 11/20/24 at 02:02 PM, the surveyor interviewed LPN#2 regarding the resident's pain med orders. The LPN acknowledged the concerns with Oxycodone-Acetaminophen orders and stated that the PRN order for Oxycodone should have been clarified to separate the PRN every 6 hours from 30 minutes prior to wound treatment. She also acknowledged that the order was duplicated for 30 minutes prior to wound treatment. On 11/21/24 at 12:44 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The surveyor notified the facility management of the above concerns about Resident#80's Oxycodone orders. A review of the facility's Physician Orders with a revision date of 7/18/24 that was provided by the LNHA did not include information about clarification of orders. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, MCL, and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-11.2(b); 29.2(d)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48423 Complaint #NJ171636 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices by failing to a.) provide meal, meal set up, and notify the physician and Resident Representative of significant weight loss for 1 of 24 residents (Resident #21), and b.) for care of 1 of 24 residents, Resident #57, with regard to medication and diagnosis for seizure for a total of three months. 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 11/18/24 at 10:57 AM, Surveyor #1 (S#1) observed Resident #21 in their bed. Resident was awake and was talking to themselves. The surveyor observed an untouched breakfast tray on the tray table, at a distance. S#1 asked the resident if they had eaten the breakfast. Resident #21 stated all they do is drop off a tray and leave. The resident further stated, I want somebody to help me to set up tray and I was able to feed myself. The resident stated that they had weight loss. At 11:57 AM, S#1 observed resident's door closed, the surveyor knocked on the door and two staff members were providing care to the residents. At 12:34 PM, S#1 checked back on Resident #21. The resident informed the surveyor that they were waiting for their lunch tray. S#1 observed the breakfast tray on the dresser and the resident informed the surveyor that the staff fed them breakfast and it was a cold french toast. The surveyor asked if the food was warmed up before the staff fed them and the resident replied back by saying No, I did not say anything. I kept quiet and ate it. At 12:37 PM, following exit from the resident's room, S#1 observed the lunch tray truck in the middle of the hallway of 3rd wing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:51 PM, S#1 asked Surveyor #2 (S#2) to check the name on the lunch slip for the tray that was on the food truck and S#2 stated it was for Resident #21. At 01:04 PM, S#2 accompanied S#1 to resident's room and the resident stated, I am waiting for lunch. Upon exiting the resident's room, the surveyors observed the Certified Nursing Aide (CNA) pushed the food truck out of wing 3 and towards the Atrium. S#2 asked the CNA if all the residents were done eating and the CNA stated Yes. The CNA further stated that she had collected all the lunch trays from resident's rooms. At 01:16 PM, S#1 observed Resident #21's used the call bell to call for staff. At 01:22 PM, S#1 observed the CNA went to answer the call light and was coming out of resident's room with their breakfast tray. At 01:23 PM, S#1 interviewed the CNA who stated, all the residents have received their lunch trays and no residents had refused their meals. She further explained when meal trays are passed she would help residents with set up as needed. She stated they had not provided Resident #21 with their lunch tray due to another employee assisting with tray passing, but Resident #21 always eats their lunch. At 01:40 PM, S#1 interviewed the Registered Nurse (RN). The RN stated, following the CNA's passing out the meal trays, the nurses check that all the residents had received trays, and will assist will putting finished trays on the tray cart. At 01:46 PM, S#1 and the RN checked the food truck and the tray that had been picked up. The RN took the tray from the food truck, uncovered the tray that belonged to Resident #21. The RN stated, it was untouched tray. The RN further stated she did not know what happened and went to speak with the RN/Unit Manager (RN/UM). At 01:55 PM, the RN acknowledged that the CNA and I should have made sure that the resident received their lunch tray. At 02:16 PM, S#1 met with the RN/UM and notified of the above-mentioned concerns for Resident #21. The RN/UM stated all the residents need to get their trays on time. The RN/UM further stated that no one wants to eat cold food and the trays should be given at the same time. S#1 reviewed the medical records of Resident #21 and revealed: The Admission Record (AR; an admission summary) included that the resident was admitted to the facility with the following medical diagnoses (dx) that were not limited to depression, hyperlipidemia (abnormally high levels of fats (lipids) in the blood), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain) with anxiety, and Parkinson's disease (an age-related degenerative brain condition, meaning it causes parts of your brain to deteriorate [worsens]) with dyskinesia (uncontrollable and involuntary movements which means when your body moves in ways you cannot control), with fluctuations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 8/15/24, reflected Resident #21's brief interview for mental status (BIMS) score of 12 out of 15, which reflected that the resident had moderately impaired cognition. Further review of MDS indicated the resident required setup or clean up assistance with eating and Section K resident's weight was 133 Lbs (pounds) A review of comprehensive MDS (cMDS) with an ARD of 5/15/23 reflected Resident #21's Section GG for Functional abilities and goals that resident required partial/moderate assistance with eating. Further review of MDS revealed resident's weight was 208 Lbs. A review of qMDS with an ARD of 11/15/23 reflected Resident #21's Section GG that resident required setup or clean-up assistance with eating. Further review of MDS revealed in Section K resident's weight was 168 Lbs and had a significant weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, and was not on a physician prescribed weight loss regimen. A review of nursing Progress Note (PN) Type: Weight change dated 9/21/23 at 9:37 PM that the dietitian notified of weight loss and will notify MD (physician) in am (morning) due to continued weight loss. A further review of PN did not reflect any physician notes in correspondence to weight loss. On 11/22/24 at 01:01 PM, S#1 interviewed the Registered Dietitian (RD). The RD stated CNAs would monitor and document resident's weights in the weight sheets and then nursing or the RD would enter the weights in the Electronic medical records (EMR). If RD observed a significant weight loss, then she would confirm if the weight was accurate. If the weight loss was accurate then she would speak with the resident and their caregiver staff (CNA's) if resident was not able to communicate. RD stated she would verbally communicate weight loss during morning meetings. She further stated she did not document morning meeting meetings. The RD also stated, nurses were supposed to communicate with the physician. The RD further stated that she did not notify Resident Representative (RR) of significant weight loss in 2023 and met with the RR for the first time in February 2024. On that same date and time, S#1 notified the RD the concerns that there were no documented evidence of resident's weights in EMR for November 2023. The RD stated November was a rough month, and she had hard time getting weights. The RD acknowledged the best practice was to monitor weights weekly for resident with significant weight loss. Further review of the EMR revealed that there was no documented evidence that the RD communicated to the physician and the RR the resident's significant weight loss in 2023. On 11/22/24 at 02:24 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Assistant Director of Nursing (ADON), the Regional Compliance Advisor (RCA) and Market President of Special Project (MPSP). S#1 notified the facility management of the above findings and concerns. A review of the facility's Nutrition/hydration Care and Services Policy with a review date of 02/01/23 included under Policy statement: The implementation of a patient's nutrition/hydration care and services occurs within the care delivery process. Staff will provide nutritional and hydration care and services to each patient, consistent with the patient's comprehensive assessment and will provide a therapeutic diet that accounts for the patient's clinical condition and preferences. Under Section Practice Standards: 6.) Observe and document oral intake of meals, supplements, and snacks. 9.) Monitor patient's weight as ordered and outlines in Weights and Heights policy and procedure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Weights and Heights Policy with a review date 6/15/22 included under Policy statement: Patients are weighted upon admission .and monthly thereafter. Additional weights maybe obtained at the discretion of the interdisciplinary care team. A review of the facility's Procedure: Weight and Heights Policy with a review date of 02/01/23 included under 2. Significant Weight Change Management: 2.2) The licensed nurse will: 2.2.1- Notify the physician/APP and Dietitian of significant weight changes; 2.2.2 -Document notification of physician/APP and Dietitian in the [Name Redacted] EMR Weight Change Progress Note. 2.3.2- Patient representative of the weight change and Dietitian recommendations. Notification will be documented. 38327 2. On 11/18/24 at 11:29 AM, the surveyor observed Resident # 57 seated in a wheelchair inside their room with right-hand limitation. The resident informed the surveyor that they had multiple hospitalization s during their stay in the facility due to a stroke. The surveyor reviewed the medical records of Resident #57 and revealed: The AR revealed that the resident was admitted to the facility with the following medical dx that were not limited to hemiplegia (paralysis that affects only one side of your body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following nontraumatic intracerebral hemorrhage (bleeding into the brain tissue; is the second most common cause of stroke) affecting the right dominant side, type 2 diabetes mellitus without complications, and conversion disorder with seizures or convulsions. The most recent cMDS (modified) with an ARD of 11/07/24, under Section Cognitive Patterns revealed a BIMS score of 15 out of 15 which reflected that the resident had intact cognition. A review of the personalized care plan (CP) revealed a focus that the resident exhibits and/or was at risk for seizure activity related to a new dx of seizure disorder that was created on 5/21/20. The CP goal was for the resident will be free of any seizure-related injury for x 90 days which was revised on 10/18/24. The CP Interventions that were included but were not limited to: medicate as ordered and monitor for effectiveness as well as side effects and report to the physician as needed that was created on 5/21/2020. According to the most recent hospitalization records in August 2024, the medication (med) list revealed that the resident will continue on Levetiracetam (also known as Keppra; med for seizure) 500 mg (milligram) tablet (tab) and take one tab by mouth twice a day. A review of the August, September, October, and November 2024 Order Summary Report (OSR) revealed that the hospital med list for Keppra was not followed. A review of the PN revealed that on 8/15/24, 8/28/24, 9/18/24, 9/29/24, 10/03/24, and 11/13/24, the physician documented and electronically signed in their Practitioner Note that Resident #57 with a dx of seizure disorder and on Keppra 500 mg BID (twice a day). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the EMR revealed that the physician had not signed the resident's orders in the OSR and the printed orders in the chart. The physician listed the resident's medications (meds) in the resident's PN. There was no documented evidence in the PN that the resident had a seizure activity upon return from the most recent hospitalization . There was no documented evidence in the medical records as to why the med for Keppra was not followed when the hospital records and the physician had documented the resident's dx for seizure and med. On 11/20/24 at 02:06 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) in the Unit 1 nursing station. The LPN informed the surveyor that Resident # 57 was alert and oriented with some forgetfulness and with dx of seizure. The surveyor notified the LPN of the above concerns and findings about the Keppra. The LPN stated that the resident had been on Keppra for a long time, but she was surprised when she learned that the resident was not on Keppra anymore. She further stated that she did not know why it was not continued. On that same date and time, the surveyor asked the LPN to review the PN of the physician. After reading the physician's PN, the LPN acknowledged that from August through November 13, 2024, the physician had documented the resident's dx of seizure disorder and Keppra BID. The LPN stated that it meant that the resident should have been on Keppra from August through November 2024. On 11/21/24 at 12:44 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The surveyor notified the facility management of the above concerns about Resident#57's Keppra. On 11/22/24 at 02:24 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The MPSP stated that it was the facility team's responsibility to review the PN of the physician and as a standard of practice, the orders in the PN should be reviewed in the morning meeting or clinical meeting. The MPSP further stated that there was no negative outcome for the resident, the resident did not have a seizure, and the physician reordered the Keppra after the surveyor's inquiry. A review of the facility's Physician/Advanced Practice Provider (APP) Orders with a revision date of 3/01/22 that was provided by the LNHA revealed: Policy: Orders will be accepted only from authorized, credentialed physicians/APPs or from other authorized, credentialed practitioners in accordance with state regulations regarding prescriptive privileges Purpose: To ensure all physician orders are received from a credentialed practitioner before implementing. Process: 1. Type Order: 1.1 Admission, Interim, Re-admission, and Renewal Orders: 1.1.2. All orders must be signed by an authorized, credentialed physician or other authorized practitioner in accordance with state regulations regarding prescriptive privileges . (continued on next page)

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	315138	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, NJ 07054

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor, and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-3.2(a,b); 11.2(b);27.1(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to maintain professional standards of nursing practice by not following a.) a physician's order for the application of a splint to right wrist, and b.) document in the Treatment Administration Record for 1 of 3 residents, Resident #68, reviewed for limited range of motion (ROM). The deficient practice was evidenced by the following: On 11/18/24 at 10:30 AM, during an initial tour, the surveyor observed Resident #68 resting in their bed while watching television, with no splint in use. The surveyor observed a picture of right hand in a splint that was posted on their room wall with instructions, indicating Right hand- Apply daily with a.m. (morning) care. Remove after 8 hours. Later on, the surveyor observed resident sitting in their wheelchair (w/c) in atrium from 12:20 PM until 02:20 PM. The surveyor did not observe resident's right wrist splint on. On 11/19/24 at 12:58 PM, the surveyor observed Resident #68 in their bed. The resident was performing stretching exercises to their upper extremities. The surveyor did not observe right wrist splint in place. On 11/20/24 at 11:28 AM, the surveyor observed the resident sitting up in their w/c, who was being brought up to Atrium for lunch by Certified Nursing Assistant (CNA). The resident did not have splint on their right hand and/or wrist at the time of observation. On 11/20/24 at 11:48 AM, during an interview with the surveyor, the CNA explained that if a resident was supposed to wear a splint or a special equipment, we would see the device at their bedside. There would be a picture posted in resident's room wall indicating what time the special equipment will be applied and taken off. The CNA also stated that when we put the device on, we would document in Electronic Medical Record (EMR). The CNA stated that she was familiar with Resident #68 and the resident had never refused care. The CNA acknowledged that she had never applied special equipment whenever she provided care to the resident. The CNA stated that she was not aware if Resident #68 required splint for their right hand. Afterward, both the surveyor and the CNA went into the resident's room to observe the posted picture and to verify if there was a splint in the room. When the CNA opened the top drawer of resident's nightstand, she confirmed that the splint and the posted sign were in resident's room. The CNA further stated the staff from previous shift did not give signoff report during change of shift and that was the reason that she did not know if resident required any special equipment, and she acknowledged that change of shift signoff report from previous shift would be very helpful. The surveyor reviewed the medical records of Resident #68 and revealed: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Admission Record (admission summary), the resident was admitted to the facility with diagnoses which included but were not limited to insomnia, Multiple Sclerosis [MS] (is an autoimmune disorder, meaning that in MS the immune system-which normally protects us from viruses, bacteria, and other threats-mistakenly attacks healthy cells), need for assistance with personal care, and muscle weakness. A review of Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 8/08/24, indicated the resident had limitations and impairment on one side of upper extremities (limbs). A review of the Order Summary Report (OSR) revealed a physician order (PO): Apply R (right) wrist splint with AM (morning) care and remove after 5-6 hours every day shift for protocol with a start date 4/20/2023. The above order for R wrist splint was transcribed in the November 2024 electronic Treatment Administration Record (eTAR) and were signed off by nurses, as splint was applied daily for day shift including the three days during when the surveyor observed that Resident #68 did not have the splint applied to their right wrist. The personalized care plan (CP) initiated on 4/17/23, revised on 4/20/23, had a focus Is at risk of contractures r/t [related to] MS. May apply splint on right wrist as tolerated per OT [occupational therapy] [NAME] [evaluation] as trial. The interventions included but were not limited to: Apply R wrist splint with AM care and remove after 5-6 hours or tolerated. On 11/20/24 at 02:32 PM, the surveyor met with the Registered Nurse/Unit Manager (RN/UM) and presented concerns regarding Resident #68's right hand splint not being applied or observed from last 3 days of observations. The RN/UM stated as far as she knew that Resident #68 did not refuse care. The RN/UM acknowledged that if a special equipment like splint was ordered for a resident, then the splint should be applied as per PO. The RN/UM stated that it was important for CNAs to give sign off report at the change of shift to oncoming shift CNA for better care. The RN/UM further explained that sign off report was the way to inform the oncoming shift staff of if the resident had special needs, their activity status, if the resident had urinary catheter or if they were incontinent and how much assistance residents required during their care. On 11/21/24 at 12:44 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Assistant Director of Nursing (ADON), the Regional Compliance Advisor (RCA) and Market President of Special Project (MPSP). The surveyor presented above mentioned concerns with the team. The ADON stated the nurses should be following PO. A review of facility's policy, Activities of Daily Living (ADLs), revised on 5/01/23, included under section Practice Standards: 3.) Assistive devices and adaptive equipment are provided as needed. A review of the facility's policy Range of Motion and Mobility reviewed on 6/15/22, included under Policy: Centers will provide services, care, and equipment to ensure that a patient: With limited mobility receives appropriate services, equipment, assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Under Section Purpose: To maintain or improve to the highest level of ROM and mobility. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing (DON), ADON, Market Clinical Lead (MCL) and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39 27.1(a); 27.2 (m)

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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. 48423 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services of residents that were receiving oxygen, according to the standard of clinical practice and the facility's policy and procedure, specifically a.) clarify the physician's order for as needed (PRN) oxygen and document the use of PRN oxygen therapy for 1 of 3 residents, Resident #33 and b.) that respiratory equipment was stored in accordance with facility policy and infection control measures for 1 of two 3 residents reviewed for respiratory care, Resident #80. 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 11/18/2024 at 11:28 AM, during the initial tour, the surveyor observed Resident #33 seated in their wheelchair (w/c) with an oxygen (O2) via nasal cannula (n/c; a tube delivering O2 into the nose). The O2 was set at 4 L (liters). At 12:25 PM, the surveyor observed Resident #33 seated in their w/c, came out to atrium to eat lunch. The surveyor observed the O2 tank behind the w/c and the resident was on O2. The surveyor reviewed the medical record for Resident #33. According to the Admission Record (AR; an admission summary), the resident was admitted to the facility with diagnoses which included but was not limited to: chronic obstructive pulmonary disease [COPD] (an ongoing lung condition caused by damage to the lungs), type 2 diabetes mellitus, and atrial fibrillation (an irregular and often very rapid heart rhythm). The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 10/10/24, reflected a Brief Interview for Mental Status (BIMS) score of 02 which indicated that Resident #33 was cognitively severely impaired. Further review of the MDS revealed the resident had used O2 while a resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's Care Plan (CP) included a focus area that indicated the resident exhibits or is at risk for respiratory complications related to COPD initiated on 7/19/2024. The interventions included O2 as ordered via n/c. A review of Resident #33's Order Summary Report (OSR) reflected a physician order (PO) for O2 on at 2-4 L/min (minute) via n/c as needed dated 9/26/2024. The PO did not specify indication when to administer O2 and/or amount of O2 to be administered. The above PO was transcribed in the electronic Medication Administration Record (eMAR). A review of Resident #33's October 2024 eMAR revealed that resident used O2 only for one day as signed off for October 7th. Further review of November 2024 eMAR reflected the resident received O2 on November 19th as it was signed off for that day only. A review of O2 sats (saturation - a measure of how much O2 is in your blood) summary, from Weights and Vitals Summary, revealed that when resident's O2 sats were obtained, there were 74 entries for October and 46 entries for November 2024, that reflected the resident was on O2 via n/c. The O2 sats summary did not reflect amount of O2 the resident was on. On 11/21/24 at 11:42 AM, during an interview with the surveyor, the Registered Nurse (RN), stated there should be an order for O2 administration except if there was an emergency situation. The RN stated she would administer O2 based on resident's needs. She spoke about Resident #33's O2 needs and stated that the resident wanted more O2, and the resident was comfortable on 3L O2 and RN stated, I modified the O2 order to 2-4 L as per PRN after she had spoken to the physician. RN further stated that she documented O2 administration with vital signs (v/s) and O2 sats assessments. The RN stated that the O2 was ordered as PRN and she would administer O2 to the resident PRN. The surveyor reviewed the PRN O2 order in October and November eMAR with the RN, and the RN stated she would document O2 with O2 sats. The RN did not speak to why there was no documentation in the eTAR (electronic Treatment Administration Record). On 11/21/24 at 12:00 PM, the Registered Nurse/Unit Manager (RN/UM) stated that we need doctors' orders for O2 tubing change, monitoring of the O2 levels (O2 sats) and v/s every shift. If the resident had problems with the amount of O2 that they were on, then the nurses would call the doctor and get the new orders as per resident's needs. The RN/UM further stated that we would start the resident on O2 at 2L if the resident was expressing shortness of breath (SOB) and/or difficulty in breathing, if it was not effective then would increase the O2 slowly until it was effective and could go up to 4L. The RN/UM further stated that PRN O2 would be documented same as PRN medications (meds) in eMARs. The RN/UM stated if the resident required more O2, then we should be reaching out to the doctor to get a standing order for continuous O2 because that's a change in condition. On 11/21/24 at 12:44 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Assistant Director of Nursing (ADON), the Regional Compliance Advisor (RCA) and Market President of Special Project (MPSP). The surveyor notified the facility management of the above findings. The ADON stated that there should be a reason indicated to administer O2 for PRN or continuously use, with specific amount of O2 in Liters to be administered. The ADON further acknowledged that the PRN O2 administration should be documented. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Respiratory Management Policy with a last revised date of 12/01/21. The policy did not address the following: a.) Indication for O2 use; b.) O2 amount in specific liters, c.) O2 administration documentation in eMAR and d.) duration for O2 use i.e. PRN or continuously. 38327 2. During the initial tour of Unit 1 on 11/18/2024 at 11:18 AM, the surveyor observed Resident #80's room with a posted sign of EBP (Enhanced Barrier Precautions; an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes). The surveyor observed the resident lying on a specialized air mattress, the nebulizer (neb) mask was hung on the nightstand table exposed to the environment of the resident's bed rails, and not stored inside a bag, there was no date on the neb mask tubing. The nightstand table with accumulation of dust, and the top and side areas of the table with dried whitish substances. The floor with accumulation of dust and dried brownish substances. The windows with accumulation of dust and cobwebs. The surveyor reviewed the medical records of Resident #80 and revealed: The AR revealed that the resident was admitted to the facility with the following medical diagnoses that were not limited to abnormal posture, COPD, peripheral vascular disease (PVD; a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), and pressure ulcer of sacral region stage 4 (the largest and deepest of all bedsore stages). The most recent comprehensive MDS with an ARD of 9/29/24, under Section Cognitive Patterns revealed a BIMS score of 15 out of 15 which reflected that the resident had intact cognition. A review of the November 2024 OSR revealed: -Budesonide Inhalation Suspension 0.5 mg (milligrams)/2 ml (milliliters), 2 ml inhale orally every 12 hours for COPD-Start Date 9/25/2024 0900 (9 AM). Further review of the OSR revealed that there were no PO for the care of the neb mask and tubing. The above PO was transcribed to the November 2024 eMAR and signed by nurses as administered from 11/01/24 through 11/19/24 at 9 AM. The PO was plotted for 9 AM and 2100 (9 PM). A review of the personalized CP revealed that there was no plan or intervention on how to care for the neb mask and tubing. Further review of the medical records revealed that there was no documented evidence of care for the neb mask and tubing and accountability. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 8:48 AM, the surveyor asked the ADON and the RCA to go with the surveyor inside the resident's room. Inside the resident's room was observed with dust, brownish stains on the floor, whitish and grayish stains on top of the nightstand and side of the nightstand table where the neb machine was located. There was an accumulation of dust on top of the light on top of the head of the resident's bed, the RCA with gloves brushed off the overhead light and there were reddish stains on her gloves and some dust, there was a total of 4 brownish stains on the ceiling tiles near the window, inside the toilet room there was an accumulation of dust on top of the light. The resident's environment was the same on the 1st day of the tour. Outside the resident's room, the surveyor interviewed the RCA and ADON regarding the observations inside the resident's room. The surveyor notified the RCA and the ADON of the above findings and concerns with the neb mask not properly stored when not in use and undated. The RCA stated that the neb mask should have been stored in a bag when not in use and dated. The RCA further stated that there should be accountability and order for the care of the neb mask and should be in the CP. The surveyor asked the ADON for the November 2024 OSR and eMAR copies. The ADON stated that she would get back to the surveyor. On 11/21/24 at 12:44 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The surveyor notified the facility management of the above concerns about Resident#80's neb mask not being stored properly, no CP, and accountability for neb tubing and mask on how to care for respiratory equipment and supplies. On 11/22/24 at 02:24 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The ADON stated that the resident's neb now had an order for every day to be changed and should be stored in a bag. The MPSP stated that the CP was also updated to include care for the neb tubing and mask after the surveyor's inquiry. The facility management acknowledged there was no accountability and order for care of respiratory prior to the surveyor's inquiry. A review of the facility's Medication Administration Nebulizers (Updraft) with a date of 01/23 that was provided by the LNHA revealed: Policy: To allow for safe, accurate, and effective administration of medication using a small volume neb. Procedure: 20. Obtain post-treatment pulse, respiratory rate, and lung sounds and document findings on the MAR or in the resident's medical record following facility policy . 23. When equipment is completely dry, store it in a plastic bag with the resident's name and the date on it. 24. Change equipment and tubing per nursing facility policy . On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor, and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-11.2(a,b); 19.4(a); 27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46049 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to complete post dialysis communication record assessments upon the resident's return from the dialysis center for 1 of one 1 resident, Resident #24, reviewed for dialysis services. The deficient practice was evidenced by the following: On 11/18/24 at 12:05 PM, the surveyor observed Resident #24 was not in their room. The Registered Nurse (RN) assigned to care for Resident #24 stated the resident was at dialysis. The surveyor reviewed the electronic medical record of Resident #24. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, end stage renal [kidney] disease, dependence on renal dialysis, hypertension (high blood pressure) and atrial fibrillation (an irregular, often rapid heart rate). A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/10/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #24 scored a 11 out of 15, which indicated the resident had moderate cognitive impairment. A physician's order dated 10/04/24 documented Resident #24 was scheduled for dialysis on Monday, Wednesday, and Friday with a pick up time of 10:15 AM. On 11/20/24 at 01:05 PM, the surveyor interviewed the RN assigned to care for Resident #24. The RN stated that the resident's dialysis access site would be monitored for any signs or symptoms of infection and active bleeding. The RN further explained there was a dialysis communication binder that was completed at the time the resident went to dialysis. On 11/21/24 at 10:46 AM, the RN provided the surveyor with Resident #24's dialysis communication binder. The binder included a form titled Hemodialysis Communication Record which had three sections. Each section documented a brief assessment of the resident which included the resident's vital signs (measurement of the body's basic function including blood pressure, temperature, and pulse), and general condition. The first section was to be completed by the facility nurse when the resident left to dialysis. The second section was to be completed by the dialysis nurse. The last section was to be completed by the facility nurse when the resident returned from dialysis. A review of Resident #24's dialysis communication binder revealed for 6 of the 8 dialysis communication record forms, the post dialysis portion of the form was not completed by the facility nurse and left blank. This was observed for the dates of 11/04, 11/11/24, 11/13, 11/15, 11/18, and 11/20/24. A review of Progress Notes (PN) from November 2024 revealed there were no PN which documented that the resident was assessed after returning to the facility from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 10:58 AM, the surveyor interviewed the RN about the dialysis communication record forms. The RN reviewed the dialysis communication record with the surveyor and stated that she believed the last section should have been completed by the nurses. On 11/21/24 at 11:45 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) about Resident #24's dialysis communication records. The RN/UM reviewed with the surveyor the 6 of 8 forms with the post-dialysis section not completed by the nurses. The RN/UM acknowledged that the forms should have been completed upon the resident's return to the facility. On 11/21/24 at 12:47 PM, the surveyor informed the Market President Special Projects (MPSP), the Assistant Director of Nursing (ADON), the Licensed Nursing Home Administrator (LNHA), and the Regional Compliance Advisor (RCA) of the above concerns. There was no verbal response by the facility at this time. On 11/22/24 at 02:24 PM, the survey team met with the LNHA, the ADON, the MPSP, and the RCA. The ADON stated that education was being provided to staff about the dialysis communication record and that it must be completed when a resident returns from dialysis. There was no additional information provided by the facility. A review of the facility's Dialysis: Hemodialysis (HD)- Communication and Documentation Policy with a last revised date of 6/15/22. Under Policy it documented that the facility staff would communicate with the certified dialysis facility regarding the ongoing assessment of the patient's condition by the monitoring for complications before and after hemodialysis (HD) treatments received at a dialysis center. Under Practice Standards it indicated, upon the resident's return to the facility, a licensed nurse would review the dialysis center's communication, evaluate the patient, and complete the post- dialysis treatment section on the Hemodialysis Communication Record or state required form. NJAC 8:39 - 27.1(a)

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Troy Hills Center	200 Reynolds Ave Parsippany, NJ 07054

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48423 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily for 2 of 7 days. This failure could affect the knowledge of the availability of staff to care for the residents, resident representative, and visitors. This deficient practice was evidenced by the following: On 11/18/24 at 9:10 AM, upon entry into the facility, Surveyor #1 (S#1) observed a posted Nursing Home Resident Care Staffing Report (NHRCSR) that was posted in the reception area of the lobby, dated 11/18/24 Day Shift, 7 AM-3 PM. The NHRCSR reflected current census of 98 that included 10 CNAs (Certified Nursing Aides) with staff to resident ratio of 1 CNA:9.8 Residents. On 11/18/24 at 10:04 AM, during entrance conference, the Licensed Nursing Home Administrator (LNHA) informed S#1 that the census (total number of residents) was 97. S#1 requested for Daily Census (DC) and Daily Staffing Sheets [DSS] (to reflect total number of staff that actually worked). A review of DC and DSS dated 11/18/24 revealed the census was 97. The DSS reflected the actual number of CNAs was 9. On 11/20/24 at 9:20 AM, Surveyor #2 (S#2) observed the NHRCSR at the receptionist desk, dated 11/20/24 Day Shift, 7 AM-3 PM, reflected current census of 97 that included 12 CNAs with staff ratio of 1 CNA:8.1 Residents. A review of DC and DSS reflected the census of 94. Further review of DSS reflected the actual number of CNAs was 11. On 11/22/24 at 02:24 PM, the survey team met with the LNHA, the Assistant Director of Nursing (ADON), the Regional Compliance Advisor (RCA) and Market President of Special Project (MPSP). S#2 notified the facility management that the census and CNAs inaccuracy between NHRCSR, DS and DSS. The LNHA stated the Staffing Coordinator (SC) was responsible for doing Staffing sheets. On 11/25/24 at 01:12 PM, the survey team met with the LNHA, ADON, RCA, Director of Nursing (DON), and Market Clinical Lead (MCL). The RCA stated, SC was printing the NHRCSR night before, before reconciliation that was why it was often wrong. The LNHA acknowledged that the NHRCSR should be accurate. The LNHA stated that education / in-service was provided to SC and in-service sign-in sheet was provided after the surveyor's inquiry. A review of facility's policy, Staffing/Center Plan, revised on 8/07/23, included under Policy: Centers will provide qualified and appropriate staffing levels to meet the needs of the patient population. The staffing plan will include all shifts, seven days per week. Under section Purpose: To assure that appropriate staffing levels are scheduled and maintained. Under Process: 2.) Staffing levels are reviewed on an ongoing basis by Center staff to evaluate compliance and provide appropriate levels of are by qualified employees. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing (DON), ADON, Market Clinical Lead (MCL) and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. N.J.A.C. 8:39-41.2 (a)(b)(c)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46049 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) administer a medication to a resident due to unavailability of the medication, accurately account and administer a medication according to the physician's orders for one (1) of five (5) residents, Resident #53, reviewed for unnecessary medications and b.) ensure accurate documentation of the receipt of a controlled substance for 17 controlled substance medications on 3 Schedule II order forms, ordered and received by the facility for use as an emergency backup supply in accordance to pharmaceutical services and professional standards of clinical practice. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, 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 casefinding; 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 11/18/24 at 12:10 PM, the surveyor observed Resident #53 resting in bed, alert, oriented, and verbally responsive. The resident stated that they would be receiving their blood thinner injection today after not receiving for four days. The resident stated that there were issues with the delivery from the pharmacy as per the explanation from some of the nurses. Resident #53 further stated that the Registered Nurse (RN) followed up with the pharmacy and they would be receiving their blood thinner later today. On 11/19/24 at 11:50 AM, the surveyor reviewed the paper and electronic medical record (EMR) of Resident #53. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, hypertension (high blood pressure), rheumatoid arthritis, and blood/bone marrow cancer. A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/05/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #53 scored a 15 out of 15, which indicated the resident was cognitive intact. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order (PO) dated 02/04/23 documented Enoxaparin Sodium Solution 40 milligram (mg)/0.4 milliliter (ml) inject 40 mg subcutaneously one time a day for preventing blood clots. A review of the November 2024 electronic Medication Administration Record (eMAR) revealed the following for the Enoxaparin injection order entry scheduled for 5 PM: On 11/13/24 the entry was signed as administered by the nurse. On 11/14/24 the entry was signed as administered by the nurse. On 11/15/24 the entry was signed as R [refused] by the nurse. On 11/16/24 the entry was signed as NN [No/see Nurse Notes] by the nurse. On 11/17/24 the entry was signed as administered by the nurse. On 11/18/24 the entry was signed as administered by the nurse. A review of the nurse progress notes (PN) revealed the following: An eMAR PN dated 11/15/24 at 4:37 PM listed the Enoxaparin medication (med) order. There was no documentation by the nurse in the note's text. An eMAR PN dated 11/16/24 at 6:52 PM detailed that the nurse was awaiting delivery from pharmacy. There was no additional documentation found in the PN related to Enoxaparin med administration from 11/13/24 to 11/17/24. On 11/19/24 at 12:03 PM, the surveyor placed a call to the facility's pharmacy and interviewed a pharmacist about the Enoxaparin 0.4 mg/0.4 ml injection delivery for Resident #53. The pharmacist stated: On 11/04/24 there were three syringes sent for delivery to the facility. On 11/10/24 there were three syringes sent for delivery to the facility. On 11/17/24 there were seven syringes sent for delivery to the facility. The surveyor asked the pharmacist about the small number of doses being delivered at a time. The pharmacist replied, it most likely was an insurance issue with the med. On 11/20/24 at 10:30 AM the surveyor requested from the Licensed Home Administrator (LNHA) delivery receipts from the pharmacy for med delivered to wing 2 from September to November 2024. On 11/20/24 at 12:27 PM, the surveyor reviewed the pharmacy delivery receipts provided by the LNHA which revealed the following for the Enoxaparin med delivery: On 10/28/24 Enoxaparin 40 mg/0.4 ml syringe, seven doses were received to the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 Enoxaparin 40 mg/0.4 ml syringe, three doses were received by the facility. On 11/10/24 Enoxaparin 40 mg/0.4 ml syringe, three doses were received by the facility. On 11/18/24 Enoxaparin 40 mg/0.4 ml syringe, seven doses were received by the facility. On 11/20/24 at 12:40 PM, the surveyor interviewed the RN who confirmed she had called the pharmacy regarding Resident #53's Enoxaparin injection. The RN stated she could not recall the day, but when she came on shift the resident told her they did not receive a med the night before. The RN continued that she asked the resident which med it was, and Resident #53 replied it was their blood thinner injection. She further stated she called the pharmacy to follow up on the med's delivery and the med was delivered on the same day. The RN could not speak to other days of the resident not receiving the Enoxaparin med. She further explained she was not aware of the issue until notified by the resident and that there was nothing endorsed to her during shift change report. She also stated Resident #53 was alert and would be able provide the surveyor with further information. On 11/20/24 at 12:50 PM, the surveyor visited with Resident #53 to ask about their Enoxaparin med. The surveyor asked the resident if they had refused their med in the last couple weeks. Resident #53 replied No, I know my medicine is important, so I would not refuse it. The resident confirmed that before 11/18/24 they missed four days of their Enoxaparin med. On 11/20/24 at 01:20 PM, the surveyor asked the LNHA about how the nurses' request refills for medications (meds) from the pharmacy and to provide completed requisition forms. The LNHA stated she would follow up and provide information to the surveyor. On 11/20/24 at 01:39 PM, the LNHA informed the surveyor requests by the nurses were made electronically. The LNHA confirmed a report could be obtained. The surveyor requested the report for Resident #53's refill requests to pharmacy for the last two months to be provided. On 11/21/24 at 8:29 AM, the LNHA provided the electronic transmission report for requests made to the pharmacy. A review of the electronic transmission report included a reorder of pharmacy order for Enoxaparin for Resident #53 on 11/04/24, 11/08/24, 11/09/24, and 11/12/24. The entries did not specify who requested the order. There were no other entries for November 2024 found. On 11/21/24 at 12:47 PM, the surveyor notified the informed the Market President Special Projects (MPSP), the Assistant Director of Nursing (ADON), the LNHA, and the Regional Compliance Advisor (RCA) of the above concerns. The surveyor asked what was expected protocol if a nurse could not administer a med as the med was not available from the pharmacy. The ADON stated it would be expected for the nurse to notify the primary physician when a resident did not receive a med due to it not being available and if needed, a therapeutic substitution of the med could be ordered by the physician. The facility was to review and provide additional information. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/24 at 02:24 PM, the LNHA, ADON, MPSP, and RCA met with the survey team. The RCA stated that an investigation was initiated for the concern of Resident #53 reportedly not receiving their Enoxaparin injection for four days. The RCA stated the resident representative and primary physician was informed. The facility stated the investigation was ongoing and would have further information on Monday. The surveyor asked the ADON if there was a facility back up supply for Enoxaparin. The surveyor requested the inventory log and history including delivery receipts. On 11/25/24 at 01:12 PM, the surveyor met with the LNHA, the Director of Nursing (DON), the RCA, and the ADON. The LNHA provided an email from pharmacy regarding use of Enoxaparin from the backup stock. The pharmacy response and documentation revealed enoxaparin 40 mg, a quantity of one was removed from the drawer (drawer G) on 11/13/24. There was no resident name listed. Additionally, the pharmacy picked up the box on 11/20/24 and it was exchanged for a new box. The surveyor asked if there was any additional documentation for back up med being taken and signed out to be used for a resident. The DON stated there was no report, a form was filled out to indicate that a backup med was used from the backup med cart. The DON continued to explain the forms were in the emergency backup med case which is locked, and once filled the form was left in the case and the pharmacy swapped the emergency kits once a week. On 11/25/24 at 01:36 PM, the surveyor accompanied the DON to the backup med cart and confirmed there was no log for the cart kept by the facility as it was taken to the pharmacy. The DON explained on the form the nurse had to document which resident the med was being used for, the med's name, the dose and the nurse had to sign the entry. The DON stated the facility did not keep copies of the forms which were taken back to pharmacy, and she was not sure the pharmacy would have it. On 11/25/24 at 02:23 PM, the LNHA, DON, ADON, RCA, and Market Clinical Lead (MCL) met with the survey team. The MCL stated the backup form was filled when removing a med. The facility acknowledged they do not keep a record of the completed form. On 11/25/24 at 3:00 PM, the MCL provided the surveyor a copy of the form filled when the enoxaparin injection was removed from back up cart on 11/13/24. The MCL acknowledged the form was not complete. A review of the form revealed there was no resident name, room number, time for when the med was removed, prescriber name and the name of the nurse who filled out the form. A review of the facility's Medication Administration General Guidelines Policy, dated 01/2024. Under Policy it revealed, Meds are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices. Under Procedure, Documentation it revealed: 2. If a dose of regularly scheduled med is withheld, refused, or given at other than the scheduled time it should be documented on the MAR. If two consecutive doses of a vital med are withheld or refused, the physician is to be notified. 49078 2. Reference: 21 CFR 1305.13 Procedure for filling DEA Forms 222. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/24 at 10:45 AM, the facility provided to the surveyor, upon request, a binder containing, but not limited to, facility Drug Enforcement Agency (DEA) 222 Forms (a form used to order controlled substances from a provider), copies of medical director state and federal controlled substance registration certificates, and other provider pharmacy proprietary record forms. On 11/22/24 at 10:55 AM, the surveyor reviewed the contents of the binder, as part of the Storage and Labeling Task, including but not limited to the facility DEA 222 Forms. A review of the facility DEA 222 Forms that were filled out and used to order controlled substances revealed the following: DEA 222 Form with order form # 231118675 dated 01/25/24 for 0.2 package of 100 hydrocodone/APAP (acetaminophen) 5/325 mg (milligram) tablet (a schedule II-controlled substance used for pain), 1 package of 30 ml (milliliters) morphine sulfate 20 mg/ml 30 ml bottle (a schedule II controlled substance used for pain), 0. 2 package of 100 oxycodone 5 mg tablets (a schedule II controlled substance used for pain), .2 package of 100 oxycodone/acetaminophen 5/325 mg tablets (a schedule II controlled substance used for pain), 1 package of 20 oxycontin 10 mg tablets (a schedule II controlled substance used for pain), with the section Part 5: to be filled in by purchaser, number received, date received, not filled in. There was no associated packing slip observed. DEA 222 Form with order form #231118682 dated 7/15/24 for 1 package of 5 Fentanyl 12 mcg/hr (microgram/hour). patches (a schedule II-controlled substance used for pain), 1 package of 5 Fentanyl 25 mcg/hr. patches, 1 package of 5 Fentanyl 50 mcg/hr. patches, 0.2 package of 100 Hydromorphone 2 mg tablet (a schedule II controlled substance used for pain), 1 package of 25 morphine 10 mg/ml single dose vial (a schedule II controlled substance used for pain), 0.2 package of 100 morphine sulfate ER (extended release) 100 mg tablet, 0.2 package of 100 morphine sulfate ER 15 mg tablet, 0.2 package of 100 morphine sulfate IR (immediate release) 15 mg tablet, 0.2 package of 100 oxycodone IR 5 mg tablet, with the section Part 5: to be filled in by purchaser, number received, date received, not filled in. There was no associated packing slip observed. DEA 222 Form with order for #231118671 dated 10/01/24 for 0.2 package of 100 oxycodone IR 5 mg tablets, 0.2 package of 100 oxycodone/acetaminophen 5 mg/325 mg tablets, 0.2 package of 100 hydromorphone 2 mg tablets, with the section Part 5: to be filled in by purchaser, number received, date received, not filled in. There was no associated packing slip observed. The surveyor reviewed the instructions for completing the DEA 222 Forms located in the Code of Federal Regulations at 21 CFR1305.13. The CFR 1305.13 revealed at section (e) The purchaser must record on its copy of the DEA Form 222 the number of commercial or bulk containers furnished on each item and the dates on which the containers are received by the purchaser. On 11/22/24 at 3:46 PM the surveyor interviewed the ADON and asked who was responsible for filling out the DEA 222 forms and completing them when the med comes in. The ADON responded that it was the DON or a designee. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/25/24 at 01:56 PM the surveyor interviewed the DON and showed a copy of the incomplete DEA 222 forms. The DON verified that the DEA 222 forms were from the facility and that part 5 of the form was not filled out for 3 of 3 forms. The surveyor asked the DON if they were familiar with the DEA 222 forms. The DON responded, somewhat. A review of the facility's Consultant Pharmacist Services Provider Requirements Policy dated 01/23 revealed: Procedures number 4 letter n the following: Assist the provider pharmacy to establish a system of records of receipt and disposition of all controlled substances that produces an accurate reconciliation and account of use on a periodic basis. A review of the facility's Storage of Medications Policy dated 01/24 revealed: the policy which did not reflect any information regarding ordering or receiving of controlled substances. On 11/25/24 at 02:15 PM, the survey team met with the LNHA, DON, ADON, MPSP, and MCL regarding the above concerns. No further pertinent information was provided. NJAC 8:39-29.2;29.7(c) 21 CFR 1305.13(e)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46049 Based on interviews, record review, and a review of pertinent facility documents, it was determined that the facility failed to identify the irregularity with regard to medications with parameters for 5 of 5 residents reviewed, Residents #24, #43, #53, #57, and #82 in accordance with facility's practice and policy. This deficient practice was evidenced by the following: 1. On 11/19/24 at 11:50 AM, the surveyor reviewed the paper and electronic medical record (EMR) of Resident #53. The Admission Record (AR; a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, hypertension (high blood pressure), and rheumatoid arthritis. A quarterly Minimum Data Set (qMDS), assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/05/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #53 scored a 15 out of 15, which indicated the resident was cognitive intact. A physician's order (PO) dated 9/04/22 documented amlodipine besylate-benazepril HCl [hydrochloride] 10-20 MG (milligram) capsule (cap), give 1 cap by mouth one time a day for high blood pressure (BP); hold for systolic blood pressure (SBP) less than 100 or a heart rate (HR) less than 60. The medication (med) was scheduled to be given at 5:00 PM (5 PM). A review of the October 2024 and November 2024 electronic Medication Administration Record (eMAR) revealed there was no BP or HR documented at the time the amlodipine-besylate benazepril HCl was scheduled to be administered. A review of the BP and HR documented under the Weights/Vitals section of the EMR, revealed BP and HR recorded during the time the resident's med was scheduled to be administered included the following: 10/10/24 at 4:43 PM and 10/28/24 at 4:03 PM. There were no other BP and HR results documented for the time the med was to be administered. A review of the facility provided Consultant Pharmacist (CP) recommendations report for October 2024 revealed there were no comments or recommendations made for Resident # 53 ' s amlodipine-besylate medication. 2. On 11/20/24 at 9:22 AM, the surveyor reviewed the EMR of Resident #24. The AR documented that the resident had diagnoses that included but were not limited to, end stage renal [kidney] disease, dependence on renal dialysis, hypertension, and atrial fibrillation (an irregular, often rapid heart rate). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A comprehensive MDS (cMDS), with an ARD of 10/10/24, indicated the facility assessed the resident's cognition using a BIMS test. Resident #24 scored a 11 out of 15, which indicated the resident had moderate cognitive impairment. A PO dated 10/17/24 documented Milk of Magnesia (MOM) Suspension 400 mg/5 ml (milliliters), give 30 ml by mouth every 24 hours as needed (PRN) for constipation daily. A PO dated 10/04/24 documented Losartan Potassium oral tablet (tab), give 1 tab by mouth one time a day for hypertension, hold for SBP [Systolic Blood Pressure] less than 120. The med was scheduled to be given at 9:00 AM (9 AM). A review of the October 2024 eMAR revealed the nurses signed the losartan med as administered when the SBP was less than 120 and the med should have been held as per the PO on the following entries: - On 10/15/24 with a documented blood pressure (BP) of 116/74. - On 10/24/24 with a documented BP of 119/60. - On 10/25/24 with a documented BP of 110/72. - On 10/27/24 with a documented BP of 119/77. A review of the November 2024 eMAR revealed the nurses signed the losartan med as administered when the SBP was less than 120 and the med should have been held as per the PO on the following entries: - On 11/08/24 with a documented BP of 116/64. - On 11/16/24 with a documented BP of 103/57. Additionally, a review of the October 2024 and November 2024 eMAR revealed the resident had not received the PRN MOM med. A review of the facility provided Consultant Pharmacist (CP) recommendations report for October 2024 revealed there were no comments or recommendations made for Resident #24's losartan med. In addition, there were no comments or recommendations related to the resident's MOM med order. The November 2024 CP report was not completed at the time of surveyor's record review. On 11/21/24 at 12:47 PM, the surveyor informed the Market President Special Projects (MPSP), the Assistant Director of Nursing (ADON), the Licensed Nursing Home Administrator (LNHA), and the Regional Compliance Advisor (RCA) of the concern that the CP did not identify in the October 2024 report of Resident #53 having no BP documented for their amlodipine-benazepril med, the occurrences of the BP parameters for Resident #24's losartan med not being followed as per the PO and there were no comments for Resident #24's MOM order. There was no verbal response from the facility at this time. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/24 at 9:20 AM, the surveyors interviewed a CP over the phone over medication regimen review (MRR) and concerns identified. The CP stated she oversaw the CP who visited the facility and could speak on their behalf. The CP stated that MRR were completed monthly, and the resident's medical records would be reviewed including the eMARs. The surveyor asked if when reviewing medications (meds) with parameters, if the vital signs (v/s) would be checked. The CP replied yes it would be expected to be reviewed and any inconsistency mention in the report. The surveyor asked the CP about a MOM order for a resident receiving dialysis. The CP replied that it should be recommended to discontinue (d/c) for resident as there would be a concern for renal function. The surveyor discussed the concerns identified for Resident #24 and Resident #53. The CP stated she would review the residents' medical records and would email a surveyor the MRR reports for September 2024, and October 2024. The CP further explained November 2024 CP report was not completed and the MRR that have been completed would be sent. On 11/22/24 at 02:17 PM, the surveyor reviewed the CP provided MRR report for October 2024 which revealed there were no recommendations for the MOM or losartan order. On 11/22/24 02:24 PM, the LNHA, ADON, MPSP, and RCA met with the survey team. The ADON stated audits were being completed for not following parameters and they were working with the Nurse Practitioner and CP to maintain no irregularities. The ADON further explained the order for MOM PRN was d/c and the resident had other meds for their bowel regimen. There was no additional information provided by the facility. A review of the facility's Consultant Pharmacist Services Provider Requirements Policy, dated 01/2023. Under Procedure it detailed: . 3. The CP agrees to render the required service in accordance with local, state, and federal laws, regulations, guidelines; nursing care center policies and procedures; community standards of practice; and professional standards of practice. 4. The CP, or designee, provides pharmaceutical care services, including but not limited to the following . d. MRR for each Skilled Nursing (SNF) resident at least monthly or more frequently under certain conditions, incorporating the federally mandated standards of care in addition to other applicable professional standards. e. Communicate to the responsible prescriber, the facility's medical director and the director of nursing potential or actual problems detected and other findings related to med therapy orders at least monthly. Communicate recommendations for changes in med therapy and the monitoring of med therapy . 49078 3. On 11/20/24, the surveyor reviewed the eMR for resident #43 and revealed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The AR reflected that the resident was readmitted to the facility with diagnoses of, but not limited to, essential hypertension and congestive heart failure (a progressive heart disease that affects pumping action of heart muscles). The most recent qMDS, with an ARD of 10/04/24, reflected that the resident had a BIMS, a tool used to screen and identify cognitive condition, score of 9 out of 15, which indicated that Resident #43 had moderately impaired cognition. A review of the resident's Order Summary Report (OSR, a listing of the resident's active meds and other orders) revealed the following: -A PO for MOM 400 mg/5 ml give 30 ml by mouth PRN for constipation give at bedtime if no BM (bowel movement) in 3 days, dated 9/03/24. -A PO for MiraLAX powder give 17 gram by mouth PRN for constipation in 4 to 8 ounces of fluid- if resident has not had a BM in 72 hours, dated 9/03/24. The above PO for MOM and Miralax were transcribed to the eMAR. The CP reports for Resident #43 which revealed that the CP did document that the resident's chart was reviewed for September and October 2024, and did not reflect any irregularities with the MOM or MiraLAX orders. On 11/20/24 at 02:26 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #43. The surveyor asked the LPN how she would know which PRN order, MOM or MiraLAX, to give to the resident first and how many times a day can the MiraLAX be administered. The LPN stated that since both orders were written to give after 3 days of no BM, the orders should be clarified with the physician for which to use first and as well as how many doses per day that the physician allows the MiraLAX to be given. 4. On 11/20/24 the surveyor reviewed the eMR for resident #82. The eMR revealed the following: A review of Resident #82's AR which reflected that the resident was readmitted to the facility with diagnoses of, but not limited to, osteomyelitis of vertebra (a rare, painful spinal infection) and type 2 diabetes (high blood sugar). A review of Resident #82's Medicare 5 Day MDS, with an ARD of 10/18/24, reflected that the resident had a BIMS, of 15 out of 15, which indicated that Resident #82 was cognitively intact. A review of the Resident #82's OSR, revealed the following: -A PO for Lidoderm Patch 5% (an anesthetic applied to the skin to relieve pain), apply to left knee topically one time a day for pain at bedtime remove and remove per schedule. The above order for Lidoderm patch 5% was transcribed to eMAR. The eMAR also reflected the timing of the application of the patch, apply 9:00 AM (9 AM), remove 8:59 AM. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the manufacturer package insert for Lidoderm Patch 5%. The package insert reflected, under dosage and administration, Apply Lidoderm to intact skin to cover the most painful area. Apply the prescribed number of patches (maximum of 3), only once for up to 12 hours within a 24-hour period. The surveyor reviewed the CP reports for Resident #82 which revealed that the CP did document that the resident's chart was reviewed for September and October 2024, and did not reflect any irregularities with the Lidoderm Patch orders. On 11/21/24 at 12:47 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON) to discuss above concerns. The surveyor asked the ADON which PRN med should be given first, MOM or MiraLAX, and how many times a day can MiraLAX can be given. The ADON responded that the orders need to be clarified with the physician. The surveyor also asked the ADON if an order for a patch in a resident's eMAR was to apply at 9 AM and remove at 8:59 AM, how long was the patch applied. The ADON stated that it would be 24 hours. The surveyor asked the ADON how a Lidoderm patch should be applied. The ADON stated it should be applied for 12 hours then removed and not re-applied. The ADON also stated that Resident #82's Lidoderm order should be clarified to have it removed after 12 hours. On 11/22/24 at 9:42 AM the survey team interviewed the CP by telephone and discussed concerns. The surveyor asked the CP if 2 PRN orders such as MOM and MiraLAX that were ordered without directions which to give first and/or how many times a day it can be given should be commented on and considered an irregularity. The CP stated, yes, that would be considered an irregularity, and a comment should be made. The surveyor also asked the CP if they were aware of the dosage, application, and timing for Lidoderm Patches. The CP stated yes, they were aware and that it should be applied for 12 hours and removed for 12 hours. The surveyor asked the CP if the Lidoderm Patch was being applied for 24 hours, would that be considered an irregularity and a comment made. The CP replied, yes, it should be commented on. 38327 5. On 11/18/24 at 11:29 AM, the surveyor observed Resident #57 seated in a wheelchair inside their room with right-hand limitation. The resident informed the surveyor that they had multiple hospitalization s during their stay in the facility due to a stroke. The surveyor reviewed the medical records of Resident #57 and revealed: The AR revealed that the resident was admitted to the facility with the following medical diagnoses that were not limited to hemiplegia (paralysis that affects only one side of your body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following nontraumatic intracerebral hemorrhage (bleeding into the brain tissue; is the second most common cause of stroke) affecting the right dominant side, type 2 diabetes mellitus without complications, and conversion disorder with seizures or convulsions. The most recent cMDS (modified) with an ARD of 11/07/24, under Section Cognitive Patterns revealed a BIMS score of 15 out of 15 which reflected that the resident had intact cognition. A review of the October and November 2024 OSR revealed: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lisinopril tab 40 mg give 1 tab by mouth one time a day for hypertension (HTN) Hold for SBP < 120 and Pulse < 50 (systolic blood pressure less than 120 and pulse less than 50); -Start Date 8/07/2024 -Metoprolol Tartrate Oral tab 100 mg give 1 tab by mouth two times a day for HTN Hold for SBP less than 120, HR (heart rate) less than 50-Start Date 8/07/2024 The above orders for Lisinopril and Metoprolol were transcribed to the October and November 2024 eMAR, signed by nurses as administered and revealed: -Lisinopril=there were six times in October and three times in November 2024 at 9 AM that the med was administered beyond the parameters and did not follow the PO. -Metoprolol Tartrate=there were seven times in October and three times at in November 2024 at 9 AM that the med was administered beyond the parameters. There were eight times in October and five times in November 2024 at 5 PM that the med was administered beyond the parameters and did not follow the PO. October and November 2024 eMAR: -Lisinopril at 9 AM: Date SBP 10/04/24 107/72 10/05/24 110/70 10/06/24 118/68 10/19/24 112/68 10/24/24 119/68 10/28/24 118/77 11/11/24 114/72 11/12/24 112/81 11/19/24 116/73 -Metoprolol Tartrate: Date 9 AM SBP 10/04/24 107/72 10/05/24 110/70 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/06/24 118/68 10/08/24 113/81 10/19/24 112/68 10/24/24 119/68 10/28/24 118/77 11/11/24 114/72 11/12/24 112/81 11/19/24 116/73 Date 5 PM SBP 10/02/24 119/87 10/03/24 102/76 10/05/24 115/67 10/08/24 115/69 10/09/24 103/81 10/14/24 114/75 10/19/24 118/63 10/20/24 118/69 11/07/24 108/83 11/10/24 107/75 11/12/24 107/74 11/13/24 96/72 11/14/24 96/70 A review of the Progress Notes (PN) revealed that on 10/20/24, the CP documented and electronically signed in their DRR (Drug Regimen Review) Documentation that a med regimen review was performed with no irregularities found. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 02:06 PM, the surveyor interviewed the LPN in the nursing station of Unit 1. The LPN informed the surveyor that the nurse should follow the PO for blood pressure med with parameters on when to hold the med. The surveyor notified the LPN of the above findings and concerns. The LPN reviewed the eMAR for Lisinopril and Metoprolol and stated that the nurse should have followed the PO not to administer when SBP was below 120, and the LPN acknowledged the concerns of the surveyor. On 11/21/24 at 10:03 AM, the surveyor interviewed the Registered Nurse (RN) via phone conference. The RN stated that the medications (meds) with parameters should follow the order of when to hold it. The surveyor notified the RN of the concern that the meds Lisinopril and Metoprolol were on dates 10/05/24, 10/06/24, and 10/19/24 that she signed the eMAR as administered when the SBP was below 120. The RN stated that she knew she should follow the instructions do not give it beyond the parameters. On 11/21/24 at 12:44 PM, the survey team met with the LNHA, ADON, Regulatory Compliance Advisor (RCA), and the Market President Special Project (MPSP). The surveyor notified the facility management of the above concerns about Resident#57's blood pressure meds and that the CP did not identify the irregularity that the meds were administered by nurses beyond the parameters. On 11/22/24 at 02:24 PM, the survey team met with the LNHA, ADON, RCA, and the MPSP. The ADON stated that the parameters should have been followed. A review of the facility's Medication Monitoring Medication Regimen Review and Reporting Policy with a date of 01/24 that was provided by the LNHA revealed: Policy: MRR or DRR is a thorough evaluation of the med regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with med. The MRR includes a review of the medical record in order to prevent, identify, report, and resolve med-related problems, med errors, or other irregularities. The MRR also involves collaborating with other members of the IDT, including the residents, their families, and/or resident representatives. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor, and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-29.3 (a)(1)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46049 Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to adequately monitor target behaviors for the use of a psychotropic medication for 1 of 5 residents (Resident #53) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 11/18/24 at 12:10 PM, the surveyor observed Resident #53 lying in bed with their head of the bed elevated. The resident was alert, oriented, pleasant, and conversant. On 11/19/24 at 11:50 AM, the surveyor reviewed the paper and electronic medical record (EMR) of Resident #53. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, hypertension (high blood pressure), depression, rheumatoid arthritis, and anxiety disorder. A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/05/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #53 scored a 15 out of 15, which indicated the resident was cognitive intact. A physician's order (PO) dated 11/03/23 documented venlafaxine HCl [hydrochloride] oral tablet (tab) 25 mg [milligrams], give 1 tab by mouth one time a day for depression. A PO dated 10/14/24 documented lorazepam 0.5 mg oral tab, give 1 tablet by mouth at bedtime for anxiety. A PO dated 9/03/22 documented, Is resident free from side effects of psychotherapeutic medications (meds)? (if no, document side effects in PN (progress notes) every shift for protocol. A PO dated 7/6/23 documented monitor for target behaviors: sadness, restlessness, insomnia, anxious. If Y[yes], write behavior observation in the nurses' notes every shift. A care plan (CP) for Resident #53 dated 9/08/22 related to the use of psychotropic meds which included lorazepam and venlafaxine. The CP interventions which included to monitor for changes in mood and to monitor for continued need of medication (med) as related to behavior and mood. A review of the October 2024 and November 2024 Medication Administration Record (MAR) revealed there were no entries for monitoring of target behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of assessments and PN revealed there was no documentation for monitoring of the resident's target behaviors. On 11/21/24 at 12:47 PM, the surveyor notified the Market President Special Projects (MPSP), the Assistant Director of Nursing (ADON), the Licensed Nursing Home Administrator (LNHA), and the Regional Compliance Advisor (RCA) of the concern that there was no monitoring of target behaviors for the resident who was receiving routine Ativan for anxiety. The surveyor asked where behavior monitoring would expect to be documented. The ADON replied, it would be documented in the MAR. The facility was to provide further information. On 11/22/24 at 02:24 PM, the LNHA, ADON, MPSP, and the RCA met with the survey team. The ADON acknowledged there was no documentation for the monitoring of target behaviors of Resident #53. The ADON stated the behavior order was added to the MAR and in-service education to be provided to staff. There was no additional information provided by the facility. The surveyor reviewed the facility's Behaviors: Management of Symptoms Policy with a last revised date of 7/01/24. Under Purpose it documented: To identify, prevent, and mange behavioral symptoms by .Monitoring outcomes of CP interventions. Under Practice Standards it detailed: . 2. Staff will monitor for and document in the medical records any exhibited behavioral symptoms . 6. When med is ordered for behavioral symptoms . 6.2 Complete the Psychotropic/Therapeutic Med Use Evaluation when a patient is newly prescribed a psychotherapeutic med and then quarterly. NJAC 8:39-27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49078 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication for 2 of 3 medication storage areas and 2 of 2 medication refrigerators inspected according to facility's policy and standard of clinical practice. 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 11/19/24 at 01:03 PM, the surveyor began to inspect selected medication (med) storage areas in the facility. The surveyor observed the following: The surveyor in the presence of the med nurse on duty, inspected the med storage area located in the Unit 1 nurses' station. The surveyor accessed the refrigerator located underneath the desk area and observed that it contained influenza vaccine and Covid-19 vaccine with a temperature log for the refrigerator (ref) located in a separate binder on a shelf. The ref log reflected documentation of internal temperatures once per day with several days not logged. The surveyor also observed a separate locked box that is used to secure controlled substances that require refrigeration. The surveyor was able to remove the locked box from the ref and observed that the chain that was attached was not permanently affixed to the ref itself. At this time, the Assistant Director of Nursing (ADON) entered the nurses' station. The surveyor showed the ADON the unattached lock box and the temperature logs with the vaccines. The ADON acknowledged that the lock box was not secured, and that the ref contained vaccines and the temperatures were recorded once per day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor in the presence of the med nurse, inspected the med storage areas located in the Unit 4 nurses' station. The surveyor accessed the ref located on top of the counter and observed that it contained influenza vaccine and pneumococcal vaccine with a temperature log located in a separate binder. The ref log reflected documentation of internal temperatures once per day. The surveyor also observed the med storage cabinet in the nurses' station had a chain through the 2 handles and a small combination lock. The surveyor proceeded to open the cabinet door, which opened with the chain attached, far enough for the surveyor to gain access and remove various medications (meds) located in the storage area. The surveyor asked the med nurse if that storage cabinet was secure. The med nurse stated that it did not look like it was. The surveyor reviewed the CDC (Centers for Disease Control and Prevention) guidelines for vaccine storage which reflected for Monitoring Vaccine Temperatures, to ensure the safety of vaccines, the storage unit minimum and maximum temperatures should be checked and recorded at the start of each workday. If using a TMD that does not display minimum and maximum temperatures, then the current temperature should be checked and recorded a minimum of two times (at the start and end of the workday). On 11/21/24 at 12:47 PM, the survey team met with Licensed Nursing Home Administrator (LNHA) and the ADON and discussed the concerns with med storage. A review of the facility's Medication and Vaccine Ref/Freezer Temperatures Policy and a policy titled Storage of Med revealed: IC401: Purpose: To ensure meds and vaccines are maintained at a safe temperature. Process: 1.2 Document internal temperatures on the Med/Vaccine Ref Temperature Log Temperature Log for Med/Vaccine Refrigerators-Fahrenheit which reflected 2. Record temps twice each day. 4.1 Storage of Medications: Policy-Meds and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations. To keep their integrity and to support safe, effective drug administration. The med supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer meds . Procedures, 2.Schedule II meds and preparations must be stored in separately locked permanently affixed compartment. Controlled substances stored in ref should be secured such as a separately locked, permanently affixed compartment. (See Section 4.2- Controlled Med Storage.) Section 4.2 was not provided by the facility. 3.Med rooms, cabinets and med supplies should remain locked when not in use . 11.The temperature of any ref that stores vaccines should be monitored and recorded twice daily . NJAC 8:39-29.4(d)(g)

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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 - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46049 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure meals were served at safe and appetizing temperatures for 1 of 4 nursing units (Wing 2), during the lunch meal service on 11/22/24. This deficient practice was evidenced by the following: On 11/18/24 at 12:10 PM, the surveyor observed Resident #53 resting in their room. The resident was alert, oriented and verbally responsive. The resident stated the staff were nice and helpful. The surveyor asked Resident #53 about the food served at the facility. The resident stated that sometimes the food was cold when received. A review of last three months of resident council minutes revealed: In September 2024, residents reported food was not always hot by the time it was served to their room. In October 2024, residents reported coffee not being hot in dining room. A review of grievances from August 2024 to November 2024 included the following: In August 2024, there was one (1) grievance related to resident concern that food was always cold. In October 2024, there was one grievance related to resident concern of food being cold. In November 2024, there was one grievance related to concern during resident council of coffee in the dining room was not hot when served. On 11/22/24 at 11:37 AM, the surveyor arrived in the kitchen, in the presence of the Food Service Director (FSD) and District Manager (DM) to observe the serving of the lunch meal for the day including food temperatures. The DM calibrated the food thermometer to 32 degrees Fahrenheit (F) in the presence of the surveyor using the ice bath method. On 11/22/24 at 11:41 AM, the surveyor observed the DM take the following temperatures for the regular texture lunch meal. Chicken patties (to be served in sandwich buns) -184 F; Mixed vegetables -193 F On 11/22/24 at 11:47 AM, the dietary cook began serving the lunch meal. The cook served the hot foods on a plate which was then placed in plastic insulated bases and covered the domes, which were then placed on the resident meal trays on the truck. (continued on next page)

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	315138	A. Building B. Wing	11/25/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/24 at 11:57 AM the surveyor observed the DM take the following temperatures for cold and hot beverages: pink lemonade juice- 35 F; milk-34 F; coffee-150 F The first three trucks were completed and went to wing 4, wing 3 and wing 1 respectively. The fourth truck completed with the atrium (dining area). On 11/22/24 at 12:49 PM, a Dietary Aide (DA) left the kitchen with the meal truck to be delivered to the wing 2 unit, which included a regular texture test tray. The surveyor and the DM with calibrated thermometer followed the meal truck to wing 2. On 11/22/24 at 12:50 PM, the DA arrived on Wing 2 with the meal truck. On 11/22/24 at 12:51 PM, the Certified Nurse Aide (CNA) on wing 2 began passing out the lunch meal trays to the residents on the unit. The surveyor asked the DM what the temperature expectations for the hot foods was to be served and on the test tray. The DM stated the expectation would be 140 F or higher. The surveyor asked about the methods to maintain hot food temperatures. The DM stated that they used hot plated domes with the insulated lids and bottoms. On 11/22/24 at 12:59 PM, the last resident meal tray on the truck was served by the CNA. The surveyor observed the DM take the following temperatures for the regular texture lunch meal: Chicken patty (served in buns)-123 F Mixed vegetables- 117 F pink lemonade juice-39 F coffee-141 F. The DM acknowledged the chicken patty and mixed veggies, were not the expected temperatures for the food served. The surveyor requested from the DM any policy related to food temps to be provided. On 11/22/24 02:24 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), the Market President Special Projects (MPSP), and the Regional Compliance Advisor (RCA) about the above concerns for the food temperatures of the test tray. On 11/25/24 at 01:12 PM, the LNHA, Director of Nursing, ADON, and RCA met with the survey team. The RCA stated for food temperature concerns that all hands-on deck approach for meal delivery would be implemented. The RCA further stated that the facility had heater on demand bottoms and would monitor the quality of temperatures when served on the units. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility provided policy titled, Food: Quality and Palatability with a last revised date of 2/2023. Under Policy it detailed, food will be palatable, attractive, and served at a safe and appetizing temperature. NJAC 8:39-17.4(a)2

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46049 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 11/18/24 at 10:04 AM, the surveyor, in the presence of the Food Service Director (FSD), observed the following during the kitchen tour: 1. On the bottom shelf of a food prep table, next to the dry food storage area, there was a metal tray with 10 bowls of cereal resting on top of boxes of napkin and other utensil supplies. On 1 of the 10 cereals' plastic lid was a clear liquid substance. The surveyor asked the FSD about the observation. The FSD pulled out the metal tray and confirmed the observation. The FSD could not speak to where the liquid came from, and no other areas were wet. 2. On a food prep table across from the walk-in refrigerators, the right side of the table was noted with a small, dried, food debris substance, beige-brown in color. There was no one in area preparing food. The Regional Director of Operations (RDO) who was present at the time acknowledged and stated the staff would clean the table. On the same food prep table on left side of the sink, the surveyor observed a chef knife soiled with white food debris in a metal quarter size pan. There was no one in the food prep area. The RDO called the cook to ask about it, he was not using it for food preparation and took both items to be washed. 3. In the dry rack storage area, the surveyor observed two stacked cooking pots. The manager in training picked up the cooking pots for the surveyor to check. The surveyor observed inside the cooking pot on top of the stack had dry food debris. The manager in training and FSD confirmed that it was soiled and needed to be re-washed. The pot was taken to the dish washing area. On 11/21/24 at 10:25 AM, the surveyor, in the presence of the FSD, toured the kitchen and observed the following: 4. The surveyor observed 4 of the steam table trays uncovered. There was clear water in the compartments and the metals were noted soiled with debris. The surveyor asked the FSD to lift the covers of the last 2 steam table trays. The two compartments also had clear water with the metals noted soiled with debris. The RDO joined the surveyor and FSD, acknowledged they were soiled and that she had just told the staff to clean upon seeing them. The surveyor asked how often the steam table trays were cleaned. The RDO stated they were drained every day and were expected to be cleaned once a week and as needed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/21/24 at 12:47 PM, the surveyor informed the Market President Special Projects (MPSP), the Assistant Director of Nursing (ADON), the Licensed Nursing Home Administrator (LNHA), and the Regional Compliance Advisor (RCA) of the above concerns observed in the kitchen. On 11/22/24 at 02:24 PM, the LNHA, ADON, MPSP, and the RCA met with the survey team. The MPSP stated the observed concerns were cleaned after surveyor observation and education provided to the dietary staff. The area where prepped cereal was stored was moved to a dry storage area to prevent reoccurrence. A review of the facility's policy titled, Warewashing with a last revised date of 9/2017, under Policy Statement indicated: All dishware, serviceware, and utensils will be cleaned and sanitized after each use. A review of the facility's undated policy titled, Equipment, under Policy Statement indicated, All foodservice equipment will be clean, sanitary, and in proper working order. Under Procedures further indicated, .3. All food contact equipment will be cleaned and sanitized after every use .4. All non-food contact equipment will be clean and free of debris . NJAC 8:39-17.2(g)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on the interview and review of facility documentation, it was determined that the facility failed to ensure that facility wide assessment included the resources required to establish policies and procedures for the management of staffing contingency plans in order to meet the requirements and needs of all residents in the facility. This failure had the potential to affect all 97 residents who currently live in the facility. This deficient practice was evidenced by the following: During the entrance conference on 11/18/24 at 10:04 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a copy of the Facility Assessment (FA). The LNHA stated that the facility's census (the number of residents currently under the care of a specific facility) was 97. A review of the facility's Facility assessment dated [DATE] did not include information about the facility's contingency plan for staffing. A review of the Nurse Staffing Report For the week of Complaint staffing from 9/10/2023 to 9/16/2023, the facility was deficient in CNA (Certified Nursing Aide) staffing for residents on 7 of 7 day shifts. Further review of the Nurse Staffing Report for 2 weeks of staffing prior to survey from 11/03/2024 to 11/16/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts. On 11/20/24 at 10:32 AM, all five residents informed the surveyor during the Resident Council meeting that there were concerns with short staff. All residents stated that the concerns with short staff were previously discussed in other Resident Council meetings and the facility management was aware of it. A review of the 10/21/24 Resident Council Meeting minutes revealed that the Assistant Director of Nursing (ADON) discussed the industry-wide nursing shortages. On 11/25/24 at 9:16 AM, the surveyor interviewed the LNHA regarding FA. The LNHA informed the surveyor that she was unaware of the updates and new memo from CMS (Centers for Medicare and Medicaid Services) about the FA, effective 8/08/24. She further stated that the facility followed the New Jersey (NJ) Mandated law for staffing, and that should be in their FA. The LNHA acknowledged that the FA should address the needs of the residents in the facility. On that same date and time, the surveyor asked the LNHA if she was aware of the short staffing in the facility, and the LNHA responded Yes, and that the facility was not meeting the state-mandated law for staffing which the CNA ratio for 1st shift 1:8, 2nd shift 1:10, and 3rd shift 1:14, and was not meeting the requirements both weekdays and weekends. The surveyor asked the LNHA do they knew how long the facility had not been able to meet the NJ-mandated law, and the LNHA responded Since I started in July 2024. The surveyor asked the LNHA for the following attachments that were not in the provided FA and she said she would get back to the surveyor: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-page 43 of 44. Additional Supporting Documents: CMS Facility Assessment-Staff.pdf (date uploaded 8/03/24) -page 44 of 44. Staffing Plan Template (date uploaded 8/15/24) At that time, the surveyor notified the LNHA of the concern that the previously submitted FA did not include information about the contingency plan for staffing. On 11/25/24 at 10:45 AM, the LNHA provided a copy of the Staffing & Personnel and stated that was page 44 of 44 Staffing Plan Template (SPT) and revealed: Nursing: Direct Care License Nurses (Registered Nurses and Licensed Practical Nurses); total # needed, average range, or ratio 20 [Day shift: 5, Evening shift: 6, Night shift: 5] Nurse Aides (CNA); total needed, average range, or ratio 27 [Day shift: 13, Evening shift: 8, Night Shift: 7] The above SPT was based on the FA's census of 97 according to the 9/05/24 records. Further review of the above SPT revealed it did not meet the NJ mandated staffing ratio for CNAs of the Evening shift: 1:10 and revealed: Census: 97 Evening shift 8 CNAs=1:12 (it should be 1:10) On 11/25/24 at 11:25 AM, the surveyor followed up on the attachments for page 43 of 44. A review of the facility's Facility Assessment Policy with review and revised date of 8/15/23 that was provided by the LNHA revealed: Policy: The Center will review and update the assessment annually and whenever there is, or the Center Plans, for any change that would require a substantial modification to any part of the assessment. If there are substantive changes that occur in the Center prior to the annual assessment, the update will occur earlier. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor, and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-5.1(a)

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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** 38327 REPEAT DEFICIENCY Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to follow appropriate hand hygiene, and use of personal protective equipment (PPE) for 2 of 7 staff (Housekeeper and non-certified Nursing Aide) and follow appropriate infection control practices when performing high contact care activities in an enhanced barrier precaution (EBP) to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 11/20/24 at 12:01 PM, the surveyor and the Licensed Practical Nurse (LPN) walked down the hallway of Unit 3 and observed Housekeeper #1 (HK#1) come out of room [ROOM NUMBER] with a surgical mask in use and with both gloves while holding a plastic bag of garbage and immediately disposed of the garbage into the cleaning cart that was parked in the middle of the hallway. Afterward, HK#1 doffed (removed) off used gloves and discarded them inside the cleaning cart garbage bag. HK#1 pushed the cleaning cart to room [ROOM NUMBER] without performing hand hygiene after gloves removal and immediately entered the room. LPN then left the surveyor and went to Unit 3 nursing station. Afterward, the surveyor asked HK#1 for an interview. HK#1 informed the surveyor that he went to room [ROOM NUMBER] to pick up the garbage and was about to check room [ROOM NUMBER]. The surveyor notified HK#1 of the above concerns that he exited room [ROOM NUMBER] without removing gloves and performing hand hygiene, and with gloves in use in the hallway, and HK#1 had no response. At this time, HK#2 came and notified the concern about HK#1's use of gloves in the hallway and did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 12:44 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), ADON, Regulatory Compliance Advisor (RCA), and the Market President Special Project (MPSP). The surveyor notified the facility management of the above regarding HK#1's use of gloves in the hallway and did not perform hand hygiene. On 11/25/24 at 9:48 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN). The surveyor asked the IPN if she was aware of the above concerns of the surveyor regarding HK#1. The surveyor asked the IPN what should have happened, and the IPN responded that HK#1 should remove gloves and perform hand hygiene after removing gloves, before exiting the room, and the cleaning cart should not be in the middle of the hallway. She acknowledged that the facility management notified her of the surveyor's concerns last week regarding HK#1. On 11/25/24 at 02:46 PM, the survey team met with the LNHA, Director of Nursing, ADON, Market Clinical Advisor, and the RCA for an exit conference. The facility management did not provide additional information and did not refute the findings. 46049 2. On 11/18/24 at 12:35 PM, during a tour on a unit, the surveyor observed the Certified Nursing Assistant (CNA) exit Resident #71's room and observed a non certified Nursing Aide (NA) in Resident #71's room, making the resident's bed. Resident #71's door had an EBP sign posted and a PPE supply bin at the door. The EBP signage indicated that PPE such as gloves and gown should be worn during high-contact care activities to reduce the spread of multidrug resistant organisms (MDROs). High-contact care activities included but were not limited to, dressing, transferring, and changing linens. On 11/18/24 at 12:38 PM, the surveyor interviewed the CNA who the NA was assigned to train under, about EBP protocols. The CNA stated that usually residents with indwelling medical devices and wounds, staff wore PPE (gown and gloves) to protect residents from infection when providing care to residents. The surveyor asked the CNA when making beds and changing linens if PPE should be worn in an EBP room. The CNA replied only if providing direct care to a resident. The surveyor reviewed with the CNA the EBP sign posted, which included a list of high contact activities requiring gown and gloves, at the resident's door. The CNA read the list which included changing linens. The surveyor asked the CNA if making the bed would be included with changing linens. The CNA replied yes and acknowledged the NA should have had on a PPE gown. The CNA stated the NA was new and she would tell her. On 11/18/24 at 12:40 PM, the surveyor interviewed the NA who was asked about EBP. The NA stated the EBP sign was to remind staff to take precautions when providing care and to wear PPE. The surveyor discussed observation of NA making the bed and not wearing PPE gown. The NA with the surveyor reviewed the EBP signage. The NA acknowledged should have worn a gown making the beds because there might be stuff on them. On 11/18/24 at 02:05 PM, the surveyor informed the Registered Nurse Unit Manager (RN/UM) of the above concerns. The RN/UM acknowledged the NA should have used PPE while making the bed in the room and she would review with the staff. On 11/21/24 at 11:16 AM, the surveyor interviewed the IPN about EBP and observed concerns. The IPN stated it was expected for staff to wear PPE gown and gloved when making beds of residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the paper and electronic medical record of Resident #71. The Admission Record (a summary of important information about the resident) revealed that Resident #71 had diagnoses that included but were not limited to, Urinary Tract Infection, and a history of enterocolitis due to clostridium difficile. A physician's order dated 10/10/24 indicated Infection precautions - enhanced barrier due to MDRO in urine. On 11/21/24 at 12:47 PM, the surveyor informed the LNHA, ADON, MPSP, and RCA of the observed concern of the not using appropriate PPE while performing high contact activity in an EBP room. On 11/22/24 at 02:24 PM, the LNHA, the ADON, the MPSP, and the RCA met with the survey team. The LNHA stated when the NA returned to work at the facility, in-service education would be provided as well as to all other staff. There was no additional information provided by the facility. A review of the facility's policy titled Enhanced Barrier Precautions with a last revised date of 5/01/24, documented the required PPE were gown and gloves prior to high contact care activity. High contact patient care activities included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, and medical device care or use. N.J.A.C. 8:39-19.4(a)(1),n