STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfront Rehabilitation and Healthcare Center	633 State Route 28 Raritan, NJ 08869

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that an air mattress was accurately set according to the resident's weight. This deficient practice was identified for 2 of 2 residents (Residents #31 and #76) reviewed for positioning and mobility, and was evidenced by the following: 1). On 9/25/2025 at 10:48 AM, the surveyor observed Resident #31 awake and alert, resting in bed on a low-air-loss mattress (a mattress used to prevent pressure ulcers), with the weight set between 250 and 280 pounds. On 9/26/2025 at 10:55 AM, the surveyor made a follow-up visit to the resident's room. Resident #31 was observed resting in bed on the low-air-loss mattress. The mattress weight setting was between 250 and 280 pounds. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to amyotrophic lateral sclerosis (a progressive neurodegenerative disease that affects motor neurons, leading to muscle weakness and eventually paralysis). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/20/2025, included that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed the resident utilized a pressure-reducing device for the bed. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 2/17/2025, that the resident was at risk of skin breakdown. The Interventions included but were not limited to providing the resident with an air mattress. A review of the Order Summary Report (OSR), dated as of 9/27/2025, included a physician order (PO), dated 9/26/25, to check the placement and function of the mattress every shift. The physician's order was obtained after the surveyor inquired. A review of Resident #31's weight summary revealed that the resident's most recent weight was obtained on 8/7/2025 and was 191 pounds. 2). On 9/25/2025 at 11:17 AM, the surveyor observed Resident #76 in bed, awake and alert, resting in bed, on a low-air-loss mattress with the weight set to 485 pounds. On 9/26/2025 at 10:45 AM, the surveyor made a follow-up visit to the resident's room. Resident #76 was observed resting in bed on an air mattress. The mattress weight setting was set to 485 pounds.A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: weakness, low back pain, and spinal stenosis (a condition where the spinal canal, the space around the spinal cord becomes narrowed). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/11/2025, included that the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS revealed the resident utilized a pressure-reducing device for the bed. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 9/23/2021, that the resident was at risk for skin breakdown. Interventions included but were not limited to: provide a pressure-reducing mattress and keep the skin clean and dry. A review of the Order Summary Report (OSR), dated as of 9/27/2025, included a physician order (PO), dated 8/28/2025, for a low-air-loss mattress and to check the placement every shift. A review of the Treatment Administration Record (TAR) revealed that on 9/25/2025, the day, evening, and night shift nurses signed that the air mattress was checked for placement.A review of the weight summary (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that Resident #76's most recent weight was obtained on 9/5/2025 and was 120 pounds.On 9/26/2025 at 11:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 who stated that the setting on the air mattress should be checked during the start of the shift and at the end of the shift. The LPN #1 stated that she was unsure how to determine what the air mattress should be set on for the resident. The LPN #1 also noted that she was not trained on how to determine the correct setting of the air loss mattress. The LPN #1 further stated that it was important for the mattress to be on the correct setting to promote healing of any wounds and to make sure the resident does not develop any new wounds, and to take the pressure off the areas that are prone to getting wounds. On 9/26/2025 at 11:24 AM, the surveyor interviewed the Licensed Practical Nurse Supervisor (LPNS), who stated that the air mattress should be checked every shift and it should be set according to the resident's weight. At that time, the surveyor and the LPNS went to Resident #31's room, followed by Resident #76's room. The LPNS confirmed the findings. A review of the facility's Support Surface Guidelines an undated policy included, Redistributing support surfaces are to promote comfort for all bed or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. NJAC 8:39-27.1 (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. Based on observation and interviews, it was determined that the facility failed to store and maintain the ice scoopers in a sanitary manner.This deficient practice was identified on 3 out of nursing 4 wings that contained ice coolers (Wings #1, #3, and #4) and was evidenced by the following: On 9/29/2025 between 11:18 AM and 12:20 PM, the surveyor observed the following:Wing #1 had a blue ice cooler that had a white mesh bag attached to it. There was an ice scooper resting in the mesh bag. The bottom of the mesh bag contained a moderate amount of black residue.Wing #3 also had a blue ice cooler with a mesh bag attached to it. Inside of the mesh bag there was an ice scooper resting inside of a foam cup. Within the cup, the surveyor observed a yellow-tinged liquid with black residue. Wing #4 had a blue ice cooler that had a mesh bag attached to it. When opened, the mesh bag revealed an ice scooper that had been placed into a plastic bag, that was not self-draining as required.On 09/29/2025 at 12:21 PM, the surveyor and the Infection Preventionist (IP) toured the units together and confirmed the findings.At that time, the surveyor interviewed the IP, who stated that ice scoopers should not be stored in foam cups or plastic bags, only the designated mesh bags. She further stated that the mesh bags used to store the scoopers should be cleaned daily by the kitchen staff, for infection control purposes.On 9/29/2025 at 12:44 PM, the surveyor interviewed the Food Service Director (FSD), who stated, That's a good question, when asked who was responsible for cleaning the mesh bags. The FSD further stated that he was unaware that the mesh bags existed, and that the kitchen staff never cleaned them. He also stated that it was important to clean the mesh bags because bacteria and mold could build up.The facility was unable to provide the surveyor with a policy that pertained to maintaining the ice scoopers and cleaning the mesh bags.NJAC 8:39-19.4 (a)