STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wellington	301 Union Street Hackensack, NJ 07601

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34421 Based on observation, interview, and record review it was determined that the facility failed to maintain the dignity of an unsampled residents. This deficient practice was found with 4 of 4 Certified Nursing Aides (CNA) observed during a dining observation on the third floor. The deficient practice was evidenced by the following: On 12/31/24 at 12:08 PM, during a lunch meal dining observation on the 2nd floor in the main dining room, the surveyor observed the lunch trays being distributed to the residents by four CNA's. The four CNA's passed out the trays to each resident and left the trays on the table underneath each of the resident's plates. There were three insulated lids left in the middle of the tables and the CNA's were observed placing wrappers and garbage inside those lids. The lids remained on the tables throughout the entire meal. At 12:18 PM, the surveyor observed CNA # 1 standing while feeding an unsampled resident. At 12:23 PM, the surveyor interviewed the CNA # 1, who stated she should have been seated while feeding the resident. On 12/31/24 at 1:00PM, the above concerns were discussed with the Director of Nursing (DON) and Administrator, who stated they will investigate this concern. On 1/02/25 at 10:17 AM, the DON and Administrator stated that there should have been dignity provided during the resident's lunch meal and that they educated the CNA's regarding these concerns. No further information was provided. NJAC 8:39-4.1(a)12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 46049 Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to ensure accurate documentation and review of a resident's advance directives for 1 of 2 residents (Resident #21) reviewed. This deficient practice was evidenced by the following: The surveyor reviewed the paper chart and electronic medical records of Resident #21. The Admission Record (a summary of important information about the resident) documented Resident #21 had diagnoses that included but were not limited to, Alzheimer's disease, heart failure, and atrial fibrillation (an irregular, often rapid heart rate). A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated 10/28/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #21 scored a 3 out of 15, which indicated the resident had severe cognitive impairment. The resident's paper chart included a New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form, dated 12/13/24, which revealed the resident had advance directives that they desired DNR, DNI, Do Not Hospitalize [DNH]. The form was signed by the resident's representative and an advance practice provider. A physician's order dated 12/12/2024 documented, DNI (Do Not Intubate). A physician's order dated 12/12/2024 documented, DNR (Do Not Resuscitate). A review of care plans revealed there was no care plan related to advance directives. On 12/31/24 at 10:07 AM, the surveyor interviewed a licensed practical nurse unit manager (LPN/UM) about advance directives. The LPN/UM stated upon admission were assessed for advance directives and as needed advance directives could be updated. He stated social services also followed up on advance directives. The LPN/UM further explained when a POLST was completed, the form would be placed in the paper chart and scanned into the EMR. The LPN/UM stated the resident's code status would be documented under the physician's orders and on the resident's dashboard (top of the screen) of the EMR. The surveyor reviewed with the LPN/UM Resident #21's POLST in the paper chart. The LPN/UM reviewed the EMR with the surveyor. The LPN/UM confirmed the physician's orders and the code status in the EMR did not include DNH. The LPN/UM could not speak to the follow up of Resident #21's POLST and stated nursing staff present when the POLST was completed should have ensured the EMR was updated. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/25 at 11:19 AM, the surveyor interviewed the Assistant Director of Social Services (ADSS) about advance directives and POLST completion. The ADSS stated social services would assess residents to determine if the resident had advance directives and if they wished to have advance directives. The ADSS stated a completed POLST would be followed up by the unit manager and nursing who would be responsible for ensuring the wishes made on the POLST were carried out. On 1/2/25 at 1:40 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) about the above concerns for Resident #21's advance directives. The DON stated that once a POLST was completed it should be completed as soon as possible. The facility was to review and provide further information. On 1/3/25 at 10:19 AM, the DON and LNHA met with the survey team. The DON confirmed the EMR was updated to reflect the POLST and code status for DNH. The DON stated in-service education was provided to staff. She further explained it was a team effort, social services were to help keep team on track with following up on advance directives, and ultimately nursing was responsible to ensure they were carried out. A review of the facility provided policy titled, Advance Directives with a revised date of September 2022 revealed under Policy Interpretation and Implementation: Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff. The residents' wishes are communicated to the residents' direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents' wishes in care planning meetings. N.J.A.C. 8:39-9.6

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, 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 2 of 18 residents (Resident #67 and #70), reviewed for MDS coding accuracy. On 1/10/25 at 10:20 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #67. The Admission Record (a summary of important information about the resident) revealed that Resident #67 was male. An entry record for the MDS assessment dated [DATE] revealed under Section A (Identification Information), A0800-Gender, the resident was coded as female. A comprehensive MDS assessment dated [DATE] revealed under section A (Identification Information), A0800-Gender, the resident was coded as female. The surveyor reviewed the EMR of Resident #70. The Admission Record revealed that Resident #70 was female. An entry record for the MDS assessment dated [DATE] revealed under Section A, A0800-Gender, the resident was coded as male. A comprehensive MDS assessment dated [DATE] revealed under section A, A0800-Gender, the resident was coded as male. On 1/3/25 at 10:29 AM, the surveyor interviewed the Registered Nurse (RN) MDS coordinator regarding MDS assessment submission. The MDS coordinator stated the guidance of the MDS 3.0 Manual [Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual] was followed. She stated MDS coordinator responsibilities included completing and ensuring the accuracy of MDS assessments. The surveyor reviewed with the MDS coordinator the MDS assessments of Residents #67 and #70. The MDS coordinator acknowledged the inaccuracies of the coding of the residents' genders on the MDS assessments. The MDS coordinator stated she would review and submit a corrected MDS assessment for the residents. On 1/3/25 at 1:09 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) about the concerns with the MDS accuracy of Resident #67 and #70. A review of the latest version of the MDS 3.0 Manual (updated October 2023), Chapter 3-page A-14, under A0800 revealed .Resident gender on the MDS must match what is in the Social Security system . NJAC 8:39-33.2 (d)

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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. 36419 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to change respiratory nasal cannula (NC) tubing according to infection control standards of practice and failed to ensure that it was stored in accordance with infection control measures for one of one resident reviewed for Respiratory therapy, Resident #24. 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 12/30/24 at 11:50 AM, the surveyor observed Resident #24 with Oxygen (O2) delivered via a nasal cannula (NC) tubing attached to the O2 concentrator at 2 liters per minute (LPM). The surveyor observed that the NC tubing was dated 12/18/24. On 1/3/25 at 10:48 AM, the surveyor entered Resident #24's room and observed that the resident was not in the room. The surveyor observed that the NC tubing was on the floor and not contained in a bag. The surveyor reviewed the medical record for Resident #24. A review of Resident #24's Admission Record indicated that the resident was admitted to the facility with diagnoses that included but were not limited to congestive heart failure, schizophrenia, and major depressive disorder. A review of Resident #24's Admission Minimum Data Set (MDS), an assessment tool, dated 12/10/24 included; a Brief Interview for Mental Status (BIMS) score of 15 of 15 which indicated the resident's cognition was intact. Section O documented that the resident was receiving respiratory treatment which included O2 therapy. A review of the Care Plan documented a focus area effective 12/9/24 which included the resident was at risk for Respiratory Impairment related to shortness of breath (SOB). Interventions included but were not limited to: Administer Oxygen therapy as per physician order. (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 January 2025 Order Summary Report revealed an active physician order (PO) with an order date of 12/9/24 for: O2 at 2LPM (liters per minute) per NC every shift for SOB and a PO: change all disposable oxygen supplies every Tuesday on night shift and as needed, label and date all supplies. On 1/3/25 at 10:50 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). The surveyor showed the ADON the NC tubing; the ADON acknowledged that the NC tubing should not be on the floor but stored in a plastic bag for Infection Control Prevention. The surveyor informed the ADON that she observed that the NC tubing was dated 12/18/24 when observed by the surveyor on 12/30/24. The ADON acknowledged that the NC tubing should have been changed and dated on 12/24/24 as it was the facility policy to change it every Tuesday on the night shift. On 1/3/25 at 11:05 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) assigned to Resident #24's care. The CNA confirmed that she should have stored the NC tubing in a plastic bag for infection control prevention. On 1/3/25 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns. The DON stated the facility policy was that the NC tubing should be changed every 7 days and stored in a bag when not in use. A review of the facility provided, Oxygen Administration policy and procedure dated/revised 10/2010, included the following: The purpose of this procedure is to provide guidelines for safe oxygen administration. N.J.A.C. 8:39- 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. 19106 Complaint NJ00170288 Based on interview, medical record review, and review of other pertinent documentation it was determined that the facility failed to ensure that residents who receive hemodialysis (HD) receive such services consistent with professional standards of practice for 1 of 2 residents (Resident #191) reviewed for dialysis services. The deficient practice was evidenced by the following: On 1/2/25 the surveyor reviewed a Reportable Event Record/Report submitted by the facility Director of Nursing (DON) to the NJ Department of Health (DOH) on 11/29/23. The Report summarized an event which occurred on 11/26/23. Resident #191 returned from the HD clinic on the evening of 11/25/23. On 11/26/23 at 5:30 PM, the resident's family member observed the resident's dialysis access site (a permanent intravenous catheter inserted into a blood vessel in the upper chest) with 2 empty syringes connected to the catheter. The syringes were used during the HD treatment at the clinic to flush the intravenous catheter with normal saline solution after the treatment was completed. The syringes should have been removed immediately after use while the resident was in the dialysis clinic. A review of the medical record and other pertinent records revealed the following information. The Admission Record indicated the resident was admitted with diagnoses including but not limited to end stage renal disease, dependence on hemodialysis, anemia in chronic kidney disease, and acute appendicitis. The 11/24/23 Admission Minimum Data Set (MDS) assessment tool indicated the resident had moderate cognitive impairment (Brief Interview for Mental Status, Section C) and received hemodialysis while a resident in the facility (Section O). The November 2023 Order Summary Report (physician's orders) included the following HD-related orders. 11/18/23 assess dialysis site for signs and symptoms of infection/bleeding every shift for monitoring. 11/20/23 dialysis Tuesday/Thursday/Saturday pick-up time 3 pm. 11/17/23 permacath to right chest every shift for dialysis site. 11/24/23 assess right chest wall permacath dialysis site for signs and symptoms of infection/bleeding every shift for monitoring. The November 2023 Treatment Administration Record (TAR) indicated Resident #191's permacath was assessed by LPN #1 on the 11 pm to 7 am shift on 11/25/23 when the resident returned from HD. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The dialysis communication report (a 3-part form which indicated the facility nurse's pre-treatment assessment, the HD clinic nurse's assessment during treatment, and the facility nurse's post-treatment assessment) accompanies the resident to the HD clinic and back with the resident to the facility. An un-named nurse documented on the 11/25/23 post-treatment section of the communication report R chest permacath - patient refuse for site to be checked. Electronic nurse progress notes on 11/25/23 did not contain an entry indicating a pre- or post-HD treatment assessment was performed. LPN #1 documented in a 12/1/23 Individual Statement Form (part of the facility's investigation of the incident) when the resident returned from dialysis at 11:30 pm there were no visible signs of bleeding (permacath) through nightclothes noted. An 11/26/23 late entry nursing progress note indicated Resident #191's family member alerted the Certified Nursing Assistant (CNA) the resident had 2 empty syringes left connected to the resident's permacath from HD the previous day. The CNA alerted the nurse, who confirmed their presence. The nurse removed the syringes and assessed the permacath. The nurse documented the site was intact with no bleeding. An 11/27/23 Care Conference Note reflected a family meeting was held with the interdisciplinary team. The note read, family requested despite if patient refuses assistance with ADLs [activities of daily living], family to be contacted to assist as needed. Family expressed concern for patient to be frequently checked on. On 1/2/25 at 10:13 AM the surveyor interviewed the DON who stated the nurse should evaluate and assess the resident's vital signs and monitor the access site and the resident's mental acuity when the resident returns from HD. The DON stated, ideally I would have them document the assessment in [the electronic record] and secondarily on the post dialysis sheet when they return. Additionally, the DON stated nursing documents each shift in the TAR the assessment of the dialysis site. However, she did confirm this is not specifically related to the timeframe of when the resident returns from an HD treatment. On 1/2/25 at 12:28 PM the surveyor conducted a telephone interview with LPN #1, the nurse who received the resident back from HD on the 11 pm to 7 am shift on 11/25/23 at 11:30 pm. LPN #1 stated the resident had on a sweater and LPN #1 only looked at the top of the permacath. She stated there was no bleeding at the top of the permacath. She stated she did not see the syringes attached to the catheter. LPN #1 stated the dialysis communication report often did not come back to her when the resident returned to the facility on the night shift. She stated she would document the post-treatment assessment in electronic nurse progress notes if she did not have the dialysis communication report. She did not explain why there was no electronic progress note for the 11/25/23 post-treatment assessment. On 1/6/25 the surveyor discussed with the Licensed Nursing Home Administrator (LNHA) and the DON the presence of 2 syringes attached to the HD access site for 18 hours without nursing intervention and the discrepancies in LPN #1's interview with the facility, the surveyor, and the documentation on the HD communication sheet. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LNHA provided the surveyor with the following dialysis-related facility policies. Hemodialysis Catheters - Access and Care of, revised February 2023, section titled Documentation instructed nurses to document in the medical record if dialysis was done during the shift, any part of report from dialysis nurse post-dialysis being given, and observations post-dialysis. Hemodialysis Pre and Post Care, revised March 2010, section titled General Information instructed nurses to assessment treatment site regularly including pre and post hemodialysis treatment. The section titled Post-Dialysis Care instructed nurses to access the dialysis access site upon return to the facility for patency, any unusual redness or swelling or bleeding. NJAC 8:39-27.1(a)

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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. 49078 Based on interviews, and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure accurate documentation of a) the receipt of a controlled substance for three (3) of three (3) Schedule II controlled substance medications ordered and received by the facility for use as an emergency backup supply, on one (1) Drug Enforcement Agency (DEA) 222 Forms (a form used to order controlled substances from a provider) reviewed and b) two (2) of two (2) controlled substances were accurately accounted for on two (2) of two (2) Controlled Drug Administration Records (CDAR) observed in one (1) of three (3) medication carts. The deficient practice was evidenced by the following: Reference: 21 CFR 1305.13 Procedure for filling DEA Forms 222. 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. On 12/31/24 at 7:56 AM, the surveyor reviewed a binder provided by the facility Licensed Nursing Home Administrator (LNHA), containing, but not limited to, facility DEA 222 Forms, copies of medical director state and federal controlled substance registration certificates, and packing slips associated with the DEA 222 Forms for controlled substance deliveries. A review of the facility DEA 222 Forms that were filled out and used to order controlled substances (CDS) revealed the following: a) DEA 222 Form with order form # 240326293 dated 3/12/24 for one (1) package of 50 oxycodone 5mg tablets (a schedule II-CDS used for pain), one (1) package of 68 oxycodone/apap 5-325mg tablets (a schedule II-CDS used for pain), and one (1) package of 21 oxycodone 15mg tablets (a schedule II-CDS used for pain) with the section Part 5: to be filled in by purchaser, number received, date received, not filled in. b) On 12/31/24, the surveyor conducted the medication storage and labeling task. The surveyor observed medication cart #1 located on the 2nd floor. The observation revealed two (2) CDAR forms for an unsampled resident where the total doses of CDS documented as available on the CDAR did not match the physical quantity located in the medication cart. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor asked the Licensed Practical Nurse (LPN) assigned to the medication cart about the discrepancy. The LPN stated that the resident who got those medications was in a rush, and I forgot to sign the sheets. The surveyor reviewed the electronic medication administration record (eMAR) for that resident which revealed that the LPN did indicate the resident received the medications. The surveyor asked the LPN what the policy and procedure was for administering CDS. The LPN stated that the CDAR should be signed as soon as the medication is removed from the packaging for administration. On 1/02/25, the surveyor met with the LNHA and the Director of Nursing (DON) to discuss the concerns with the CDS documentation and DEA form. The surveyor asked the DON how the staff should document CDS use. The DON stated the staff should document on the CDAR when the medication is removed from the packaging. On 1/3/25, the surveyor met with the LNHA and DON for responses to the CDAR and DEA form concerns. The DON provided a packing slip that coincided with the DEA 222 form that was not filled out that reflected the CDS were received by the facility. The surveyor asked the DON if the DEA 222 form should be filled in when the medications are delivered. The DON stated, yes, the form should be properly filled out at the time of receipt. No other pertinent information was provided by the DON or LNHA. 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. The surveyor reviewed the facility policies titled Medication Labeling and Storage with a revision date of February 2023. And the policy titled Administering Medications with a revision date of April 2019. The policies did not reflect any pertinent information relating DEA 222 forms or CDAR documentation. NJAC 8:39-29.3(a)6, 29.4(g), 29.7(c) 21 CFR 1305.13(e)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for one (1) of twenty-four (24) residents reviewed, (Resident #85). The deficient practice was evidenced by the following: The surveyor reviewed Resident #73's electronic medical record (EMR) which revealed the following: A review of Resident #85's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to COVID-19, heart disease, and urinary tract infection. Resident #85's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, Section C, dated 12/6/24, reflected that the resident had a Brief Interview for Mental Status (BIMS), a tool used to screen and identify cognitive condition, score of 15 out of 15, which indicated that Resident #85 was cognitively intact. Section H of the MDS reflected that the resident had a urinary catheter (a tube placed into the bladder to facilitate the passage of urine) in place. A review of Resident #85's Care Plan (relevant information about a patient's diagnosis, the goals of treatment) revealed that the resident required catheter care as of 12/6/24. A review of Resident #85's Order Summary Report (OSR), a listing of the resident's physician orders, revealed that the resident was being administered Tamsulosin .4mg, (Flomax), a medication used to relax muscles in the bladder and prostate in men to facilitate the flow of urine. A review of the resident's physician's progress notes revealed that the resident, who was admitted [DATE], did not have a catheter at that time, and as reflected in the progress note was continent of bladder. Further review of the progress notes revealed that the catheter was started 12/6/24. A progress note dated 12/14/24 but created on 12/20/24 as a late entry by the attending physician revealed On evaluation. Tamsulosin for urinary retention management which reflected the starting date for Flomax as 12/15/24, which was after the catheter was inserted. The surveyor reviewed the Manufacturer Package Insert for Flomax which reveal the approved use of Flomax under INDICATIONS AND USAGE FLOMAX (tamsulosin hydrochloride, USP) capsules are indicated for the treatment of the signs and symptoms of benign prostatic hyperplasia (BPH). The package insert also reflected the statement FLOMAX is not indicated for use in women. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the resident's physician progress notes did not reveal any notes or comments regarding the use of Flomax for an unapproved or off-label use, or a statement of benefit vs risk to the resident. On 1/3/25 at 11:41 AM the surveyor interviewed the facility's Nurse Practitioner (NP). The surveyor asked if the NP was familiar with Resident #85, the NP stated that they were. The surveyor asked the NP about the use of Flomax in Resident #85. The NP stated that the resident still had difficulty passing urine without the catheter and still has the catheter inserted and the Flomax was started to relax the bladder. The surveyor asked the NP if they thought the Flomax was effective if removal of the catheter had failed. The NP stated that they could try again and follow up with a urology consult. The surveyor asked if the NP was aware that Flomax is not indicated or approved for use in females and would a note addressing this be appropriate. The NP stated that they were aware that it is not approved, but they would not necessarily document about it because they felt it was something common. On 1/2/25 at 1:47PM, the surveyor met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) to discuss the use of Flomax in Resident #85 without any apparent benefit and without any supportive documentation in the medical record. On 1/3/25 at 10:21AM, the survey team met with the DON and LNHA for responses to concerns. The facility did not provide any further pertinent information in reference to the concern with Flomax use. N.J.A.C. 8:39-27.1(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49078 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to ensure that all medications (meds) were administered with an error rate of less than 5%. During the medication administration observation conducted on 12/311/24, the surveyor observed three (3) nurses administer meds to six (6) residents. There were twenty-six (26) opportunities, and three (3) errors were observed which resulted in a medication error rate of 15.38%. This deficient practice was identified for two (2) of six (6) residents observed (Resident #15 and an unsampled resident), which was administered by one (1) of three (3) nurses. 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. On 12/31/24 at 9:36 AM, the surveyor observed the Registered Nurse (RN) prepare meds for an unsampled Resident. The meds included an active physician's orders (PO) dated 2/22/22 for the following: Docusate Sodium capsule 100mg give one capsule by mouth two times a day for constipation. The surveyor observed the RN remove Docusate Sodium tablet 100mg from the bottle and place in a medication dose cup. The surveyor asked the RN to see the bottle for Docusate. The surveyor observed that the label reflected the tablet dose form. The surveyor showed the RN the label and asked if the this was the medication they wanted to give. The RN stated that the resident needed medication crushed and uses the tablets. The surveyor observed the RN crush the tablet and administer to the resident. At 9:51 AM, the surveyor observed the same RN prepare meds for Resident #15. The meds included active PO's for: Docusate Sodium Capsule 100mg give 1 capsule by mouth two times a day for constipation. 9/15/23. Phenytoin Sodium Extended Capsule 100mg give 2 capsule by mouth two times a day for seizure Do not crush, open. Separate from calcium by at least 2 hours.10/23/24. Budesonide Suspension 0.5 MG/2ML 1 vial inhale orally via nebulizer two times a day for COPD-Start D 9/17/23. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor observed the RN remove Docusate Sodium tablet 100mg from the bottle and place in a medication dose cup. The surveyor asked the RN to see the bottle for Docusate. The surveyor observed that the label reflected the tablet dose form. The surveyor showed the RN the label and asked if the this was the medication they wanted to give. The RN stated that the resident needed medication crushed and uses the tablets. The surveyor observed the RN remove an individually wrapped Budesonide Suspension vial from the bottom drawer of the medication cart and place on the top of the cart. The RN stated that she could not find the resident's other medications and they may be in another cart. The surveyor observed the RN move to a different med cart and leave the Budesonide on top of the first cart. The RN then proceeded to access Resident #15's meds from the 2nd cart. The surveyor observed the RN remove a vial of Budesonide from the 2nd cart. The surveyor asked the RN about the previous vial. The RN responded that the other vial must have been another resident's medication. The surveyor observed the RN remove the Phenytoin from the packaging and start to open the capsules for administration. The surveyor stopped the RN at that time and asked if that was appropriate for that medication and resident. The RN stated the resident has difficulty swallowing and gets the med in apple sauce. The surveyor asked the RN to read the medication order including any cautionary or administration notes. The RN did so and stated that it was OK to open the capsule as the resident needs it this way. The surveyor observed the RN administer due medications to the resident. The surveyor completed the medication pass observation. On 1/2/25 at 1:47 PM, the surveyor met with Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) to discuss the concerns with the medication pass observation. The surveyor asked the DON if the nursing staff should give resident's only medications that were ordered for them and the proper dosage form ordered. The DON stated, yes. The surveyor asked the DON if the staff should follow medication cautions or warnings. The DON stated, yes, and they should call the physician or pharmacy if there is a problem or question. On 1/3/24, the surveyor met with the DON and LNHA for any responses to the medication pass concern. The DON provided attendance sheets for education that was provided to the nursing staff after surveyor inquiry. The surveyor reviewed the facility policy titled Administering Medications with a revision date of April 2019. The policy reflected: 4. Medications are administered in accordance with prescriber orders . 8. If a dosage is believed to be inappropriate or excessive for a resident .contact the prescriber. 10. The individual administering the medication checks the label THREE (3) times to verify the .right dosage . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	26. Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services. The facility did not provide any further pertinent documentation. N.J.A.C 8:39-29.2 (d)

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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 carts 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 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 1/2/25 at 10:57 AM, 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 Unit Manager/Licensed Practical Nurse (UM/LPN), the surveyor inspected the med cart identified as Cart 2 located on the 2nd floor. The surveyor observed one (1) foil package of budesonide inhalant suspension (a medication that is inhaled to reduce lung inflammation) that did not reflect a date when the foil was originally opened. The surveyor also observed one (1) foil package of albuterol/ipratropium inhalant solution (DuoNeb) (a medication used to treat lung or breathing disorders) that did not reflect a date when the foil was originally opened. The budesonide foil package label reflected once the foil envelope is opened, use the vials within 2 weeks. The DuoNeb foil package reflected once removed from the foil pouch, the individual vials should be used within one week. The surveyor verified with the UM/LPN that there was no date on either foil package. The surveyor asked the UM/LPN if either of those medications should have a date when opened. The UM/LPN stated, yes, they should be dated. The surveyor in the presence of the LPN/med nurse on duty (LPN), inspected the med cart identified as cart 1 located on the 2nd floor. The surveyor observed one (1) foil package of DuoNeb solution that did not reflect a date when the foil was originally opened. The surveyor asked the LPN if the vial should have a date when opened. The LPN stated, yes, there should be one written on it. On 1/2/25, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) to discuss the concerns with medication storage. On 1/3/25 the surveyor met with the LNHA and DON for responses related to concerns with medication storage. The DON provided sign in attendance sheets reflecting staff education that was done after surveyor inquiry. The facility did not provide any further pertinent information. The surveyor reviewed the manufacturer packaging information for DuoNeb and budesonide. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The manufacturer label for DuoNeb reflected: Once removed from the foil pouch, the individual vials should be used within one week. The packaging information for budesonide, under storage and handling, reflected: When an envelope has been opened, the shelf life of the unused ampules is 2 weeks when protected. The surveyor reviewed the facility policy titled Medication Labeling and Storage with a revision date of February 2023. The policy did not reflect any pertinent information in relation to dating opened packaging of nebulizer solutions. NJAC 8:39-29.4(d)(g)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On [DATE] at 9:19 AM, the surveyor, in the presence of the Culinary Service Director (CSD) observed the following during the kitchen tour: 1. On the dry rack storage shelf, there were a stack of three half sheet pans. The surveyor observed 1 of the 3 stacked half sheet pans was soiled with white solid debris on the inside of the pan. The CSD was able to scratch the debris off and acknowledged that the pan was soiled. The surveyor observed 1 of the 3 stacked half sheet pans was wet on the inside portion. The CSD acknowledged it was wet and that it should have been dried before stacking with the other pans. The CSD took the half sheet pans to be re-washed. 2. On another dry rack storage shelf, there was a stack of two full size pans. The CSD lifted the top pan, which on the inside was observed wet. The CSD acknowledged that the pan should have been dry and took the pan to be re-washed. 3. On a countertop next to the cooking range area, there was an 8- ounce (oz) paper cup with a plastic lid which was undated and unlabeled. The surveyor asked the CSD about the item. The CSD opened the cup and stated it contained oatmeal. The CSD explained he believed it may be a staff item. The CSD acknowledged it should not be kept there and staff items should be in the staff break room. The CSD removed the item. On [DATE] at 11:46 AM, the surveyor interviewed the CSD about the refrigerators used to store outside food for residents in the facility. The CSD stated there were nutrition refrigerators on the second and third floor units. The CSD further explained that either he, dietary staff, or the manager on duty would check the refrigerator every morning. The CSD stated that when he rounded in the morning, he would check to ensure items were dated, labeled, and not expired. On [DATE] at 11:57 AM, the surveyor inspected the second-floor unit nutrition refrigerator with the registered nurse unit manager and observed the following: 4. In the freezer, there were 3 tubs of sea salt caramel ice cream, with dates of [DATE] which indicated that the ice cream was placed in the freezer and had a manufacturer's expiration date in 2025. The ice cream containers' label did not indicate who the ice cream belonged to. The RN/UM did not know who the items belonged to and acknowledged the items should have been labeled to show the resident's name. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. In the freezer, there was a jar containing an unknown food item wrapped in foil paper stored in a clear plastic bag. The container and bag were not labeled with a resident name or a date. The RN/UM did not know who the item belonged to and acknowledged it should have been labeled. On [DATE] at 12:06 PM, the surveyor inspected the 2nd floor unit refrigerator with the CSD. The CSD checked the sea salt ice cream containers, confirming it was not a facility stocked item, and that it should have been labeled to indicate which resident it belonged to. The CSD stated he would follow up with nursing staff to try to identify who it belonged to and would dispose of if unable to determine. The CSD acknowledged the jar wrapped in foil paper should have been labeled with a resident's name and dated. The CSD did not know who the item belonged to, did not know when item was placed in the refrigerator, and would dispose the item. On [DATE] at 12:10 PM, the surveyor inspected the 3rd floor unit nutrition refrigerator with a Licensed Practical Nurse (LPN) and observed the following: 6. There was a half-gallon carton of eggnog which was labeled with a date of [DATE] and had an expiration date of [DATE]. The carton of eggnog did not have a resident name or room number to indicate who they belonged to. On [DATE] at 12:12 PM, the surveyor interviewed the LPN unit manager (LPN/UM) about items going into the unit refrigerator. The LPN/UM stated items should be labeled with a date, resident name and/or room number. The surveyor showed the LPN/UM the carton of eggnog in the refrigerator. The LPN/UM stated it should have the resident's name or resident room number besides the dates. The LPN/UM did not know who it belonged to and would have to follow up. On [DATE] at 12:15 PM, the surveyor informed the CSD about the concern of the eggnog container found in the 3rd floor refrigerator which was not labeled with a resident name. The CSD stated it was not a facility stocked item and would follow up about who it belonged to. On [DATE] at 1:16 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) about the above concerns observed in the kitchen and the nutrition refrigerators. The LNHA acknowledged it was expected for personal food items going into the refrigerators to be labeled with the resident name, room number and dated. The LNHA stated that it was a team effort among the staff to ensure items were appropriately labeled and routine checks of the refrigerators were conducted. The LNHA further explained it did not meet expectations as the team routinely checked the refrigerators. On [DATE] at 11:12 AM, the LNHA, CSD, and regional CSD met with the surveyor. The CSD stated in-service education was provided to staff about where staff items should be stored and ensuring clean dishware was dried appropriately to prevent wet nesting (stacking of wet dishes and pans, which prevents them from drying and can lead to bacteria growth). The CSD further explained that the chef who the cup of oatmeal belonged to was going on break, left it there and we happened to see it there during the tour. The surveyor asked about the items in the nutrition refrigerators. The CSD stated the items were disposed and they were unable to determine who the items belonged to. The LNHA added that a QAPI would be initiated and the CSD or designee would be doing audits to monitor and prevent reoccurrence of concerns. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor reviewed the facility's policy titled, Sanitization with a last revised date of [DATE]. Under the Policy Statement revealed: The food services area is maintained in a clean and sanitary manner. Under Policy Interpretation and Implementation, it revealed: . 3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions . Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical . The policy did not further address drying protocols for dishware and cookware. The surveyor reviewed the facility's policy titled, Food Brought by Family/Visitor with a last revised date of [DATE]. Under Policy Interpretation and Implementation, it revealed: 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility prepared food. 5b. Perishable foods are stored in re-sealable containers with tightly fitted lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. NJAC 8:,d+[DATE].2(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19106 Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to use appropriate infection control practices specifically for: a) Nursing not wearing the required Personal Protective Equipment (PPE) when entering the room of a resident on Transmission-Based Precautions (TBP) (LPN #1); b) Houskeeping (H) staff not removing soiled PPE when exiting the room of a resident on TBP (H #1, #2, #3); c) a Unit Secretary (US) wearing her surgical mask inappropriately below her nose and mouth while on the unit hallway; and d) Certified Nursing Assistants (CNA) not following appropriate hand hygiene during meal service (CNA #1, #2, #3, #4). The deficient practice was evidenced by the following: Reference: Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html Reference: Hand hygiene should be performed immediately before touching a patient; before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or patient's surroundings; after contact with blood, body fluids, or contaminated surfaces. CDC recommendations for Hand Hygiene: Updated February 27, 2024: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html#cdc_clinical_safety_best_practices_recomm-recommendations 1. On 12/30/24 at 10:20 AM the surveyor observed Resident #25 from the hallway as they were in their room in the window side bed. The resident called out to the Licensed Practical Nurse #1 (LPN #1) who was at the doorway to the room preparing the resident's morning medication. A bin was located outside the entrance to the room containing PPE. Signage at the doorway indicated the resident was on TBP. The surveyor observed LPN #1 enter the room and walk across the room to the resident's bedside. LPN #1 wore a blue surgical mask and was putting on disposable gloves as she approached the resident's bedside. LPN #1 wore no other PPE. She spoke to the resident and exited the room back to her medication cart. The surveyor approached LPN #1 and confirmed with her that Resident #25 was COVID-19 positive. The surveyor asked LPN #1 what PPE was required for COVID-19 infected residents. She responded an N-95 respirator mask, gown, and gloves was required. She stated she heard the resident call out and went in to respond to her call. She stated she did not follow the facility's policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 12/30/24 at 10:25 AM the surveyor observed a housekeeper in the hallway outside Resident #25's room with an N-95 respirator mask in place and a blue surgical mask hanging below her chin. H #1 also wore a disposable gown and gloves. The surveyor asked H #1 if she should be wearing PPE in the hallway. She did not seem to understand the surveyor, however, she stated she did speak English. At that time, LPN #1 overheard the conversation and stated to H #1 when you come out of a COVID positive room you must remove the PPE before exiting the room. On 12/30/24 at 10:30 AM the surveyor interviewed the Unit Manager and described the surveyor's observations of LPN #1 and H #1. The Unit Manager stated a surgical mask is required in the hallways and full PPE with an N-95 mask, gown, and gloves in rooms of COVID-19 positive residents. He stated Resident #25 was COVID-19 positive. He stated he would re-educate LPN #1 and H #1. On 12/30/24 at 11:21 AM the surveyor interviewed the Infection Preventionist (IP). The IP stated the current COVID-19 outbreak began on 12/27/24. The IP stated all departments were re-inserviced on COVID-19 infection control prevention practices on 12/27/24. A review of inservice sign-in sheets revealed LPN #1 received education on 12/27/24. However, H #1 who was not working on 12/27/24, was not re-inserviced prior to beginning the 12/30/24 shift. The IP inserviced her after the surveyor's observations. 3. On 12/31/24 at 10:36 AM the surveyor observed the US on unit 2 wearing her surgical mask down under her chin in the unit hallway. She told the surveyor she should be wearing the surgical mask up over her nose and mouth. She stated it was the first day back to work since her vacation and had not been re-inserviced. The surveyor discussed the 3 infection control breaches with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) on 12/31/24 at 12:42 PM . On 01/02/25 at 10:08 AM the DON stated that facility-wide education had been completed regarding infection control, including the proper use of PPE and will be repeated on an on-going basis. 36419 4. On 12/31/24 at 10:20 AM, the surveyor observed H #2 in the hallway outside of room [ROOM NUMBER] with signage at the doorway that indicated the resident was on TBP. H #2 was wearing a surgical mask, a disposable gown, and gloves. The surveyor asked H #2 if she should be wearing PPE in the hallway. The H#2 did not seem to understand the surveyor. At that time, the CNA overheard the conversation and explained to H#2 that she needed to remove the PPE inside of the Resident's room. On 12/31/24 at 10:35 AM, the surveyor interviewed the LPN/UM on the 3rd floor who stated that there were bins inside all TBP rooms where the PPE should be doffed and that all staff were educated on the proper use of PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Wellington	301 Union Street Hackensack, NJ 07601

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/31/24 at 10:40 AM, the surveyor observed H #2 in room [ROOM NUMBER]. The surveyor observed signage at the doorway that indicated the resident was on TBP. The LPN/UM confirmed that the resident was Covid +. The H #2 was wearing a disposable gown, gloves, an N-95 mask and face shield. The surveyor observed that H #2 exited room [ROOM NUMBER] without doffing the PPE. H #2 wearing the same soiled gloves removed cleaning supplies from the housekeeping cart and went back into room [ROOM NUMBER]. H #2 then went back into the hallway and with the same soiled gloves removed the soiled mop head and placed it in the bin on the housekeeping cart. At that time,the LPN/UM observed H #2 in the hallway wearing full PPE and informed her that she needed to remove PPE inside the room. 5. On 1/3/25 at 11:00 AM, the surveyor observed H #3 in the hallway in front of room [ROOM NUMBER]. The surveyor observed signage at the doorway that indicated the resident was on Enhanced Barrier Precautions (EBP). The surveyor observed that H #3 was wearing a surgical mask, disposable gown, and gloves. The surveyor and the ADON observed H #3 removed her disposable gown and gloves in the hallway. At that time, the ADON told H #3 that she should have removed her PPE inside the room. The H #3 put the gown in a plastic bag and discarded it in the housekeeping supply cart, not in the bins inside the room as instructed by the ADON. The H #3 then entered room [ROOM NUMBER] and washed her hands for 3 seconds. The surveyor asked H#3 how long she should wash her hands. The HK replied 20 seconds. The Infection Prevention Nurse (IPN) overheard the conversation and told the surveyor she believed that H#3 understood English and that there was no language barrier. The surveyor accompanied H #3 back into the room and observed that H #3 applied soap to her hands and immediately placed them under the stream of water without first lathering outside of the water for 20 seconds. On 1/3/25 at 11:10 AM, the surveyor interviewed the IPN who stated that she had in-serviced the staff on the proper use of PPE and proper hand hygiene. On 1/3/25 at 11:15 AM, the surveyor interviewed the Director of Housekeeping (DHK) who stated that he had educated H#2 and H#3 several times and that they had each demonstrated knowledge of PPE donning and doffing and proper hand hygiene techniques. On 1/3/25 at 1:06 PM, the survey team met with the LNHA and DON to discuss the above observations and concerns. 34421 6. On 12/31/24 at 12:08 PM, during a lunch meal dining observation on the 2nd floor in the main dining room, the surveyor observed the lunch trays being distributed to the residents by four CNA's. There was no observed hand hygiene done by the four CNA's prior to passing out trays. There was also no observed hand hygiene done by the four CNA's while assisting the residents with meal set up. On 12/31/24 at 1:00 PM, the above concerns were discussed with the Director of Nursing (DON) and Administrator, who stated they will investigate this concern. On 1/02/25 at 10:17 AM, the DON and Administrator stated that it was expected that the staff use hand hygiene prior to assisting resident's with their meals. NJAC 8:39-19.4 (a)