STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315199	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Care Center	919 Green Grove Road Neptune, NJ 07753

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 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 a.) keep 2 of 2 garbage disposal areas free of garbage and debris, and b.) keep the garbage contained in a closed container for one 1 of 3 (one of three) garbage containers. This deficient practice was evidenced by: On 1/07/26 at 8:55 AM, upon arrival at the facility, the surveyor observed the facility's garbage disposal area #1. The surveyor observed 3 garbage containers (GC). The first GC was uncovered and exposed to the elements. The surveyors also observed 2 black trash bags, parts of a truck with wheels and a grey piece of cloth lying on it, a wet, flattened cardboard box, pieces of cardboard, used bottles, used disposable gloves, 2 wheelchairs (WCs), 2 small trash bins, blue vinyl coverings, paper, multiple plastic pipes, and worn sponges discarded on the side of a grey metal storage container. On 1/07/26 at 10:40 AM, the surveyor accompanied by the Food Service Director (FSD), observed the facility's garbage disposal area #2. The surveyor observed that the area surrounding the side of the metal storage container was littered with 4 bread carts (3 blue and 1 black) stacked on a red container transport dolly. Also, a pink rag and the side of a cardboard box were discarded onto the top of the black bread crate. The surveyor also observed 4 empty, white laundry drums, a piece of plastic, pieces of wood, worn disposable gloves, and a plastic cup. When questioned about the condition of the garbage disposal areas, the FSD stated that maintenance of the facility's garbage disposal areas was a shared responsibility between the kitchen, maintenance, and housekeeping departments. On 1/9/26 at 10:03 AM, the surveyor interviewed the FSD who stated the empty laundry containers belonged to the housekeeping department. The FSD explained that the containers should not have been discarded outside and that the housekeeping should have moved the containers or called the collection company to collect them. The FSD confirmed that the garbage container's lid should always be closed. On 1/9/26 at 12:25 PM, the surveyor interviewed the Director of Maintenance (DOM) who stated that the dumpster was full due to construction. When the surveyor pointed out that the trash appeared to have been discarded in the location for some time as the shrubs had overgrown the trash. The DOM admitted that staff should have placed the broken equipment in the dumpster immediately. When questioned about the process for handling trash when the dumpster is full, the DOM explained that he would call the collection company to have the dumpster emptied. On 1/9/26 at 12:35 PM, the surveyor interviewed the Director of Housekeeping and Laundry (DHL), who confirmed that was the kitchen, maintenance, and housekeeping departments' responsibility to ensure that the trash disposal area was maintained in a sanitary condition. The DHL explained that since the empty laundry containers were not collected, he should have called the collection company and have them collected or returned to the laundry room if it was not possible to collect them the same day in order to maintain sanitary conditions. On 1/12/2026 at 9:28 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who confirmed that the waste was not properly contained in dumpster and that the lid of one of the dumpsters was opened. The LNHA stated that wind may occasionally cause dumpster lids to open; however, staff are responsible for ensuring that dumpsters remain closed to contain odors and prevent pests and contamination. The surveyor reviewed the facility's garbage pickup schedule, which indicated (continued on next page)

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled pickups on Monday, Tuesday, Thursday, and Friday. Despite this schedule, garbage and debris were observed in the outdoor trash area on Wednesday. The surveyor also reviewed the facility's policy/procedure titled Housekeeping - Outdoor Trash Area revised 5/2025 and provided by the Administrator. The policy/procedure reflected that our nursing home is committed to maintaining a clean, safe and hygienic environment for our residents, staff, and visitors. The policy/procedure also noted that no litter is allowed in or around the trash area. 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** Based on observation, interview, review of medical records, and review of other pertinent facility documentation, it was determined that the facility failed to a.) implement infection control measures for the handling and storage of respiratory equipment for 1 of 3 residents reviewed for respiratory care (Resident #40) and b.) contain stored soiled linen appropriately and follow appropriate Personal Protective Equipment (PPE) practices for 1 laundry staff during handling of soiled laundry, 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 evidenced by the following: Reference: Have a separation between the soiled linen and clean linen storage areas. https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-d.html Reference: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-d.html Reference: Laundry workers should wear appropriate personal protective equipment (e.g., gloves and protective garments) while sorting soiled fabrics and textiles. https://www.cdc.gov/infection-control/media/pdfs/guideline-environmental-h.pdf 1.) On 01/07/2026 at 10:06 AM, during initial tour, surveyor #1 observed Resident #40's nasal cannula (a tube used to deliver oxygen through the nose) on the floor next to the oxygen concentrator (a medical device that delivers extra oxygen to the patient). The oxygen concentrator was turned on. The nasal cannula was dated 01/07/2026, 6AM. On 01/09/2026 at 10:36 AM Resident# 40 was observed in therapy with nasal cannula in place, and at 11:56 AM during rounds surveyor #1 observed Resident # 40's nasal cannula laying on the resident's bed next to the resident. The tubing was dated 01/07/2026 6am. A review of Resident # 40's admissions record revealed that, Resident # 94 was admitted with but not limited to Pneumonia (an infection of the lungs). A review of Resident #40's admission Minimum Data Set (MDS) dated [DATE] revealed under section O that the resident received continues oxygen. A review of Resident #40's Electronical Medical Record revealed a physician's order for oxygen at 2 liters via nasal cannula continuous. During an interview on 01/09/2026 at 12:11 PM with surveyor #1 the Infection Preventionist (IP) said the nasal cannula should be kept in a paper bag when not in use and should never be on the floor. The IP said if found on the floor the nasal cannula should be replaced along with a new paper bag and all should be dated. During an interview on 01/12/2026 at 12:45 PM with surveyor #1, the Director of Nursing (DON) said the nasal cannulas should be kept in a brown bag when not in use for infection control and should not be on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility provided policy titled Oxygen and Respiratory Tubing's, revised on 06/2024 revealed under section, Procedure that, 1. Oxygen mask, cannula, nebulizer tubing requires changing weekly every Wednesday 11-7 shift, these must be dated. It will be changed as needed when soiled. 8:39-19.4 (k) 2.) On 1/7/2026 at 12:35 PM, during the initial tour of the facility laundry area with the housekeeping director (HSKPD), Surveyor #2 observed 2 large bins, 1 black and 1 white of unbagged linen that the HSKPD confirmed were dirty laundry along the laundry service corridor. The 2 bins were filled to the brim with soiled laundry and uncovered. Two smaller uncovered white laundry bins containing unbagged linens were also observed in the area. The HSKPD identified one bin as containing soiled linen and the other bin as containing clean linen. All the bins in the area were unmarked whether they were for clean or dirty laundry use. There was no laundry staff sorting out the laundry at that time. On 1/9/2026 at 9:45 AM during the second tour of the facility laundry area with HSKPD, the surveyor observed laundry aide #1 sorting out what the HSKPD confirmed as soiled laundry in 3 large blue bins. Laundry aide #1 wore gloves with no gown. There was no gown immediately available in the area. On 1/9/2026 at 9:50 AM, the surveyor with HSKPD observed an uncovered bin containing unbagged soiled laundry near the chute area. The HSKPD stated that the laundry bins need to be covered while not being sorted out just so nothing or no one will not be touching it. On 1/9/2026 at 1:00 PM, during an interview with the surveyor, the HSKPD stated that the laundry aide who sorted the dirty laundry earlier should have gowned up. On 1/12/2026 at 11:28 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated that soiled linen needs to be bagged with bins covered while stored in the laundry area. The IP further stated that laundry staff should be wearing gloves and gown when sorting out soiled laundry for environmental protection. On 1/12/2026 at 11:32 AM, the Director of Nursing (DON) stated that soiled laundry, while in storage should be bagged and the bins should always be closed. The DON also stated that laundry staff should be wearing gown and gloves when sorting soiled laundry. A review of facility policy revised in October 2025, titled Soiled Laundry and Bedding reflected the following under Policy Statement: Soiled laundry/ bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. Under Policy Interpretation and Implementation, the following were indicated: 2.) Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g. gowns if soiling of clothing is likely). N.J.A.C. 8:39 – 19.4 (a) (c) N.J.A.J. 8:39 - 21.1 (a)(b)(d)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to report a fracture of unknown origin to the New Jersey Department of Health (NJDOH) within 2 hours as mandated for 1 of 1 resident (Resident #43) reviewed for investigations and was evidenced by the following:On 1/7/2026 at 10:20 AM, the surveyor observed Resident #43 sitting on a wheelchair in the therapy room. The surveyor noted a yellow chair alarm hanging at the back of the resident's wheelchair. The chair alarm was attached to the resident's shirt by a clip and string at the back of the resident.A review of the electronic medical record of Resident #43 revealed the following: A review of the admission Record face sheet (an admission summary) reflected that Resident #43 was admitted to the facility with diagnoses which included but were not limited to; fracture of unspecified part of left clavicle and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 1/3/2026, reflected that Resident #43 had a severely impaired cognitive skills for daily decision making.A review of the readmission progress notes (PN) dated 1/1/2026 and timed at 10:14 AM, revealed that the resident was assessed with a new 3 out of 10 pain level of the left arm and swelling on the left hand. The pain was described to be sharp and intermittent. The PN also indicated that the resident did not have a fall prior to reentry to the facility. According to the orders administration note, the resident was administered with acetaminophen 650 milligrams due to the left arm pain. The PN on 1/2/2026, timed at 10:51 AM, indicated the nurse practitioner (NP) was made aware of the swelling and pain with guarding behavior on the left arm. The NP ordered an x-ray of the left arm. The PN on 1/3/2026, timed at 3:56 AM, indicated a mildly displaced acute fracture of the distal clavicle with mild osteopenia (lower bone density) and osteoarthritis (a joint disease that causes pain and stiffness caused by a breakdown of cartilage). The PN on 1/3/2026, timed at 8:58 AM, indicated the attending physician ordered an orthopedic consult and a sling for the resident's left arm.A review of the facility-initiated investigation of the resident's fracture on the left clavicle did not include any documentation that the New Jersey Department of Health was notified of the fracture of unknown origin.On 1/12/2026 at 9:06 AM, during an interview with the surveyor and another surveyor, the Director of Nursing (DON) acknowledged that the fracture on the resident's left clavicle was a fracture of unknown origin. When asked if it was reported to the NJDOH, the DON stated that they did not report it because they knew from their investigation that it did not happen in the facility. The DON also stated that the investigation was concluded on 1/8/2026.On 1/12/2026 at 9:09 AM, during an interview with the surveyor and another surveyor, in the presence of the DON, the Licensed Nursing Home Administrator (LNHA) stated that they did not report the fracture of unknown origin to the NJDOH because they knew that it did not happen in the facility.A review of the facility-provided policy revised on 3/1/2025, titled Resident Abuse included under Investigation, Protection and Reporting: The Department of Health and the Office of the Ombudsman must be notified no later than 24 hours of the incident. N.J.A.C. 8:39-27.1(a)

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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** Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 18 residents (Resident # 6) reviewed. This deficient practice was evidenced by the following:A review of Resident # 6's admission Recorded revealed the resident was admitted to the facility with the following but not limited to diagnosis, dementia (a of cognitive functioning that interferes with daily life and activities). A review of Resident # 6's Electronical Medical Record (EMR) revealed physician's orders for Zoloft 100 milligrams (mg) (a medication used to treat depression and anxiety.) to be given one time a day for social anxiety. The EMR also revealed a physician's order for buspirone 7.5 mg (a medication used to treat anxiety) to be give twice a day for anxiety.A review of Resident #6's Care Plan (CP) revealed a focus, I have impaired cognitive function/Dementia or impaired though process r/t Dementia, mental disorder (eg: depression). with an initiated date of 10/03/2025. The CP also revealed a focus stating I am at risk for Adverse effects related to the use of anti-depressant with an initiated date of 09/25/2025.A review of Resident # 6's admission Minimal Data Set (MDS) dated [DATE], revealed under section I that there was no active diagnosis for depression or anxiety. Also, on the MDS in section N revealed that Resident # 6 was taking an antidepressant.A review of Resident # 6's EMR revealed a progress note from behavioral health dated 10/09/25 for initial evaluation for anxiety, recommended initiating - Sertraline 25mg PO (by mouth) Daily for social anxiety and Xanax 0.25mg (by mouth) q8hrs (every 8 hours) prn (as needed) for anxiety.During an interview on 01/09/2026 at 11:36 AM with the surveyor, the MDS coordinator stated they review hospital records, nursing and therapy notes, and medications when completing the MDS. When asked if Resident # 6 should have a diagnosis of depression and anxiety on their MDS, the MDS coordinator stated, Yes, there should be diagnoses.During an interview on 01/12/2026 at 12:45 PM with the surveyor, the Director of Nursing (DON) said it was important for the MDS to be accurate because that is how they get reimbursed, and they do not want to get fines for having false information. The facility policy titled Resident Assessment Instrument revealed that, 6. The assessment will accurately reflect the resident's status.NJAC 8:39-2(e)1

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) obtain a physician's order for the use of a chair alarm; b.) identify the medical symptom that warranted the use of a chair alarm; c.) conduct ongoing evaluations for the continued use of the chair alarm; d.) document the least restrictive interventions that were utilized prior to using the chair alarms; and e.) document interventions to decrease and/or discontinue the use of the chair alarm in accordance with professional standards of clinical practice. This deficient practice was identified for 1 of 1 resident reviewed for restraints (Resident #43) and 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 1/7/2026 at 10:20 AM, the surveyor observed Resident #43 sitting on a wheelchair in the therapy room. The surveyor noted a yellow chair alarm hanging at the back of the resident's wheelchair. The chair alarm was attached to the resident's shirt by a clip and string at the back of the resident.On 1/8/2026 at 11:24 AM, the surveyor observed Resident # 43 in bed. Certified Nursing Assistant (CNA) #1 was with the resident. The surveyor asked CNA #1 when the resident's last fall was. CNA #1 could not recall the resident's last fall. CNA #1 was asked by the surveyor what the resident's chair alarm was for. CNA #1 stated that the resident moves around.On 1/8/2026 at 11:26 AM, the surveyor asked Licensed Practical Nurse (LPN) #1 when the resident's last fall was. LPN #1 stated that the resident was not a faller. The surveyor asked LPN #1 why the resident had a chair alarm. LPN #1 stated that the resident would lean forward, get up and move around the building.On 1/8/2026 at 11:32 AM, after the resident was transferred to a wheelchair, the surveyor observed LPN #1 clip a string connected to the yellow chair alarm on the back of the resident's shirt.A review of the admission Record face sheet (an admission summary) reflected that Resident #43 was admitted to the facility with diagnoses which included but were not limited to; fracture of unspecified part of left clavicle, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, and dementia. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 1/3/2026, reflected that Resident #43 had severely impaired cognitive skills for daily decision making. The MDS also indicated that no chair alarm was used on the resident.A review of the Order Summary Report (OSR) active as of 1/8/2026, did not reveal an order for the chair alarm use. There was also no order for assessment, monitoring, and evaluation of the resident for continued chair alarm use.A review of the Skilled Evaluation notes dated 1/7/2026 and 1/8/2026, did not reveal the use of chair alarm.A review of the facility's standard assessments did not reveal any resident assessment for their ability to remove the clip of the chair alarm from their body on their own. A review of the individualized comprehensive care plan (ICCP) revised on 1/2/2026, reflected a focus for risk of falls because of history of falls. The interventions included the use of chair alarm so staff would know when the resident gets up without any assistance.A review of the resident's falls risk assessments revealed no documented falls since the resident's admission and prior to admission to the facility in 2021.On 1/9/2026 at 10:15 AM, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during an interview with the surveyor, Registered Nurse/ Unit Manager (RN/UM) #1 stated that alarms need an order from the doctor.On 1/12/2026 at 9:13 AM, during an interview with the surveyor and another surveyor, the Director of Nursing (DON) stated that the resident's alarm was for safety because the resident slides down the wheelchair. The surveyor asked the DON when the last fall of the resident was. The DON stated that there were no recent falls. The surveyor asked the DON what happens when the alarm gets triggered. The DON stated that the alarm makes noise when triggered and staff would see if the resident would need to be repositioned. The surveyor asked the DON when the last assessment and evaluation were for the continued use of the alarm on the resident. The DON stated that they have not assessed and evaluated the resident for continued use of the alarm. The DON further stated that they had do an evaluation if the resident needs the alarm or not.A review of the facility policy revised in April 2024, titled Charting and Documentation included under Policy Statement the following: All services provided to the resident, .shall be documented in the resident's medical record.A review of the facility policy revised in March 2022, titled Utilization of Bed and Chair Alarm reflected the following under Procedure: 2.) Nurse will complete the Alarm Utilization Guideline for appropriateness of bed and chair alarm. 3.) If deemed appropriate, nurse will order bed/ chair alarm for 30 days. This will be re-assessed thereafter. 4.) IDT (interdisciplinary team) may recommend utilization of alarm for a new fall incident if appropriate. 5.) IDT will evaluate utilization of alarm every 30 days. 6.) If the resident did not have any fall incident for 30 days, alarm use will be discontinued. N.J.A.C. 8:39 - 27.1

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, review of medical record and other pertinent facility documentation, it was determined that the facility failed to ensure that a resident who was identified as having a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity or rigidity of joints) received services to prevent further decreased range of motion (ROM) after discharge from therapy. This deficient practice was identified for 1 of 3 residents reviewed for limited ROM, (Resident #36) and was evidenced by the following: On 1/7/2026 at 9:37 AM, the surveyor observed Resident #36 resting in bed. The surveyor noted the resident's right fingers flexed in a fist. The fingernails of the right hand were observed to be about 4 millimeters long. The resident's right palm was noted dry with no marks nor redness. The resident stated that they could not move their right hand and fingers. The resident stated that they did not go to therapy and could not recall the last time they attended one. No positioning device was observed on the resident's right arm and right hand. There was no hand splint or hand roll noted on the resident's person, bed and room. On 1/7/2026 at 12:19 PM, the surveyor observed the resident eat lunch in the room using only their left hand. The surveyor asked the resident if staff had a device used for their right arm and hand while they eat. The resident denied that staff applied any device on their right hand. There was no positioning device or splint noted on the table, bed, wheelchair or room. The resident's right hand was observed resting on the lap with fingers flexed into fist.The surveyor reviewed the medical record for Resident #36.A review of the admission Record face sheet (an admission summary) reflected that Resident #43 was admitted to the facility with diagnoses which included but were not limited to; hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease affecting right dominant side and major depressive disorder. The admission record did not include a diagnosis of contracture of the right hand.A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 12/3/2025, revealed a Brief Interview Mental Status (BIMS) score of 11 out of 15 indicating a moderately impaired cognition. Further review of the MDS reflected no participation on physical therapy, occupational therapy or restorative nursing program.A review of the Order Summary Report active as of 1/7/2026 did not reveal any order for devices used for positioning of the right hand.A review of the last physical therapy report evaluation summary dated and signed on 4/5/2022 revealed the resident was referred due to progressing contracture on the right upper extremity (hand and elbow).A review of the last physical therapy report Discharge summary dated and signed on 5/30/2022 revealed the following discharge recommendations: Flexion contracture right elbow and right hand - completed evaluation, fitting and trial of right-hand splint, wearing schedule at bedtime. The RNP (Restorative Nursing Program) part in the report was marked with N/A (not applicable). A review of the resident's individualized comprehensive care plan revised on 9/5/2025 reflected a focus for limited mobility related to cerebrovascular accident (CVA) (stroke) did not include interventions from physical therapy recommendations addressing the resident's contracture of the right hand.On 1/9/2026 at 10:02 AM, during an interview with the surveyor, Registered Nurse/ Unit Manager (RN/ UM) #1 stated that the therapists initiate/ queue orders for positioning devices in the electronic medical record (EMR) which the nurses would activate if the physician were agreeable.On 1/9/2026 at 11:40 AM, during an interview with the surveyor, the Director of Rehabilitation (DOR) confirmed to the surveyor that the last physical therapy provided to the resident related to the contracture of the right hand was for certification period 3/26/2022 to 4/21/2022. The surveyor asked the DOR why there was no recent comprehensive evaluation of the resident's right upper extremity contracture. The DOR stated that the resident could not tolerate the hand roll. The DOR stated that the facility had RNP for residents discharged from therapy. The DOR stated that therapists educate and train the Certified Nursing Assistants (CNA) for discharge recommendations including positioning devices. The surveyor asked (continued on next page)

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	315199	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Care Center	919 Green Grove Road Neptune, NJ 07753

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DOR for documentation of any CNA training for Resident #36 after being discharged from therapy services. No documentation was provided. On 1/9/2026 at 11:46 AM, the surveyor together with the DOR, observed resident' s right hand. The DOR stated that the contracture of the right hand was identified when the resident was first admitted to the facility. The surveyor asked the DOR why no evaluation was completed for the resident after 2022. The DOR stated that they were going to do an evaluation on the resident's right hand right at that moment and see if the resident would be compliant to the gauze roll. On 1/12/2026 at 9:13 AM, during an interview with the surveyor, the Director of Nursing (DON) confirmed that when residents are discharged from therapy, the therapy department queues the order in the EMR.A review of the facility policy revised in June 2025, titled Rehabilitation Procedure reflected under Therapy the following: Place therapy order in PCC (EMR) under queued, nursing staff will activate order as needed. Writes treatment plan on resident's plan of care.N.J.A.C. 8:39-27.1(a), 27.2(m)

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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. Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to store of respiratory equipment in accordance with infection control standards. This deficient practice was identified for 1 of 3 (Resident #84) residents reviewed for respiratory concerns and was evidenced by the following: On 01/07/2026 at 9:59 AM, the surveyor observed Resident # 84 exiting the room. The surveyor observed the nebulizer machine (a nebulizer machine delivers aerosol medication to the person via a mouthpiece and chamber/cup that holds the medication, via tubing that is attached to the machine. It is used to treat respiratory conditions such as COPD, bronchitis, and asthma.) on a bedside table with stuffed animals. The tubing was observed positioned across the table open to air and not in a bag. On 01/08/2026 at 9:46 AM, the surveyor observed the tubing and mouthpiece of the nebulizer machine exposed to air and uncovered and on the bedside table. The surveyor observed moisture in the chamber of the mouthpiece that was attached to the tubing. At that time the Licensed Practical Nurse entered the room and placed the tubing in a brown paper bag next to Resident #84's bed. A review of the medical record revealed Resident #84 had diagnoses that included but were not limited, asthma. A review of Resident #84's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/06/2025 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that Resident #84's cognition was intact. A review of a Physician Order Sheet (POS) revealed a physician's order dated 01/01/2026, for Resident # 84 to receive ipratropium 0.5 milligrams(mg)-albuterol (a medicine that helps opens the airways) 3 mg/3 ml (milliliter) nebulization, inhale 3 milliliters by nebulizer every 6 hours for cough for 5 Days AND 1 vial inhale orally via nebulizer every 4 hours as needed for shortness of breath do not exceed 6 doses daily. During an interview with the surveyor on 01/12/2026 at 11:34 AM, the Unit Manager stated the nebulizer mouthpiece should be in a brown paper bag. The Unit Manager went on to say that when not in use the nebulizer mouthpiece and chamber should not be stored with moisture in it. A review of a facility policies did not refer to how to store nebulizer tubing. NJAC 8:39-15.1(a)

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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. Based on interview, record review and review of other facility documentation, it was determined that the facility failed to follow the recommendation identified by the Consultant Pharmacist. This deficient practice was identified for 1 of 5 Residents (Resident #57) reviewed for unnecessary medications, psychotropic medications, and medication regimen review and was evidenced by the following: On 01/08/2026 at 9:26 AM, the surveyor observed Resident #57 sitting up in bed. A review of Resident #57's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to anxiety and multiple myeloma (a blood cancer). A review of Resident #57's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/06/2025, reflected that Resident #57 had long and short-term memory deficits. A review of Resident #57's August 2025 electronic Medication Administration Record (eMAR) revealed a Physician order (PO) with a start date of 08/21/2025, for prochlorperazine maleate (an antipsychotic medication used to treat anxiety) 5mg every 8 hours PRN (as needed) for anxiety/nausea. A review of the Consultant Pharmacist's Medication Regimen Recommendations dated 09/30/2025,10/27/2025, 11/26/25, and 12/17/2025 indicated need duration of PRN prochlorperazine. Upon review of the September, October, November, December 2025 Medication Administration Record of Resident # 57 the facility did not address this recommendation until January 10, 2026.During an interview on 01/12/2026 at 11:24 AM, the Unit Manager stated that when the pharmacy consultant sends the monthly recommendations the nurse or unit manager review them with the physician and follow their instructions. She stated she tries to get them done right away. During an interview on 01/12/2026 at 11:47 AM, the Pharmacist Consultant said that she reviews the Resident charts and electronic health records once or twice a month. She submits irregularities via email to the Director of Nursing, Assistant Director of Nursing, and the Unit Managers monthly.A review of the facility's policy titled, Consultant Pharmacy, with a revised date of 1-2024 reflected that the Director of Nursing or Administrator should review the entire report and assign someone to follow up on the findings in a timely manner. NJAC 8:39 - 29.3

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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. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a physician's order for as needed (PRN) psychotropic drug was limited to 14 days for 1 of 5 residents (Resident #57) reviewed for unnecessary medications. This deficient practice was evidenced by the following: N.J.A.C. 8:39-27.1(a) On 01/08/2026 at 9:26 AM, the surveyor observed Resident #57 sitting up in bed. A review of Resident #57's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to anxiety and multiple myeloma (a blood cancer). A review of Resident #57's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/06/2025, reflected that Resident #57 had long and short-term memory deficits. A review of Resident #57's August 2025 electronic Medication Administration Record (eMAR) revealed a Physician order (PO) with a start date of 08/21/2025, for prochlorperazine maleate (an antipsychotic medication used to treat anxiety) 5mg every 8 hours as needed for anxiety/nausea. Further review of the above PO did not have a stop date of 14 days. On 01/12/2026 at 11:24 AM, the surveyor interviewed the Unit Manager (UM)regarding the order for prochlorperazine maleate PRN. The UM stated that if an antipsychotic medication is ordered PRN, it is ordered for fourteen days. The UM stated that after the fourteen days, the need for the continued use of the medication was reevaluated. She furthered that she is not sure why the PRN antipsychotic medication was ordered with no stop date for Resident #57. On 01/12/2026 at 12:39 PM, the surveyor interviewed the Director of Nursing regarding the order for prochlorperazine maleate PRN. The Director of Nursing stated the medication should have only been ordered for 14 days. A review of the facility's Use of Psychotropic Medications , with a revised date of 3-2025 included the following: Procedure: 5. Gradual dose reduction as per OBRA regulations: d. Antipsychotic PRN orders. I. Time limitation: 14 days ii.no exception iii. If the physician wishes to write a new order for the prn antipsychotic, the physician must first evaluate and directly examines the resident to determine in the new order for the PRN antipsychotic is appropriate N.J.A.C. 8:39-27.1(a)

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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, interview, and review of pertinent facility documents it was determined that the facility failed to a) ensure medical supplies were stored in accordance with professional standards and b) loose, unidentified pills were found in the drawer of a medication cart, and c) remove expired drugs from the facility inventory. The deficient practice was identified in 2 of 2 medication carts reviewed under the Medication Task. The deficient practice was evidenced by the following: On 01/07/2026 at 12:08 PM, the surveyor observed the 1st Unit Low Side medication cart in the presence of the Licensed Practical Nurse (LPN) #1. At that time, the surveyor observed the following concerns: 6 safety syringes that expired on 12/31/2025.A multidose vial of insulin glargine- U-100 flex-pen (injectable medication to control blood-sugar levels) marked opened on 12/03/2025. There was no expiration date on the vial. 2 opened bags of melted marshmallows that LPN # 1 confirmed belonged to an unsampled resident. The bags were placed on top of other medications in the drawer. At that time, during an interview with the surveyor, LPN # 1 stated that the multi-dose insulin vials once opened, were good for 30 days. On 01/08/2026 at 11:36 AM, the surveyor observed the 2nd Unit High Side medication cart room in the presence of the Licensed Practical Nurse #2. At that time, the surveyor observed the following concerns: 11 loose, unidentified pills in the second drawer from the top. 1 Fiasp Flex Pen marked opened on 12/2/2025. There was no expiration date on the bag or the flex-pen. At that time, during an interview with the surveyor, the LPN # 2 stated that there should be no loose pills found within the medication cart and the surveyor observed LPN#2 discard the loose pills. Further LPN #2 stated that the insulin pens were good for 30 days after opening and the vials 45 days after opening. On 1/12/2026 at 11:23 AM during an interview with the surveyor, the Director of Nursing (DON) said that insulin vials and pens once opened, are labeled with an opened date and typically good for 28 days once opened. The DON said that all the nurses knew this. On 1/12/2026 at 12:33 PM during an interview with the surveyor, the DON confirmed that there should not be any loose pills in the medication carts also that there should not be any expired syringes. During this time, the DON was informed that the two nurses interviewed did not provide the same discard dates for the insulin multi-dose vials and pens. The DON stated that there was a form available on the medication carts for the nurses to reference insulin expiration dates. The DON acknowledged that it is important to ensure the medications are discarded within the appropriate amount of time to ensure that the residents are receiving medications that are still in good standing. A review of the facility provided policy titled Medication Storage with a revision date of 8/2024 revealed, Medications shall be stored in a manner that maintains the integrity of the product and ensures the safety of the residents. Further under procedure, the policy revealed, 5. Discontinued and/or contaminated medications shall be removed from the medication storage areas and returned to pharmacy or discarded. Review of the policy titled Expiration Dates for Opened Medications with a revision date of 09/2024 revealed that insulin flex-pens and multi-dose vials, both should be discarded after 28 days. N.J.A.C. S 8:39-29.4 (a)(b)2