STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44605 Based on observations, interviews, and review of facility policy, it was determined that the facility failed to ensure residents were treated with dignity and respect by failing to remove the weekly menus posted from resident's rooms who had a physician's order (PO) for NPO (nothing per orem (mouth)). This deficient practice was identified for 3 of 3 residents (Resident #40, #88, and #141) reviewed that had a PO for NPO. The deficient practice was evidenced by the following: 1. On 10/10/24 at 10:13 AM, the surveyor observed Resident #141 seated on a Geri-chair (geri-chair is a large, padded chair that is designed to help seniors with limited mobility) in their room awake with their ongoing tube feeding (TF) (a way of providing nutrition directly into the gastrointestinal tract through an enteral access device (feeding tube) that is placed with its tip in the stomach or small intestine) machine. The surveyor further observed the facility's weekly menu posted on the wall next to Resident #141's bed. A review of Resident #141 medical records revealed that the resident was admitted to the facility with diagnosis that included but were not limited to Dysphagia (difficulty in swallowing), Gastrostomy (tube inserted directly into the stomach to assist with feeding), Depression, and Muscle Weakness. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/24/24, revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated the resident had severely impaired cognition. A review of the October 2024 Physician Orders Sheet (POS) revealed a PO dated 9/21/23, NPO diet, NPO texture, NPO consistency. A review of Resident #141 care plan (CP) with a reviewed date of 9/25/24 revealed under the nutrition portion of the CP a Focus titled, Resident is at risk for malnutrition related problem secondary to diagnosis and past medical history of dysphagia, gastrostomy, reliance on TF/PEG to meet nutrition al and hydration need r/t (related to) NPO status. 2. On 10/10/24 at 10:50 AM, the surveyor observed Resident #40 with eyes closed in bed with their ongoing TF machine. The surveyor further observed the facility's weekly menu posted on the wall next to the resident's bed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident #40's medical record revealed that the resident was admitted to the facility with diagnosis that included but were not limited to Dysphagia, Gastrostomy, and Muscle Weakness. A review of the Quarterly MDS, an assessment tool used to facilitate management of care, dated 7/2/24, revealed the resident could not have a BIMS score due to cognitive impairment. A review of the October 2024 POS revealed a PO dated 10/5/23 for NPO diet, NPO texture, NPO consistency. A review of Resident #40 CP with a reviewed date of 9/27/24 revealed under the nutrition portion of the CP with a Focus statement titled, Resident is at risk for malnutrition related problem secondary to enteral feeding tube/PEG as their primary source of nutrition and hydration r/t NPO status. 3. On 10/10/24 at 11:30 AM, the surveyor observed Resident #88 awake in bed with their ongoing TF machine. The surveyor observed the facility's weekly menu posted in resident's room on wall, within sight of the resident. A review of Resident #88's medical record revealed that the resident was admitted to the facility with diagnosis that included but were not limited to Aphasia (a language disorder that affects your ability to speak and understand what others say), Gastrostomy, and Tracheostomy (hole that surgeons make through the front of the neck and into the windpipe (trachea) for breathing). A review of the Quarterly MDS, an assessment tool used to facilitate the management of care, dated 7/9/24, revealed the resident could not have a BIMS score due to cognitive impairment. A review of the October 2024 POS revealed an order dated 2/2/24, NPO diet, NPO texture, NPO consistency. A review of Resident #88's CP with a reviewed date of 7/10/24 revealed under the nutrition portion of the CP a Focus titled, Resident has enteral feeding tube/PEG as her primary source of nutrition and hydration r/t NPO status. On 10/15/24 at 9:46 AM, the surveyor interviewed the Recreation Director (RD), who stated their department placed the menus in the room, the recreation staff did not have a list of the resident's diets prior to placing the menus. The RD further stated they place a menu for every resident. The surveyor questioned the RD for any residents who had a PO for NPO/do not eat by mouth if it would be appropriate for those residents to have menus posted. The Recreation Director responded, No, it would not be appropriate for those residents to have menus On 10/15/24 at 11:30 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Quality of Life - Dignity with a revised date on 12/2023. The policy statement stated, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Under the Policy interpretation and Implementation section of the policy it stated, 1. Resident shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .12. Shall treat cognitively impaired residents with dignity and sensitivity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/15/24 at 12:02 PM, the survey team met with the LNHA, Director of Nursing, Chief Nursing Officer, and Regional Nurse Educator to discuss the above concerns. All agreed that residents who were currently with a PO for NPO should not have menus posted in their room as it is a dignity concern. No further information provided. NJAC 8:39-4.1(a)(12)(28), 17.3(c), 17.4(d)

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on observation, interview, and record review, it was determined that the facility failed to accurately complete the resident's status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care in accordance with the federal guidelines for 1 of 33 residents (Resident #45) reviewed for the accuracy of MDS coding. This deficient practice was evidenced by the following: 1. On 10/9/24 at 10:05 AM, the surveyor observed Resident #45 seated in their wheelchair in the dining room. The resident was unable to respond to the surveyor's questions. On 10/16/24 at 9:45 AM, the surveyor reviewed the electronic Medical Record of Resident #45, which revealed the following: A review of the Admission Record (AR) (an admission summary) reflected that Resident #45 was admitted to the facility with diagnoses that included but were not limited to unspecified Dementia (loss of memory), unspecified severity with agitation. A review of the most recent Quarterly Minimum Data Set (Q/MDS), dated [DATE], reflected that Resident #45 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severely impaired cognition. Further review of the Q/MDS reflected in Section N for High-Risk Drug Classes: Use and Indication under the Antipsychotic medication reflected that Resident #45 was taking anti-psychotic medication. A review of the same Q/MDS under Section N, titled Anti-Psychotic Medication Review reflected that Resident #45 did not receive antipsychotics. A review of the resident's October 2024 Order Summary Report reflected a Physician's Order (PO) dated 5/7/24 for Risperidone tablet 0.25 mg (milligram) Give 1 (one) tablet by mouth one time a day for depression with psychosis. A review of Resident #45's electronic Medication Administration Record (eMAR) revealed that the nurses signed the PO for Risperdone from July 17 to 23, 2024 indicating the resident received the medication. On 10/16/24 at 12:01 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #45, who confirmed that the resident was taking Risperdone, an antipsychotic medication of classification. On 10/16/24 at 1:15 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Chief Nursing Officer, and Regional Nurse Educator to discuss the above concern. All agreed that if there's an order for psychotropic medication, it should reflect yes in the Q/MDS assessment. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	According to the CMS (Centers for Medicare & Medicaid Services) MDS 3.0 RAI (Resident Assessment Instrument) Manual of October 2024, the RAI manual was revealed under Version 3.0 Manual, pages N-14. Steps for Assessment 1. Review the resident's medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent. On 10/15/24 at 9:32 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) over the phone. The MDSC/RN stated that the psychotropic medication was an error and should be coded as yes. The MDSC/RN added that the facility followed the RAI (Resident Assessment Instrument) manual. On 10/15/24 at 12:02 PM, the survey team met with the LNHA and DON regarding the above concern. All acknowledged that the A/MDS did not reflect the accurate information for the resident. NJAC 8:39-33.2(c)2, (d)

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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. 44605 Based on observation, interview, record review and policy review it was determined the facility failed to document PO (by mouth) intake of a resident who is NPO (nothing by mouth). This deficient practice was observed for 1 of 9 residents reviewed for Nutrition, Resident #40, and was evidenced by the following: On 10/10/24 at 10:50 AM, the surveyor observed Resident #40 with eyes closed in bed and their ongoing Tube Feeding (TF) (a way of providing nutrition directly into the gastrointestinal tract through an enteral access device that is placed with its tip in the stomach or small intestine) machine. A review of Resident #40's medical record revealed that the resident was admitted to the facility with diagnosis that included but were not limited to Dysphagia (difficulty in swallowing), Gastrostomy (tube inserted directly into the stomach to assist with feeding), and Muscle Weakness. A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate management of care, dated 7/2/24, revealed the resident's Brief Interview of Mental Status score could not be obtained due to cognitive impairment. A review of the October 2024 Physician's Order Summary revealed a physician's order dated 10/5/23 for, NPO diet, NPO texture, NPO consistency. A review of Resident #40 care plan (CP) with a reviewed date of 9/27/24 revealed under the nutrition portion of the CP with a Focus statement titled, Resident is at risk for malnutrition related problem secondary to enteral feeding tube/PEG as their primary source of nutrition and hydration r/t NPO status. A review of the most recent progress notes (PN) from the Registered Dietitian (RD) dated 9/27/24 at 6:58 AM stated, RD enteral/quarterly review: Diet order: NPO. Enteral Order: Glucerna 1.2 via G-tube at 75 milliliters per hour (ml/hr)., Total volume to infuse: 1500ml. Free water flush 160ml every 6 hours plus medication pass. This provides 1800 calories, 90 grams protein, and 1850 ml fluid plus medication pass. Recommendations: Continue current nutrition Plan of care (POC), Monitor tolerance to EN support. Goals: Maintain PO meal and snack intake >50% through next review date. See care plan for detailed goals and interventions. Will continue to monitor PO intake. On 10/11/24 at 12:07 PM, the surveyor interviewed the RD#1 via a phone call who stated, Resident #40 was NPO (nothing per orem (mouth) and does not take food or medication via mouth. The RD further stated that she made a mistake documenting to Maintain PO meal/snack intake >50% through next review date in her PN. The facility was unable to provide the surveyor with a policy regarding accuracy of documentation. On 10/15/24 at 12:02 PM, the survey team met with the Licensed Nursing Home Administrator , Director of Nursing, Chief Nursing Officer, and Regional Nurse Educator to discuss the above concerns. All agreed that the residents who had a physician's order for NPO should not have goals or recommendations regarding PO intake in the RD's notes. No further information provided. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39- 29.3 (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** 37175 Based on observation, interview, record review, and review of other documentation, it was determined that the facility failed to: a.) consistently follow a physician's order (PO) for the application of a hand splint to the left arm, b.) consistently document accountability for the placement of heel booties, and c.) follow the residents individualized comprehensive care plan (ICCP). The deficient practice was identified for 3 of 3 residents (Resident #51, #45 and #96) reviewed for positioning and mobility. This deficient practice was evidenced by the following: 1. On 10/9/24 at 11:05 AM, the surveyor observed Resident #51 in bed. There were two heel boots on the bedside table. On 10/10/24 at 12:30 PM, the surveyor observed Resident #51 in bed. There were two heel boots on the bedside table. The surveyor reviewed Resident #51 electronic Medical Record (eMR). A review of the residents Admission Record (AR) (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to Dysphagia (difficulty swallowing), Hypertension (elevated blood pressure) and Dementia (loss of memory). A review of the residents most recent Quarterly Minimum Data Set (Q/MDS), a tool used to facilitate the management of care, dated 7/16/24, revealed a Brief Interview for Mental Status (BIMS) score 00 out of 15, which indicated a severely impaired cognition. A review of the October 2024 Order Summary Report (OSR), revealed a PO dated 7/15/24 for bilateral heel booties with no time frame and accountability record for the application or removal for the heel booties. A review of the October 2024 electronic Medication Administration Record (eMAR) and the electronic Treatment Administration Record (eTAR) did not reflect the above PO. A review of the ICCP, revealed a care plan that the resident had the potential for skin breakdown related to total dependence for activities of daily living and incontinence, that included an intervention dated 2/26/24 for heel boots to bilateral feet. On 10/15/24 at 12:42 PM, the surveyor interviewed the Rehabilitation Director, who stated applying the heel boots to the resident are the responsibility of the nursing department. On 10/15/24 at 1:00 PM, the surveyor interviewed the Certified Nursing Assistant (CNA #1), who stated that when she cared for the resident she did not know where to document for the application of the heel boots. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 1:06 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated that for residents who wear heel booties there would be an area on the eMAR or on the eTAR that the nurse would sign for and know what to do for the resident. LPN #1 and the surveyor reviewed the residents eMAR and eTAR and which did not reflect the documentation for the resident's heel booties. On 10/16/24 at 10:10 AM, the surveyor interviewed the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) in the presence of the survey team and was informed that the booties were not observed on the resident for the two observation days and that there was no documentation on the eMAR/eTAR for the application for the heel boots. 46889 2. On 10/9/24 at 10:05 AM and 10/16/24 at 11:50 AM, the surveyor observed Resident #45 seated in a wheelchair in the dining room, unable to respond to the surveyor's questions. Resident #45 did not observe the resident wearing a hand splint to the left hand on both days. On 10/16/24 at 9:45 AM, the surveyor reviewed the eMR of Resident #45, which revealed the following: A review of the AR reflected that Resident #45 was admitted to the facility with diagnoses that included but were not limited to Hemiplegia (complete loss of strength on one side of the body) and Hemiparesis (partial weakness on one side of the body) following non-traumatic subarachnoid hemorrhage (bleeding in the brain) affecting left non-dominant side. A review of the most recent Q/MDS, dated [DATE], reflected that Resident #45 had a BIMS score of 7 out of 15, indicating severely impaired cognition. Further review of the Q/MDS under Section GG titled, Functional Limitation in Range of Motion reflected that the resident had impairment on one side of the upper extremity (shoulder, elbow, wrist or hand). A review of the resident's October 2024 OSR reflected a PO dated 4/2/24 for Left palm Splint: Apply after breakfast, remove before dinner check skin integrity to left hand before applying and after removal of the splint in the morning for Splint and remove per schedule. On 10/16/24 at 11:50 AM, the surveyor interviewed CNA #2, who stated that the resident was supposed to wear a carrot splint (a type of orthotic device that is used to position the finger away from the palm to protect the skin from moisture, pressure and nail puncture). CNA #2 went to the resident's room to look for a splint and found the splint on the bedside table. CNA #2 stated that she was unaware Resident #45 had to wear the splint in the morning. On 10/16/24 at 12:01 PM, the surveyor interviewed the LPN#2, who stated that the resident was supposed to wear a splint and added that the CNA's were supposed to put it on the resident and the nurses will document it to reflect that the resident's splint was applied. On 10/16/24 at 12:05 PM, the surveyor interviewed the Director of Rehab/Occupational Therapy (DOR/OT), who stated that Resident #45 had an order for the carrot splint for the left hand; she stated that all the staff, including nurses and the CNAs on the morning shift, was in service of how to put on the splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 1:15 PM, the survey team met with the LNHA, DON, Chief Nursing Officer (CNO), and Regional Nurse Educator (RNE) to discuss the concern. The staff agreed that if there's an order for devices, the resident should be wearing them. A review of the facility policy titled Splinting Procedure with a reviewed/revised date of December 2023 stated under 8. Nursing staff in-serviced on appropriate application techniques and monitoring requirements specifically associated with equipment . 3. On 10/9/24 at 11:49 AM and 10/17/24 at 10:05 AM, the surveyor observed Resident #96 in bed with eyes closed. On both observation days, Resident #96 was not observed wearing their heel boots on both feet. On 10/16/24 at 1:12 PM, the surveyor reviewed the eMR of Resident #96, which revealed the following: A review of the AR reflected that Resident #96 was admitted to the facility with diagnoses that included but were not limited to Bipolar (a mental illness that causes extreme mood swings) Disorder. A review of the recent Q/MDS, dated [DATE], reflected that Resident #96 had a BIMS score of 10 out of 15, indicating moderately impaired cognition. A review of the resident's October 2024 OSR reflected a PO dated 7/8/24 to Apply heel booties to b/l (bilateral) feet daily while in bed every shift for preventative care. On 10/17/24 at 10:05 AM, the surveyor interviewed CNA#3 regarding the heel boots. CNA #3 went to the resident's bedside table to get them and apply the heel boots to the resident. On 10/17/24 at 10:10 AM, the surveyor interviewed CNA #4 who stated that the resident had their blanket on and CNA#4 did not see whether the resident were wearing the heel booties. On 10/17/24 at 10:20 AM, the surveyor interviewed LPN #3, who confirmed that Resident #96 had a PO for heel booties to both feet while in bed after checking the eMR. On 10/17/24 at 11:00 AM, the surveyor interviewed the DON regarding the above concern. The DON acknowledged that if the resident had a PO for heel boots, it should be followed as stated in the PO. A review of the Facility policy's Medication and Treatment reviewed/revised date of January 2024, Pressure Ulcer/Skin Breakdown-Clinical Protocol reviewed/revised date of December 2023, and Splinting Procedure reviewed/revised date of December 2023, did not address complete orders and accountability documentation for heel boots. NJAC 8:39-27.1(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44605 Based on observation, interview, and record review it was determined that the facility failed to ensure nutritional evaluation for a resident on a 3-day calorie count were addressed in a timely fashion. This deficient practice was identified for 1 of 8 residents reviewed for Nutrition (Resident #20), and was evidenced by the following: On 10/10/24 at 10:07 AM, the surveyor observed Resident #20 awake in their room. During the surveyor's interview, Resident #20 stated, the food was horrible and were lacking flavor. The resident further added they have not seen the Registered Dietitian (RD) to address these concerns and believed they may have lost weight. A review of Resident #20 Face Sheet (an admission record) revealed that the resident was admitted to the facility with diagnosis that included but were not limited to Dysphagia (difficulty in swallowing), Gastrostomy (tube inserted directly into the stomach to assist with feeding), and Gastritis. A review of the most recent Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated 8/6/24 reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident's cognition was intact. A review of the resident's Physician's Orders (POs) from the electronic medical record (EMR) for September 2024 included a PO dated 9/11/24, Calorie Count x 3 days Observe at each meal, fluids, po, and snack acceptance. With meals for calorie count, hold TF document percentage (%) consumed. A review of the Nutrition Progress Note dated 9/11/2024 at 10:11 AM stated, . Plan/Recommendations: Initiate a three-day calorie count to assess their nutritional intake. Reassess the appropriateness of continuing tube feedings based on calorie count and weight data. Further review of Resident #20's progress notes revealed no evaluation of the 3-day calorie count was observed until 10 days later following the completion. On 10/11/24 at 9:50AM, the Assistant Director of Nursing (ADON) provided the surveyor with a paper copy of Resident #20's 3-day calorie from 9/12-9/14/24. The surveyor observed there was no meal percentage recording for lunch and dinner on 9/14/24. On 10/11/24 at 10:08 AM, the surveyor interviewed the RD, who stated they work 100% remotely and do not come into the facility. The RD stated, following completion of the calorie count, the RD will assess the resident's meal intake and document a progress note discussing the results and further recommendations for the resident, if any are needed. The RD further stated following the completion of the calorie count, the progress note must be written within a day or two after completion of the 3-day calorie count. The RD added that 10 days between the completion of Resident #20's calorie and progress note was an oversight and should have been completed in a timely manner. No further information was provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 8:30 AM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Calorie Counts with a revised date of February 2024. Under the policy interpretation and implementation section, 8. The completed form will be returned to the Dietitian. The Dietitian will review daily caloric intake and average the caloric intake over the three-day period .11. The Dietitian will assess adequacy of caloric intake. If necessary, interventions will be initiated in accordance with current Standards of practice. On 10/15/24 at 12:02 PM, the survey team met with the Licensed Nursing Home Administrator, DON, Chief Nursing Officer, and Regional Nurse Educator to review the above concern. The LHNA stated, they were aware of the late RD evaluation note. No further information was provided. NJAC 8:39 - 11.2(e)(1)(f), 17.1(c), 17.2(c)(d), 27.1(a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Park Healthcare and Rehabilitation Center	101 North Grove Street East Orange, NJ 07017

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46889 Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident's routine pain level assessment was being completed and documented according to the facility's policy and standard of practice. This deficient practice was identified for 1 of 2 residents (Resident #16) reviewed for pain management. This deficient practice was evidenced by the following: On 10/9/24 at 9:45 AM, the surveyor observed Resident #16 awake in bed. The resident reported they had pain to their wound on the back. The resident further stated that they request to take pain medication frequently. On 10/9/24 at 12:17 PM, the surveyor reviewed Resident #16's electronic medical record and revealed the following information: A review of the Admission Record (an admission summary) reflected that Resident #16 was admitted to the facility with diagnoses that included but were not limited to Chronic Osteomyelitis (inflammation of the bone), Open Wound Left Lower Leg, Pressure ulcer of sacral region unstageable, Pressure ulcer of left heel stage 3, and Paraplegia (inability to voluntarily move the lower parts of the body). A review of the most recent Annual Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care, dated 8/27/24, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had an intact cognition. Further review of the A/MDS reflected under Section J. Pain Management, reflected that Resident #16 was on pain medication regimen. A review of the October 2024 Order Summary Report (OSR) reflected the following pain management which included but were not limited to the following Physician's Orders (PO): Morphine Sulfate ER (extended-release) tablet 15 mg (milligram), give 1 tablet by mouth every 12 hours for pain. with an order date of 3/8/24. Oxycodone Hydrochloride (HCl) oral tablet 5 mg, give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. with an order date of 6/27/24. Acetaminophen tablet 325 mg: give 2 tablets by mouth every 6 hours as needed for mild pain. with an order date of 8/23/24. There were no PO to document the resident's pain assessment and/or pain monitoring. On 10/15/24 at 10:20 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated the resident was alert and oriented, and was able to verbalize if they were in pain. The LPN further added that the resident would request for the pain medication almost every day. The LPN stated they don't complete a pain assessment every shift. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 12:23 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) and discussed the above concern. All acknowledged that there was no pain assessment and/or pain monitoring. A review of the facility policy titled Pain Assessment and Management with a reviewed/revised date of January 2024 under General Guidelines 6. Assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. NJAC 8:39-27.1(a)

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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. 46889 Based on observation, interview, record review, it was determined that the facility failed to monitor and document any potential side effects (SE) for a resident who was psychotropic medication as per Physician's Order (PO). This deficient practice was identified for 1 of 5 residents (Resident #94) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 10/9/24 at 11:28 AM, the surveyor observed Resident #94 in bed with eyes closed. On 10/10/24 at 11:38 AM, the surveyor reviewed the electronic medical record of Resident #94, which revealed the following: A review of Resident #94's Admission Record (an admission summary) reflected that Resident #94 was admitted to the facility with diagnoses that included but were not limited to unspecified Dementia (loss of memory), unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and Anxiety (feeling of uneasiness). A review of the most recent Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated 9/26/24, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status score of 3 out of 15, which indicated that the resident had severe cognition impairment. Further review of the Q/MDS under Section N: High-Risk Drug Classes reflected that resident was on Anti-Psychotic medication. A review of Resident #94's September and October 2024 electronic Medication Administration Record (eMAR) included the following PO: Olanzapine (antipsychotic medication) tablet 5 mg (milligram) give 1 tablet by mouth at bedtime for dementia, with a start date of 7/11/2024. A review of the psychiatric progress note (PPN) dated 7/15/24 documented the resident's diagnosis which included but not limited to, Depression, Dementia, Insomnia (inability to sleep), Psychosis (loss of contact with reality) and Mood Disorder. Further review of the PPN revealed Resident #94 was on Zyprexa (antipsychotic medication) 5mg PO (by mouth) at bedtime for target symptoms including, anxiety, depression, hitting, kicking, and throwing. The surveyor did observe a PO to monitor Resident #94 for any psychotropic medication use SE. On 10/11/24, at 10:59 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the eMAR did not have a PO for monitoring or assessing the psychotropic medication use SE. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:20 AM, the survey team met with the Licensed Nursing Home Administrator and Director of Nursing (DON) regarding the above concern. The DON acknowledged that there was no PO for monitoring or assessing the psychotropic medication use SE. The surveyor reviewed the facility's policy titled Psychoactive Medication Use, with the reviewed/revised date of December 2023 stated under Policy Interpretation and Implementation, 14. Nursing staff shall monitor for and report side effects and adverse consequences of psychoactive medications to the Attending Physician. NJAC 8:39-27.1(a)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 46889 Based on the interview and review of facility records, it was determined that the facility failed to consistently serve the residents a nourishing snack when there were more than 15 hours between dinner and breakfast mealtimes. This deficient practice was identified for 4 of 5 residents (Residents #29, #61, #132, and #144) who attended during the resident council meeting and was evidenced by the following: On 10/11/24 at 10:00 AM, the surveyor conducted a group meeting with 5 alert and oriented residents selected by the facility to attend the group meeting. Four of the five residents stated they did not receive bedtime snacks. On 10/10/24 at 11:19 AM, the surveyor interviewed the Food Service Director (FSD), who stated that the kitchen provided the five units in different floors with bedtime snacks. She could not provide an information if there was an accountability system the nursing staff used to document and ensure the residents were served their bedtime snacks. The FSD stated they do not keep a snack log to document and cannot provide accountability for the snacks that were delivered to the nursing units that showed the daily snack schedule. The surveyor reviewed the for form titled, Resident Council Meeting Minutes dated 7/29/24, 8/26/24, and 9/30/24 which did not address the food and bedtime snacks. A review of the undated facility's policy titled, Meal Delivery Times list reflected the following: First-floor dinner was scheduled to arrive at 4:30 PM and breakfast at 7:30 AM, yielded a 15-hour time gap. The second-floor dinner was scheduled to arrive at 4:45 PM and breakfast at 7:45 AM, which yielded a 15-hour time gap. Third-floor dinner was scheduled to arrive at 5:00 PM and breakfast at 8:00 AM, yielded a 15-hour time gap. The fourth-floor dinner was scheduled to arrive at 5:15 PM and breakfast at 8:15 AM, yielded a 15-hour time gap. Fifth-floor dinner was scheduled to arrive at 5:30 PM and breakfast at 8:30 AM, yielded a 15-hour time gap. On 10/16/24 at 10:15 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). Both LNHA and DON acknowledged that the facility should have a log to document or records the bedtime snacks provided to the residents. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility policy titled, Snacks, with a reviewed/revised date of December 2023, included the following: It is the center policy to provide: 3) bedtime (HS-hours of sleep) snacks to residents. NJAC 8:39-17.2 (f); 17.2 (f) 1

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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. 39399 Based on observation, interview and record review, it was determined that the facility failed to maintain appropriate kitchen sanitation practices and sanitary environment to prevent the development of food borne illness. This deficient practice was evidenced by the following: During the initial tour of the kitchen, the surveyor, together with the facility's Dietary Manager (DM) on 10/9/2024 at 10:15 AM, the surveyor observed the following: Upon entering the room where the dish machine was located, the surveyor observed 2 dietary staff inside cleaning the dishes that were used during breakfast. The surveyor asked the DM to turn on the dishwasher machine. When the DM turned on the dishwasher, the surveyor observed a significant amount of water splashing towards the drying rack where there were trays placed. The DM stated to the surveyor to step back because the dishwasher had water splash. The DM stated that the rack that was placed next to the dishwasher was a drying rack used to dry the meal trays. The surveyor observed the drying rack that was placed right next to the dishwasher machine exposing the trays of water splash from the dish machine. In the drying rack, there were several trays that was observed to be wet nesting and were stacked together in two and three. The DM stated to the surveyor, the trays were used to serve the resident's meals. The DM further stated that the trays were placed there after being washed to dry. The DSD acknowledged that the trays were not supposed to be stacked together to allow them to completely dry. On 10/15/24 at 12:02 PM, the surveyor discussed the above concern to the Licensed Nursing Home Administrator (LNHA), Director of Nursing, Chief Nursing Officer, and the Regional Educator. On 10/16/24 at 10:05 AM, the LNHA stated to the surveyor that the facility does not have a policy and procedure regarding tray drying. The LNHA further stated to the surveyor that the DM agreed that the trays must not be stacked to allow for them to completely dry. No further information was provided. NJAC 8:39-17.1(a);17.2(g)