STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315179	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Oceanview	2721 Route 9 Ocean View, NJ 08230

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 41442 Based on observation and interview, it was determined that the facility failed to make survey results readily accessible to residents and visitors. This deficient practice was evidenced by the following: On 01/07/2025 at 10:30 AM, the surveyor conducted the resident council task with five (5) facility long-term residents. When asked if the residents were made aware of the location of the most recent state survey results, 5 of 5 resident responded that they were not aware of the existence of a state survey book and were not notified as to where the most recent survey results were located. On 01/07/2025 at 11:30 AM, the surveyor went to the front reception area to look for the State Survey Result Book. The surveyor did not visualize the State survey book. The surveyor asked the receptionist where the State Survey Results Book was, she replied she was not familiar with the book. The Surveyor did observe a books behind the reception desk. The surveyor reviewed the books, and identified the unmarked State Survey Results Book. On 01/08/2025 at 09:46 AM, the surveyor went to the Serenity Unit Nursing Station. When the surveyor asked the staff at the desk where the State Survey Result Book was, they were not able to provide the book initially. The book was eventually located on a shelf behind the nursing station, above the counter, which would be unreachable and unattainable to a resident in a wheelchair. On 01/08/2025 at 10:19 AM, the surveyor met with Administration to discuss the Resident Council Meeting. At that time, the concerns regarding the inaccessible State Survey Results were reviewed. N.J.A.C. 8:39-9.4 (b)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41442 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident environment, equipment, and living areas in a safe, sanitary and homelike manner. This deficient practice was idenfied on 2 of 3 units, (Serenity and B Wing) and was evidenced by the following: On 01/05/2025 at 10:44 AM, Resident # 3 approached Surveyor # 1 and stated that he/she wanted Surveyor #1 to go to his/her room (#126) to observe a concern. Resident #3 stated that he/she reported mold to the Maintenance Department many times yet it remains present in his/her room and that he/she is concerned that it is affecting his/her health. Resident #3 directed Surveyor #1 to the area of the packaged terminal air conditioner unit (PTAC) under the window. Resident #3 pointed out an area in the corner to the left side of the PTAC and around 2 pipes protruding from the floor. Surveyor #1 observed the area to the left of the PTAC unit covered with a board, Surveyor #1 moved the board from the wall and observed scattered dark blackish stains in and around the corners of the wall and floor and in clustered groups. There were also dark shiny substances observed on the pipes. Resident #3 stated that the Maintenance Department did spray the area once, but the substance remains and that he/she was told that they did all they could. Resident #3 was not satisfied with the outcome. On 01/09/25 at 09:59 AM during an interview with Surveyor # 1, the Director of Maintenance (DOM), stated that he was aware of the issue of mold and that there are other resident rooms affected by this. The DOM stated that they have been treating these areas however to rectify, the pipes from the old units need to be removed. The DOM stated that a plumber has been out to give an estimate and that they are waiting on approval to contract for repair. 34423 On 01/05/2025 at 9:30 AM, during the initial tour of the Serenity unit, Surveyor #2 observed the PTAC unit in room [ROOM NUMBER], the right side was damaged and peeling dry wall down the entire right side. On the left side of the PTAC unit was pool noodle type material affixed to it and damage to the wall beside it. The closet was missing a drawer for A-side bed and their wardrobe had a stain on the right side. On 01/07/2025 at 10:00 AM, Surveyor #2 observed the hallway floor on Serenity had dark colored stains and where the baseboard and floor meet were dark marks along the entire length of the baseboard in both hallways. On 01/08/2025, Surveyor # 2 observed the following on the Serenity Unit: 12:01 PM, the wall in the small common area observed had peeling wallpaper by the rainbow. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Oceanview		STREET ADDRESS, CITY, STATE, ZIP CODE 2721 Route 9 Ocean View, NJ 08230	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:02 PM, the baseboard was peeling off by janitor door. 12:03 PM, observed the wallboard on the support column had holes and was peeling paint. There were also chipped tiles on the wall outside room [ROOM NUMBER]. 12:05 PM, observed the door frames of multiple rooms had chipped paint and rust looking areas exposed. 12:06 PM, observed chipped floor tiles outside room [ROOM NUMBER]. 12:10 PM, observed the radiator cover in room [ROOM NUMBER] was chipped and peeling paint. 12:11 PM, observed in room [ROOM NUMBER] the toilet grab bars in bathroom had a green and white colored substance on it. 12:12 PM, observed missing wall tiles in the hall across from room [ROOM NUMBER] by the fire extinguisher cabinet. 12:15 PM, observed the wall between the nurse's station and the emergency eye wash station the door had peeling paint and dark marks. 12:16 PM, observed the door frame to nurse's station had peeling paint. 12:17 PM, observed uneven, cracked floors upon entering and exiting the unit. 39460 On 1/9/25 at 10:28 AM, Surveyor #3 observed on the following on B wing : 10:28 AM, outside room [ROOM NUMBER] the paint was peeling in patches exposing the previous paint beneath. 10:32 AM, paint was chipped outside room [ROOM NUMBER] on the corner of the wall. 10:33 AM, mismatched chipped paint outside room [ROOM NUMBER]. 10:34 AM, the baseboard edging around the nurse's station was chipped and scuffed. 10:36 AM, observed in the smoking patio cigarette butts disposed of on the ground and not in the smoking materials receptacle. 10:37 AM, observed the switch plate on wall in B wing dayroom, was cracked and broken. 10:39 AM, observed the ledge in the B wing dayroom was chipped and lifting. 10:47 AM, observed the doorway to the B wing dayroom had chipped paint at the door jam. 10:47 AM, observed the endcap for the railing across from B wing nurse's station was missing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:51 AM, observed the baseboard was missing and the wall was damaged on right side of nurse's station near the Unit Manager' office. 10:52 AM, observed the ceiling tile was stained outside B wing dayroom in the ocean hall, On 01/08/2025 at 12:53 PM, surveyor #2 interviewed the District Manager for the Housekeeping/laundry department who stated there was no current director of housekeeping at the facility at this time. When asked what the process was for cleaning rooms was the Manager stated the process for cleaning the units in morning was, they would pull the trash from the resident's rooms, when the food trucks arrived the housekeeping staff would move to the common areas to clean. The housekeepers would sweep, wipe horizontal surfaces with disinfectant, and mop the floors. In the bathrooms all surfaces were disinfected including the toilet and the floor was mopped. The porter was responsible for removing soiled linens and trash then dust and mop the floors using the auto scrubber machine daily. Unit inspections and individual room carbolizations were done monthly. If something is found to be in need of repair then staff were to verbally notify the Director of Maintenance (DOM). Cleaning of corners and edges was a scheduled monthly task. On 01/09/2025 at 10:05 AM, surveyor #2 interviewed the DOM who stated the facility conducted environmental rounds and would look for things in the room that needed attention. When asked if there was a schedule or a checklist to follow when performing rounds and the DOM stated, Can't say we have schedule of rounds or checklist. A review of the facility's undated Resident Room Cleaning policy revealed . All resident rooms are to be cleaned daily . the process of 7 steps of cleaning and disinfecting resident rooms . empty trash, .using EPA approved solutions disinfect all horizontal surfaces . clean walls, wipe down all vertical surfaces .clean and disinfect the bathroom . dust mop . all corners and along all baseboards must be dust mopped to prevent buildup . damp mop . NJAC 8:39-31.4(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40039 Based on observation, interview, medical record review and review of other facility documentation, it was determined that the facility failed to contain nebulizer/respiratory equipment (a machine used to administer medication in the form of a mist inhaled into the lungs) delivery systems in protective coverings for 4 of 4 residents (Resident #26, #42, #55 and #368) reviewed for respiratory care. This deficient practice was evidenced by the following: 1. On 01/05/2025 at 10:28 AM, Surveyor #1 observed a nebulizer machine on top of Resident #55's dresser. The nebulizer machine was not currently in use. The nebulizer mask was lying on top of the dresser with the interior of the mask facing upwards. The mask was not covered while not in use and was exposed to contamination. The nebulizer tubing was dated but not able to determine exact date except 24. The surveyor asked Resident #55 if he/she had used the nebulizer and Resident #55 responded that he/she had not used the machine. On 01/07/2025 at 08:46 AM, Resident #55 was observed lying in bed, awake and alert. Resident #55 was pleasant and cooperative. No nebulizer machine was observed in the residents room on this observation Resident #55 was the only occupant of room. According to the Admission record, Resident #55 was admitted to the facility with the following but not limited to diagnoses: Alzheimer's disease early onset, dementia, anxiety disorder, major depressive disorder and atherosclerotic heart disease. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 11/14/2024, revealed that Resident #55 had a Brief Interview for Mental Status (BIMS) score of 6,which indicated severe cognitive impairment. According to Section O of the MDS, Resident #55 did not receive oxygen therapy. On 01/07/2025 at 10:57 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #55 as follows: A review of the 12/1/2024-12/31/2024 Medication Administration Record (MAR) revealed that Resident #55 received Ipratropium-Albuterol Solution 0.5-2.5(3) MG/3ML (milligrams/milliliter) 1 vial inhale orally every 6 hours as needed for chest congestion on 12/3/2024 at 05:36. According to the MAR no other treatments were provided following the administration on 12/3/2024. According to the MAR the order was discontinued on 1/5/2025 at 1500, which indicated that the order was discontinued after the survey team left the faciity on [DATE]. The order was actively in place during the observation of the nebulizer machine/mask on the initial tour/observation on 1/5/2025 at 10:28 AM as described above. A review of Resident #55's comprehensive care plan did not reveal a care plan for the use of respiratory equipment, specifically a nebulizer. On 01/08/2025 at 09:03 AM, a review of the EMR revealed a progress note dated 12/2/2024, Resident has occasional n/p (non productive) cough. Received new order for duoneb as prn (as needed) as RX (prescription) for cough and congestion. Course Rhonchi (low-pitched, coarse lung sounds that are often described as snoring or gurgling) heard in bilateral upper lobes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 01/08/2025 at 10:21 AM, Licensed Practical Nurse/ Unit Manager (LPN/UM #1) was asked what the facility practice was for respiratory equipment when not in use. LPN/UM#1 responded that the mask and O2 (oxygen) tubing when not in use are to be placed in a plastic bag. The oxygen tubing is to be changed every Sunday on 11-7 shift. The surveyor then asked LPN/UM #1 why is was important to protect respiratory equipment when not in use and LPN/UM #1 responded, It's an infection control practice to ensure resident safety. On 01/08/2025 at 02:17 PM during a meeting with the facility administration including the Licensed Nursing Home Administrator, Director of Nursing (DON), Regional Director of Nursing, and Infection Preventionist the surveyor asked what the facility practice was for respiratory equipment when not in use. The DON told the surveyors that the nebulizer mask should be bagged when not in use and tubing was to be dated weekly. The DON further explained that nebulizer masks are to bagged when not in use and the reason was It is important for infection prevention. 41442 2. On 01/06/2025 at 11:28 AM, during the initial tour of the facility, Surveyor #2 observed Resident # 26 in bed. At that time, Resident # 26 was wearing a nasal cannula (tube used to deliver oxygen through the nostrils). Upon further observation, the surveyor was unable to determine if the oxygen tubing was dated however, Surveyor #2 also observed a nebulizer face mask (mask used to deliver aerosolized medications) on top the nightstand attached to the nebulizer machine by the elastic band of the face mask. The face mask was not inside a container or bag exposing it to air. On 01/06/2025 at 12:48 PM, the surveyor reviewed Resident # 26's Electronic Medical Record (EMR) as follows: A review of Resident # 26's EMR revealed he/she had a diagnosis of but not limited to Multiple Sclerosis and Pneumonia. A review RFesident #26's most recent MDS dated [DATE], under Section O, did not indicate that Resident #26 received oxygen therapy. Under Orders section of EMR Resident #26 had a physician order for Ipratropium-Albuterol Solution Nebulization Solution, 3 milliliters to inhale orally via nebulizer every 4 hours as need for shortness of breath. According to the Medication Administration Record (MAR) for the month of January 2025, it was revealed that Resident #26 received Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML on 01/3/2025 at 05:15 PM, 01/04/2025 at 07:30 AM , and 01/05/2025 at 08:00AM. A review of Resident #26's Comprehensive Care Plan did not address the use or care of respiratory equipment, specifically a nebulizer. 51337 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During the initial tour on 01/05/2025 at 09:26 AM, Surveyor #3 observed a BiPAP (Bi-Level Positive Airway Pressure) face mask (a mask that is connected to a BiPAP machine which delivers pressurized air to help with breathing) on the windowsill of Resident #42's room. It was unbagged with the interior part exposed to the air. Resident #42 pointed to their BiPAP machine on the side table to their right. Another unbagged BiPAP face mask was lying beside the BiPAP machine with the interior part exposed to the air and contamination The resident stated that they used the machine every night. On 01/07/2025 at 08:30 AM, Surveyor #3 observed a BiPAP face mask in the same position as observed on the initial tour, unbagged and on the windowsill. An additional unbagged BiPAP face mask was located on the side table to the with the interior exposed to air and contamination. On 01/08/25 at 09:55 AM, Surveyor #3 observed the unbagged BiPAP masks located on the windowsill and on the side table to the right. Surveyor #5 showed LPN #2 the masks and they stated that the masks should have been bagged. LPN #2 proceeded to bag the BiPAP face masks. According to the Admission Record, Resident #42 was admitted to the facility with diagnoses including but not limited to: Surgical Aftercare following surgery on the Respiratory System (the group of organs in the body that enables breathing), Obstructive Sleep Apnea (a sleep disorder in which breathing stops), Respiratory Failure and Malignant Neoplasm (abnormal growth of tissue) of the Left Lung. A review of the most recent MDS, dated [DATE] reflected a BIMS score of 15 out of 15, which indicated that the resident was cognitively intact. Section O of the MDS did not reflect that Resident #42 received BiPAP therapy. A review of the active Physician's Orders (PO) did not reflect an order for BiPAP machine use until 01/08/2025, when an order to apply BiPAP at night with settings at 10/5 and remove in AM was initiated. A further review of the PO revealed a previous order for BiPAP machine use initiated on 9/3/2024 and was discontinued on 10/3/2024. 4. During the initial tour on 01/05/2025 at 10:02 AM, Surveyor #3 observed Resident #368 in bed with continuous oxygen (O2) at 2 liters per minute (lpm) via nasal cannula (NC). The oxygen tubing was observed to be unlabeled and undated. According to the Admission Record , Resident #368 was admitted to the facility with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease (a lung disease that makes breathing difficult), Systemic Inflammatory Response Syndrome, and Pleural Effusion (too much fluid buildup in the space between the lungs and chest wall). A review of the most recent comprehensive MDS dated [DATE], reflected a BIMS score of 13 out of 15 which indicated that the resident was cognitively intact. A review of the active Physician's Orders reflected an order with an initiated date of 1/5/2025 for continuous supplemental O2 therapy at 2 lpm via NC. The PO also included another order for changing the O2 tubing every night shift every Sunday was initiated on 1/7/2025. A review of the Baseline Care Plan initiated on 1/4/2025 reflected oxygen therapy at 3 lpm via NC. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/08/2025 at 02:20 PM, the survey team met with the facility administration including the Director of Nursing (DON). The DON stated that the facility protocol would have the nasal cannula and tubing bagged when not in use and dated. The DON stated that there should be an order for it. DON further stated that the same goes for nebulizers and BiPAP machine use. A review of a facility policy titled Oxygen Administration updated in October 2024, included under Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. 5.d. If applicable, change nebulizer tubing and delivery devices every 72 hours or per facility policy and as needed .e. Keep delivery devices covered in plastic bag when not in use. The facility was unable to provide a policy addressing the use of Nebulizer equipment. NJAC 8:39-27.1(a)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 51337 Based on observations, interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission. This deficient practice was observed for 2 of 25 sampled residents, (Resident #367 and #7) . This deficient practice was evidenced by the following: 1. On 01/05/2025 at 09:45 AM, the surveyor observed Resident #367 lying in bed. Resident #367 stated they had not seen the doctor but just saw their bills. A review of Resident #367's hybrid (electronic and paper) medical records (MR) from December 2024 - January 2025 revealed the following: The Admission Record (AR) reflected that the resident was admitted to the facility with diagnoses that included Hemiplegia (complete paralysis of one side of the body) and Hemiparesis (partial weakness on one side of the body) following Cerebral Infarction (blood vessel blockage in the brain) Affecting Left Non-Dominant Side, Malignant Neoplasm (abnormal growth of tissue) of the Lungs. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/30/24 revealed that Resident #367 had a Brief Interview for Mental Status (BIMS) score of 14 of 15 which indicated that the resident was cognitively intact. A review of the Electronic Medical Record (EMR) revealed the Nurse Practitioner (NP) visit progress notes (PN) dated 12/6/24, 12/9/24, 12/10/24, 12/11/24, 12/12/24, and 12/16/24. A further review of the PN did not reveal any PN from the attending physician from December 2024 to January 2025. A review of the paper medical records did not reveal any PN from the attending physician from December 2024 to January 2025. 2. On 01/05/2025 at 09:55 AM, the surveyor observed Resident #7 waiting outside their room for a medical appointment. A review of Resident #7's hybrid medical records from November 2024 to January 2025 revealed the following: The Admission Record reflected that the resident was admitted to the facility with diagnoses that included End Stage Renal (Kidney) Disease, Cerebral Infarction (blood vessel blockage in the brain). A review of the most recent comprehensive MDS, an assessment tool used to facilitate the management of care, dated 12/03/24 revealed that the resident had a BIMS score of 13 of 15 which indicated that the resident was cognitively intact. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the EMR revealed the NP visit progress notes PN dated 12/03/24, 12/10/24, 12/12/24, 12/17/24, and 12/19/24. A further review of the PN did not reveal any PN from the attending physician from December 2024 to January 2025. A review of the paper medical records did not include documentation of the attending physician visit from November 2024 to January 2025. During an interview with the surveyor on 01/08/2025 at 09:30 AM, Licensed Practical Nurse (LPN #2) stated that physicians make rounds and update their notes. During an interview with the surveyor on 01/08/2025 at 10:05 AM , Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated that after the physicians see the patients, they will document and flag the paper charts. LPN/ UM #2 further stated that the doctors (MD #1 and MD#2) have access to the electronic medical record. During an interview with the surveyors on 01/08/2025 at 02:00 PM, the Director of Nursing (DON) stated that all physicians have access to the electronic medical record. The DON further said that some physicians did handwritten notes which should have been scanned and uploaded to EMR or placed in the residents' paper charts. A review of the facility provided policy titled Physician Visits and Physician Delegation revised in October 2022, included under Policy Explanation and Compliance Guidelines section: 2. The Physician should: a. See resident within 30 days of initial admission to the facility. d. Date, write and sign a progress note for each visit. NJAC 8:39-23.2 (b)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 40039 Based on interview and review of pertinent facility records it was determined that the facility failed to follow through on recommendations made by the consultant pharmacist (CP) during their monthly medication regimen review (MRR) in a consistent and timely manner. This deficient practice was observed for 1 of 5 residents (Resident #55) and was evidenced by the following: On 01/07/2025 at 08:48 AM Resident #55 was observed lying in bed awake and alert. Resident #55 was pleasant and cooperative and answered surveyor questions. No maladaptive behaviors were observed, and Resident #55 did not appear to be in any distress. Resident #55 was observed to be confused at times. According to the Admission record, Resident #55 was admitted to the facility with the following but not limited to diagnoses: Alzheimer's disease early onset, dementia, anxiety disorder, major depressive disorder, and atherosclerotic heart disease. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 11/14/2024, revealed that Resident #55 had a Brief Interview for Mental Status score of 6/15 which indicated severe cognitive impairment. On 01/07/2025 at 01:19 PM, the surveyor reviewed the past 6 months of consultant pharmacist (CP) therapeutic suggestions for Resident #55 during the monthly medication regimen review process. The CP made the following recommendation on 11/20/2024: PRN (as needed) medications that have not been used for over 60 days are recommended to be discontinued. Please consider discontinuing Diphenhydramine (an antihistamine). On 11/21/2024 the facility responded to the CP's therapeutic suggestion and indicated that the Diphenhydramine had been discontinued by writing D/c'd (discontinued) on the therapeutic suggestion sheet. However, when the surveyor reviewed the 11/1/2024-11/30/2024 Medication Administration Record (MAR) for Resident #55 to ensure that the medication had been discontinued by the facility, the MAR revealed that the order for Diphenhydramine was discontinued on 01/07/2025 at 0919 (9:19 AM). This was done approximately 45 days after recommendation and the same day the reports were made available to the survey team. On 01/08/25 at 02:31 PM the surveyor conducted an interview with the facility Director of Nursing (DON). The surveyor asked the DON what the facility process was for responding to the CP's therapeutic suggestions once received by the facility and the DON told the surveyor that recommendations are addressed by unit managers, and they are completed prior to the next CP visit. I spot check them or I'll address something if I am notified. I do not regularly review them for accuracy or completion. The surveyor then asked the DON to provide the surveyor with the last date that the CP visited the facility for the monthly medication regimen review. The DON told the surveyor that the last visit to the facility by the CP was 12/23/2024. A review of a facility policy titled Pharmacy Services-Role of the Consultant Pharmacist revealed the following under Policy Interpretation and Implementation: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Providing the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review. The facility will review the reports before the next subsequent review is available. NJAC 8:39-29.3(a)(1)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34423 Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to ensure that specific target behaviors exhibited were documented as well as the non-pharmacological interventions attempted prior to the administration of an antianxiety medication. This deficient practice was identified for 1 of 1 resident reviewed for Psych (psychotropic)/Opioid side effects, (Resident # 45) and was evidenced by the following: On 01/05/2025 at 09:52 AM, the surveyor observed Resident #45 in the unit activity room sitting in his/her wheelchair (w/c) at the table. Resident appeared lethargic, leaning forward in the w/c, and appeared to have difficulty staying awake. A review of the EMR on 01/06/2025 at 01:00 PM, revealed the following: According to the Admission Record, Resident #45 was admitted to the facility with diagnoses including but not limited to: cognitive communication disorder, Alzheimer's disease late onset. A review of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care dated 12/05/2024, revealed Resident #45 had a Brief Interview for Mental Status score of 10/15, indicating moderately impaired cognition. A further review indicated that the resident had wandering behavior 1 to 3 days and is taking an Antianxiety medication. A review of the Order Summary Report with Active orders as of 12/01/2024 and 01/01/2025, revealed a physician order for Lorazepam (medication used to commonly treat anxiety) Oral Tablet 0.5 MG (milligrams) Give 0.5 mg by mouth every 6 hours as needed for agitation for 14 Days. A review of the EMAR (Electronic Medication Administration Record) progress notes from 12/22/2024 through 1/5/2025 as follows: Resident #45 received Lorazepam 52 times from 12/22/24 thru 1/5/25. There was no documentation in the EMAR progress notes for 23 of the 52 times of behaviors that Resident #45 exhibited and any non-pharmacological interventions that were attempted prior to administering the medication. Resident #45 received the medication on the following dates: 12/22/2024, 12/23/2024, 12/24/2024, 12/25/2024, 12/26/2024, 12/27/2024, 12/28/2024, 12/29/2024, 12/30/2024, 12/31/2024, 01/01/2025, 01/02/2025, 01/03/2025, 01/04/2025, and 01/05/2025. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan for Resident #45 revealed a Focus are of [resident name] has a behavior problem related to interfering with roommate care, pulling on the blinds to look out the window .can become agitated when redirected (hitting staff, verbally abusive towards staff) with Date Initiated: 02/09/2022. Under the Goal section resident will have fewer episodes of interfering with roommates' care. Interventions include but are not limited to: Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, monitor behavior episodes, and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. During an interview with the surveyor on 01/08/2025 at 10:31 AM, Licensed Practical Nurse (LPN #3) was asked what the facility policy was for a resident who is prescribed a PRN (as needed) psychotropic medication (drugs that affect a person's mental state). LPN #3 replied psychiatry sees the resident and makes recommendations. We get family and physician approval. There is behavior charting for 14 days for adverse side effects or targeted behaviors. When asked where is this documented, LPN #3 stated in the EMR under progress notes. LPN #3 confirmed that Absolutely it is expected to document non-pharmacological interventions prior to administration and the final effect of the medication. During an interview with the surveyor on 01/08/2025 at 10:36 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) was asked what the facility policy was for a resident is who is prescribed a PRN psychotropic medication. LPN/UM #1 replied that prn antianxiety medications are 14 days only, and after that we reach out for new order from the physician. LPN/UM #1 went on to say for PRN we notify family and get consent prior to administering. The nurse prior to administration goes through nonpharmacological interventions such as walks, snacks and conversation. If that is ineffective, they administer the medication and document effective or not effective. LPN/UM #1 said the expectation is to document behaviors, non-pharmacological interventions attempted, and administer medication and document effect post administration. During an interview with the surveyor on 01/08/2025 at 01:59 PM, the Director of Nursing (DON) was asked what the facility policy was for a resident who is prescribed a PRN psychotropic medication. The DON said it depends on the order. If the patient requests, or if they exhibit signs/symptoms of agitation we would give the medication. The nurses document on EMAR and there should be a section to note effective and go back and check. The DON confirmed yes, there should be documentation of any non-pharmacological interventions used and this would be in the EMAR progress notes. The DON also said yes, there should be documentation of signs and symptoms exhibited by the resident prior to administering the medication. On 01/08/2025 at 01:13 PM, a review of a facility policy titled Use of Psychotropic Medication with a reviewed date of October 2024, revealed under Policy Explanation and Compliance Guidelines section: 4. The indications for use of any psychotropic drug will be documented in the medical record. b. For psychotropic drugs that are initiated after admission into the facility, documentation shall include the specific condition as diagnosed by the physician. ii non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation. NJAC 27.1(a)

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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. 40039 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 01/05/2025 from 08:54 to 9:38 AM,, the surveyor, accompanied by the Assistant Food Service Director (AFSD), observed the following in the kitchen: 1. Upon entry to the kitchen the surveyor observed three (3) staff actively working on the breakfast tray line. 3 of 3 female staff did not have hairnets and their hair was exposed while actively working with food. One (1) staff had lengthy hair in a ponytail, a second staff had lengthy hair in a bun style with a head band around their forehead and the third staff also had lengthy hair pulled back and in a hair tie. On interview the AFSD told the surveyor, Yes, we should have hair nets. I'm sorry. 2. Observation of the Walk-In refrigerator temperature log revealed that no temperatures were recorded for the following: 1/2/2025 PM, 1/3/2025 AM, 1/4/2025 AM and 1/5/2025 AM. According to the AFSD the morning and evening cook were responsible for recording refrigeration temps. 3. Observation of the prep table/sink adjacent to the walk-in refrigerator revealed what appeared to wilted lettuce and an unidentified white substance on the tile floor. In addition, several plastic portion control cups were observed under the table. When interviewed the AFSD agreed that the area had not been cleaned from the previous day. 4.In the dry storage area on a middle shelf of a multi-tiered storage rack a previously opened bag of dry pasta had no open or use by dates. On interview the AFSD agreed that previously opened food products required an open and use by date. 5. On an upper shelf of the walk-in refrigerator a Styrofoam take out style container contained a large baked potato. The container had no dates. In addition, a deep 1/4 pan contained baked beans and was covered with plastic wrap. The pan had no dates. A second deep 1/4 pan covered with clear plastic wrap contained red grapes, pieces of pineapple and pieces of honey dew melon. The pan had no dates. On a middle shelf an opened cardboard box contained iceberg lettuce heads. Visual inspection of the lettuce revealed that several heads of lettuce were brown and slimy on appearance. When interviewed the AFSD told the surveyor that all food products should be dated. The AFSD told the surveyor that she would throw them out and proceeded to remove the undated foods from the walk-in. 6. Prior to entering the walk-in freezer the surveyor observed the walk-in freezer temperature log attached to the door. The temperature log did not have internal freezer temperatures recorded for the following dates: 1/2/2025 PM, 1/3/2025 AM, 1/4/2025 AM, and 1/5/2025 AM. When interviewed the AFSD told the surveyor that the AM and PM cooks were responsible for recording the refrigerator and freezer temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a facility policy titled Food Storage: Cold Foods, [company name] Policy 019, revised 2/2023, revealed under Procedures: 4. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A review of a facility policy titled Staff Attire, [company name] Policy 024, revised 10/2023, revealed under Procedures: 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. A review of a facility policy titled Food Storage: Dry Goods, [company name] Policy 018, revised 2/2023, revealed under Procedures: 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. N.J.A.C. 8:39-17.2 (g)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 40039 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris and failed to have a cover over the opening of 3 of 3 garbage containers/dumpsters. This deficient practice was evidenced by the following: On 01/05/2025 at approximately 9:30 AM, the surveyor, accompanied by the Assistant Food Service Director (AFSD), observed four (4) yard dumpsters that were designated for garbage in the facility parking lot. According to the AFSD three of the dumpsters were designated for garbage and one dumpster was designated for recyclables. 3 of 3 dumpsters designated for garbage had the contents of bagged trash exposed due to the dumpster lids not being fully closed. Each dumpster had two (2) plastic lids to cover the garbage dumpster. Dumpster #1 had 2 of 2 plastic lids in the open position which exposed the bagged garbage. Dumpster #2 had 1 of 2 lids opened exposing bagged garbage and dumpster #3 had 1 of 2 lids opened exposing bagged garbage. On interview the AFSD told the surveyor that the garbage area was a shared responsibility between the kitchen staff and environmental staff, and they were responsible for the maintenance of the area. In addition to the exposed contents of the dumpsters the area surrounding the garbage dumpsters was observed to have garbage on the ground. The garbage included plastic cups, disposable gloves, plastic bags, plastic milk crates and other unidentified debris. On 01/09/2025 at 10:47 AM, during a meeting with facility administration the Licensed Nursing Home Administrator agreed that garbage dumpsters must be covered at all times. A reviewed of a facility policy titled Dispose of Garbage and Refuse, [company name] Policy 030, dated 8/2017, revealed the following under Policy Statement: All garbage and refuse will be collected and disposed of in a safe and efficient manner. In addition, the following was revealed under Procedures: 1. The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster is maintained in a manner free of rubbish or other debris. NJAC 8:39-19.3(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51337 Based on observation, interview, review of medical records, and other facility documentation, it was determined that the facility failed to follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for 4 of 6 staff (2 Housekeepers, 2 Certified Nursing Assistants) to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy. This deficient practice was evidenced by the following: 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; immediately after glove removal. 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 01/07/2025 at 09:16 AM, the surveyor observed the housekeeping staff (HSK #1) transfer bags of soiled linens wearing gloves from the subacute rehab (SAR) unit soiled linen room to a rolling covered linen cart. HSK #1 removed their gloves but did not wash nor sanitized their hands after removing the gloves. HSK #1 pushed the cart in the hallway until it reached the laundry soiled linen room. On 01/07/2025 at 12:35 PM, the surveyor observed Certified Nursing Assistant (CNA #2) in room [ROOM NUMBER] exit the bathroom with wet paper towels in her hand. CNA #2 proceed to touch the cover of a foot-operated trash can with bare hands to discard the wet paper towels. CNA #2 did not wash nor sanitized hands after touching the trash can cover. On 01/08/2025 at 12:03 PM, the surveyor observed CNA #1 pickup soiled linens from the floor and place them in a plastic bag without wearing gloves. He then placed the bag into a bin in the soiled linen room. CNA #1 returned to the resident room and picked up a soiled pink blanket and walked in the hallway carrying the pink blanket unbagged. CNA #1 then opened the soiled linen door and threw the blanket into a bin. CNA #1 did not wash nor sanitized their hands after discarding the spoiled blanket. CNA #1 then went to the clean linen cart, obtained clean linen then proceeded to put the clean linen on the mattress in the resident's room. 2. On 01/07/2025 at 09:20 AM, the surveyor observed HSK #1 sort soiled linens in the laundry soiled linen room wearing only gloves. Another housekeeping staff #2 (HSK #2) put on gloves, opened the soiled linen plastic bags, and sorted dirty linens. Neither HSK staff wore any other PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/07/2025 at 10:23 AM, the surveyor observed two yellow reusable gowns hanging from a wall in the laundry washing area next to the soiled linen room. When surveyor asked HSK #2 when they should use the reusable gowns, HSK #2 stated we have these things and I guess we are supposed to wear them. that they were supposed to wear them but have never used them. On 01/08/25 at 01:05 PM, the surveyor interviewed the Housekeeping District Manager (HDM). The HDM stated that there were reusable yellow gowns in the sorting area to wear while sorting dirty laundry as well as gloves. During an interview with the surveyor on 01/08/2025 at 01:05 PM, the Housekeeping District Manager (HDM) was asked who collects the soiled linens. The HDM stated that porters collect soiled linens and should be wearing gloves when transferring soiled linen bags to the rolling cart. HDM further stated that after transferring bags to the cart, porters should remove their gloves and wash their hands if soiled, if not soiled they need to use sanitizer to sanitize their hands. At that time, the HDM stated that there were reusable yellow gowns in the sorting area to wear while sorting dirty laundry as well as gloves. A review of the facility policy titled Hand Hygiene updated in April 2024, under Policy Explanation and Compliance Guidelines revealed: 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, .after touching a patient or the patient's immediate environment; after contact with blood, body fluids or contaminated surfaces; immediately before putting on gloves and after glove removal. A review of facility policy titled Laundry Operation with a revised date of 06/2016, under section Transferring Soiled Linen included but was not limited to; Statement . all soiled linen must be covered during transportation and while being stored on unit or floors. A review of facility policy titled Laundry Operation with a revised date of 06/2016, under section Sorting Soiled Linen included but was not limited to; 2. As soiled linens are sorted out into the proper wash classifications, employees must wear the proper protective equipment (PPE), which includes gloves and a protective apron. NJAC 8:39-19.4 (a)(1); 21.1 (b)