STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315196	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Manchester	1770 Tobias Avenue Manchester, NJ 08759

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of pertinent facility documentation, it was determined that the facility failed to treat residents with respect and dignity. Specifically, by a.) staff failed to provide timely assistance to Resident #2, who was observed with drool and an orange liquid substance dripping from the mouth and beard and b.) staff failed to provide privacy for Resident #95 during hygienic care. This deficiency was identified in 2 of 2 residents (Resident #2 and Resident #95) reviewed for dignity and was evidenced by the following:1.) Review of the admission Record (AR), the Resident #2 was admitted to the facility with diagnoses including, but not limited to, Parkinson's Disease (a nervous system disorder that affects movement), dementia (a condition that impairs mental abilities needed for everyday activities), muscle weakness, and lack of coordination.A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 06/18/2025, included a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating moderately impaired cognition. Further review of the MDS revealed that Section GG-Functional Abilities: Self Care revealed that personal hygiene was coded as a 3, indicating the resident required partial/moderate assistance.On 08/20/2025 at 10:52 AM, the surveyor observed Resident #2 seated in a wheelchair on the second-floor hallway with a bedside table in front of them, coloring on a sheet of paper. The resident had a large amount of drool visibly dripping from their mouth. Two facility staff members walked by without offering assistance or making any attempt to clean the drool from the resident's mouth.On 08/21/2025 at 10:40 AM, the surveyor observed Resident #2 in the main dining room, seated in a wheelchair at a dining table, asleep while activity staff and other residents participated in an exercise activity. An orange liquid substance was observed dripping from the resident's mouth onto their beard. The surveyor continued observing the resident for five minutes, during which time multiple staff members entered and exited the dining area. At no point did any staff offer or attempt to assist the resident in cleaning their mouth or beard.2/) Review of the AR indicated that Resident #95 the was admitted to the facility with diagnoses which included but was not limited to muscle weakness, difficulty in walking, and lack of coordination. A review of the resident's admission MDS, an assessment tool used to facilitate care management, dated 06/17/2025, included a BIMS score of 13 out of 15, indicating intact cognition. Further review of the MDS revealed that Section GG- Functional Abilities: Self Care revealed that toileting hygiene was coded as a 2, indicating the resident required substantial/maximal assistance. On 08/21/2025 at 10:09 AM, the surveyor observed a certified nurse aide (CNA) providing incontinence care to Resident #95 in the bathroom of room [ROOM NUMBER]. The resident had a bowel movement, and the CNA was seen wiping the resident's buttocks with tissue. The bathroom door was left open during care, and Resident #95's abdomen, breasts, and buttocks were fully exposed and visible from the bathroom. The resident's roommate was present in the shared bedroom, seated in a wheelchair near the bathroom entrance, watching television.The resident's comprehensive care plan, dated 06/20/2025, included a focus area indicating that the resident has impaired mobility. The resident's comprehensive care plan, dated 06/19/2025, included a focus area indicating that the (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident has impaired mobility. During an interview with the surveyor on 08/21/2025 at 12:34 PM, the Licensed Practical Nurse/Unit Manager stated that staff should have offered or assisted with helping Resident #2 clean their mouth and beard. During an interview with the surveyor on 08/27/2025 at 11:35 AM, the Director of Nursing (DON) stated that staff should have offered assistance or helped Resident #2 clean their mouth and beard. The DON acknowledged that Resident #95 should have been provided privacy during hygienic care and confirmed that both residents should have been treated in a manner that maintained their dignity.A review of a facility policy undated titled, Resident Rights, revealed that, The facility will treat you with dignity and respect in full recognition of your individuality. N.J.A.C. 8:39-4.1(a)(16)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, record review, and review of facility policy, the facility failed to ensure the SNF ABN (skilled nursing facility advanced beneficiary notice) was complete and accurate which placed the residents and/or representatives at risk of not being fully informed. This was identified for 1 of 3 residents (Resident # 98) reviewed for SNF Beneficiary Protection and was evidenced by:A review of Resident #98's admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Muscle Weakness, Dysphagia, and Malignant Neoplasm of the Colon.Review of Resident #98's SNF Beneficiary Notification Review, which was provided by the facility, indicated the resident no longer required skilled care effective 5/6/2025. Continued review of Resident #98's ABN revealed Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on 5/7/2025, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. Resident# 98's ABN noticed also documented Therapy and the reason listed was Met Max Potential . The Estimated Cost was left blank. In addition, on the lower half of the page was an area with three boxes. The instructions read, Check one box. We can't choose a box for you. All three option boxes were left blank. During an interview on 8/26/2025 at 9:07 AM, the Social Worker (SW#1), in the presence of of SW #2, stated that no estimated cost was not required as the business office would take care of the estimated cost and that the resident or representative don't always check a box. During an interview on 8/26/2025 at 1:48 AM with the surveyor the Licensed Nursing Home Administrator, in the presence of the Regional Clinical Director (RCD) acknowledged that one of the three options and that an estimated cost should have been filled in. The facility did not provide a policy referencing SNF ABN. NJAC 8:39-5.1(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that appropriate care and services were provided to prevent complications of enteral feeding (delivers nutrition directly into the digestive system through a tube), by failing to check for proper placement of the feeding tube before administering the enteral feeding.This deficient practice was identified for 1 of 1 resident (Resident #46) investigated for tube feeding and was evidenced by the following: On 8/21/25 at 9:15 AM, the surveyor reviewed the medical record for Resident #46.A review of the admission Record (admission summary) reflected that Resident #46 was admitted to the facility with diagnoses that included but not limited to; aphasia (disorder that affects communication), dysphagia (difficulty swallowing), adult failure to thrive (FTT), and pneumonitis (inflammation of the lungs) due to inhalation of food and vomit.A review of the admission Minimum Data Set (MDS), an assessment tool dated 5/31/25, reflected that Resident #46 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated severe cognitive impairment. Further review of Section K (Swallowing/Nutritional Status) revealed that Resident #46 had a feeding tube in place and received 51% or more total caloric intake through tube feeding.A review of the Order Summary Report of active orders as of 8/27/25 included a physician's order (PO) dated 3/17/25, for enteral feeding. The order directed staff to check the feeding tube for proper placement prior to each feeding, flush, or medication administration at every shift.A review of the August 2025 Medication Administration Record (MAR) for the physician's order dated 3/17/25, reflected that tube placement checks were documented as completed every shift, as ordered.A review of the Interdisciplinary Care Plan (IDCP) revealed a focus area, revised on 3/18/25, indicating that Resident #46 required tube feeding due to poor oral intake, dysphagia, and a diagnosis FTT. The IDCP included an intervention to check tube placement and assess gastric contents/residual volume in accordance with facility protocol and record.On 8/25/25 at 10:13 AM, the surveyor observed Resident #46 in his room lying in bed. On 8/25/25 at 10:15 AM, the surveyor observed a Registered Nurse (RN) attempting to flush Resident #46's feeding tube without first verifying tube placement, as required by facility policy. The surveyor interviewed the RN who acknowledged that tube placement should be checked prior to administering flushes and confirmed that this step had been missed.On 8/26/25 at 1:49 PM, in the presence of the survey team, the Director of Nursing (DON) confirmed that the RN should have checked the feeding tube placement prior to administering flushes. The DON stated that verifying tube placement was essential to ensure the feeding tube was properly positioned and prevent potential complications.A review of the facility's Bolus Nasogastric/Gastrostomy Tube-Feeding policy, dated February 1, 2021, and revised on March 10, 2023, indicated the purpose as to provide a means of feeding per tube to meet the nutritional requirements of residents who are unable or unwilling to take nutrients by mouth. NJAC 8:39-25.2(c)2,5

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, record review, interview, and pertinent facility documentation, it was determined that the facility failed to ensure that a medication was secured in a locked compartment accessible only to authorized personnel with a key. Specifically, the facility failed to secure medication that was left at a resident's bedside. This deficient practice was identified for 1 of 1 resident (Resident #10) and was evidenced by the following: On 08/21/2025 at 11:21 PM, the surveyor observed Resident #10 in their bedroom, seated in a wheelchair with a bedside table in front of them. On the table was a box containing a 10-milliliter bottle of eye itch relief drops (used to relieve itching in the eyes). The resident stated that their daughter had brought the eye drops because their eyes sometimes feel dry.Review of the electronic medical record on 08/20/2025 at 10:00 AM, revealed the following: A review of the admission Record indicated that Resident # 10 was admitted to the facility with diagnoses that included but was not limited to, dementia (a condition that impairs mental abilities needed for everyday activities), and lack of coordination. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate care management dated 07/08/2025, included a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderately impaired cognition. A review of Resident #10's comprehensive care plan dated 05/06/2025, included a focus area which indicated that the resident had cognitive deficits. A review of the Medication Administration Record, dated as of 08/2025, included the following physician orders (PO): a PO, dated 01/06/2025, for ophthalmic eye solution 1.4-0.6%, to instill 1 drop in both eyes every 4 hours as needed for dry eyes; and a PO, dated 06/17/2025 for ophthalmic eye solution, to instill 1 unit in both eyes as needed for dry eyes.The surveyor conducted an interview on 08/21/2025 at 12:34 PM with the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that she was aware the resident had the eye drops at the bedside and that she would speak with the resident's family. She admitted that the resident should not have the eye drops at the bedside if she had not been assessed for safe self-medication administration. During an interview with the surveyor on 08/27/2025 at 11:40 AM, the Director of Nursing stated that Resident #10 should not have had eye drops at the bedside due to safety reasons. A review of the facility's undated policy, titled, Storage of Medication, revealed that, The nursing staff shall be responsible for maintaining medication storage. A review of the facility's undated policy, titled, Administering Medications, revealed that, Residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. NJAC 8:39-29.2(d)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Complaint: NJ183978Based on interview, review of medical records and other pertinent facility documentation it was determined that the facility failed to maintain medical records accurately and completely in accordance with acceptable standards and practice. This identified for 1 of 46 residents (Resident # 150) reviewed medical records and evidenced by the following:A review of the admission Record, an admission summary, revealed that Resident #150 had diagnoses which included, but were not limited to: metabolic encephalopathy and moderate protein-calorie malnutrition. A review of the resident's individual comprehensive care plan (ICCP) had the following a focus areas, dated 2/27/2025, that the resident had an alteration in gastro-intestinal status [related to] presence of colostomy. Interventions included, but not limited to, monitor colostomy site for [signs/symptoms] of infection every shift and provide colostomy care every shift; that the resident used antidepressant medication [related to] the management of depression. Interventions included, but not limited to, antidepressant medications as ordered by physician; that the resident has chronic pain [related to] quadriplegia, presence of wounds, and polyneuropathy. Interventions included, but not limited to, monitor/record/report to nurse my complaints of pain or requests for pain treatment; that the resident had a suprapubic catheter [related to diagnosis] of neurogenic bladder. Interventions included, but not limited to, empty drainage bag [every] 8 hours. Record output if necessary; render catheter care every shift.A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated as of 8/21/2025, included, but not limited to, the following physician orders (PO) and corresponding blank entries:A PO, dated 2/22/2025, for Duloxetine oral capsule delayed release particles 80 miligrams (mg) to give 1 capsule by mouth at bedtime related to depression. On 2/23/2025 a blank space was observed. A PO, dated 2/22/2025, for Fluoxetine HCL oral capsule 10mg to give 5 capsules by mouth at bedtime related to depression. On 2/23/2025 a blank space was observed. A PO, dated 2/22/2025, for Blaclofen oral tablet 10mg to give 1 tablet by mouth two times a day (2pm and 9pm) for muscle spasm *give with 20mg to equal 30mg). On 2/23/2025 a blank space was observed for the 9 PM entry.A PO, dated 2/22/2025, for Blaclofen oral tablet 200mg to give 1 tablet by mouth two times a day (2pm and 9pm) for muscle spasm *give with 10mg to equal 30mg). On 2/23/2025 a blank space was observed for the 9 PM entry.A PO, dated 2/22/2025, for Methenamine Hippurate oral tablet 1 gram (GM) to give 1 tablet by mouth every 12 hours for ESBL of urine. On 2/23/2025 a blank space was observed. A PO, dated 2/22/2025, for Gabapentin oral capsule 400mg to give 3 capsule by mouth three times (9am, 2pm, 9pm) a day for neuropathy. On 2/23/2025 a blank space was observed for the 9 PM entry.A PO, dated 2/22/2025, to monitor vital signs every shift for assessment. On 2/23/2025 (second shift) and 2/27/2025 (morning shift) did not have vital signs entered. On 2/23/2025 (day), 2/24/2025 (day), 2/27/2025 (day) blank spaces were observed. A PO, dated 2/22/2025, for Santyl External Ointment 150unit/GM to apply to sacrum and right heel topically every day and evening shift for wound care. A PO, dated 2/22/2025, to monitor colostomy stoma for [signs/symptoms] of infection every shift for infection. On 2/23/2025 (day) and 2/24/2025 (day) blank spaces were observed.A PO, dated 2/22/2025, to offload heels when in bed every shift for prevention. On 2/23/2025 (day) and 2/24/2025 (day) blank spaces were observed.A PO, dated 2/22/2025, for skin protectant to apply to buttock topically every shift for prevention. On 2/23/2025 (day) and 2/24/2025 (day) blank spaces were observed.A PO, dated 2/22/2025, to record supra pubic cather output every shift for monitoring. On 2/24/2025 (day) a blank space was observed.A PO, dated 2/22/2025, to render suprapubic catheter care every shift for prevention. On 2/24/2025 (day) a blank space was observed.On 8/26/2025 at 8:41 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that upon administered medication and/or treatments the MAR/TAR should be checked off to show that it was given or completed. When asked what a blank box could mean, LPN #1 stated that the medication was not given or the treatment was not completed. On 8/26/2025 at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:57 AM, the surveyor interviewed the Licensed Nurse Practioner/Unit Manager (LPN/UM) who stated that physicians orders should be carried out as written and that there should never be blanks in the MAR/TAR. When asked what a blank could mean, the LPN/UM responded that it was not done. During an interview on 8/26/2025 at 1:48 AM with the surveyor the Director of Nursing, in the presence of the Licensed Nursing Home Administrator Regional Clinical Director acknowledged that the MAR/TAR should be completed in its entirety upon completion of the order and that if it was not filled in it could mean that the order was not done. A review the undated facility policy titled, Administering Medications revealed the following under Policy Interpretation and Implementation: [.] 3. Medications must be administered in accordance with the orders, including any required time frame. [.] 11. The individual administering the medication must document in [electronic records] after giving each medication by clicking the Y. [.] 13. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall click the N on the EMAR and then document as prompted by PCC. A review the undated facility policy titled, Charting and Documentation revealed the following under Policy Interpretation and Implementation: 1. All observations, medications administered, services performed, etc, must be documented in the resident's clinical record. NJAC 8:39- 23.2

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) sanitize reusable medical equipment in between resident use during medication administration and b.) contain soiled laundry securely and transport to the designated holding area to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was identified for 2 unsampled residents (Resident #81 and Resident #155) observed during medication administration and was evidenced by the following:Reference: Contaminated textiles and fabrics often contain high numbers of microorganisms from body substances, including blood, skin, stool, urine, vomitus, and other body tissues and fluids. Disease transmission attributed to health-care laundry has involved contaminated fabrics that were handled inappropriately. Contaminated textiles and fabrics are placed into bags or other appropriate containment in this location; these bags are then securely tied or otherwise closed to prevent leakage. https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.htmlReference: Perform low-level disinfection for noncritical patient-care surfaces and equipment (e.g. blood pressure cuff) that touch intact skin. https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html#cdc_generic_secti 1. On 8/25/2025 at 8:13 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 prepare to administer medications to Resident #155. LPN #1 sanitized their hands with alcohol-based sanitizer. LPN #1 proceeded to take the vital signs machine to the resident's bedside. The nurse applied the blood pressure (BP) cuff on the resident's right upper arm and the pulse oximeter (a device used to measure the percentage of oxygen in the blood) on the resident's left forefinger. The surveyor observed the nurse touched the resident's right temple area with the touch-less sensor thermometer. LPN #1 did not clean or sanitize the BP cuff, pulse oximeter, and thermometer prior to use and after using them.On 8/25/2025 at 9:57 AM, the surveyor observed LPN #1 prepare to administer medications to Resident #81. LPN #1 sanitized their hands with alcohol-based sanitizer. LPN #1 proceeded to take the vital signs machine to the resident's bedside. The nurse applied the blood pressure (BP) cuff on the resident's right upper arm and the pulse oximeter (a device used to measure the percentage of oxygen in the blood) on the resident's left forefinger. The surveyor observed the nurse touched the resident's left temple area with the touch-less sensor thermometer. LPN #1 did not clean or sanitize the BP cuff, pulse oximeter, and thermometer prior to use and after using them.On 8/26/2025 at 1:49 PM, during an interview with the survey team, the Director of Nursing (DON) stated that reusable medical equipment like the BP cuff, thermometer and pulse oximeter should be cleansed after each use in between residents. A review of the facility-provided undated policy titled Cleaning and Disinfection of Resident-Care Items and Equipment included under Policy Interpretation and Implementation, 1.) . c.2) Most non-critical reusable items can be decontaminated where they are used. 4.) Reusable resident care equipment will be decontaminated and/ or sterilized between residents according to manufacturer's instructions. 2.) On 8/26/2025 at 12:13 PM, the surveyor entered the nursing unit's shower room with Certified Nursing Assistant (CNA) #1. The surveyor observed a big pile of soiled linens, towels, and clothes in an opened plastic bag on the floor. One white wet towel was observed partly inside the plastic bag and partly on the floor. The surveyor asked CNA #1 if the soiled laundry should be sitting on the floor. CNA #1 stated that they should have been taken out to the dirty utility room because there are germs. CNA #1 also stated that nothing should be on the floor. CNA #1 was observed to put on gloves and transported the plastic bag of soiled laundry to the soiled utility room. On 8/26/2025 at 12:19 PM, Licensed Practical Nurse (LPN) #1 stated that dirty laundry should not sit on the floor. LPN #1 further stated that the dirty laundry should be bagged and put on the chute in the soiled utility room. On 8/26/2025 at 1:07 PM, the Infection Preventionist (IP) stated that soiled laundry should be put in a bag, tied, and thrown in the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soiled utility room. On 8/26/2025 at 1:50 PM, during an interview with the survey team, the Director of Nursing (DON) stated that soiled laundry should go to a bag and to the linen chute immediately. The DON further stated that the soiled laundry should not sit on the floor in the shower room.A review of the facility-provided undated policy titled Departmental (Environmental Services) - Laundry and Linen included under General Guidelines, 3.) Consider all soiled linen to be potentially infectious. 5.) All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture. N.J.A.C. 8:39 - 19.4 (a); 21.1 (a)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure the Infection Preventionist actively performed responsibilities in accordance with her facility designated role. Specifically, by not administering an annual influenza vaccine to 1 of 5 residents reviewed for vaccinations (Resident #10). The deficient practice was evidenced by the following: On 08/25/2025 at 12:10 PM, the surveyor reviewed the electronic medical records of Resident #10, which revealed that the resident was admitted to the facility on [DATE], during the influenza season. Documentation showed that the resident signed an influenza immunization consent form on 11/01/2024, indicating agreement to receive the vaccine. However, the record also indicated that the last documented administration of the influenza vaccine was on 11/23/2023, prior to the resident's admission to the facility, with no evidence that the vaccine was administered during the 2024 influenza season. Review of the admission record indicated that Resident #10 was admitted to the facility with diagnoses including, but not limited to, dementia (a condition that impairs mental abilities needed for everyday activities), and lack of coordination. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate care management dated 07/08/2025, included a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderately impaired cognition. A review of Resident #10's comprehensive care plan, dated 05/06/2025, included a focus area indicating that the resident has cognitive deficits. During an interview with the surveyor on 08/25/2025 at 1:10 PM, Resident #10 stated that she could not remember the last time she received an influenza vaccination. On 08/27/2025 at 10:20 AM, the surveyor interviewed the Infection Preventionist who stated that Resident #10 received an influenza vaccine at a pharmacy on 11/17/2023, prior to admission, and was not due for another influenza vaccine until 07/2025.On 08/27/2025 at 11:45 AM, the surveyor interviewed the Director of Nursing who stated that Resident #10 should had received an influenza vaccination between 10/01/2024 to 03/31/2025, which was considered influenza season. She further stated that the facility did not administer influenza vaccines in 07/2025 because it was outside of the influenza season. A review of the facility's undated policy, titled, Influenza Vaccine, revealed that, Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. NJAC 8:39-19.1(b)