STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manahawkin Health and Rehabilitation Center	1211 Rt 72 West Manahawkin, NJ 08050

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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. 34423 Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other documentation, it was determined that the facility failed to ensure a resident was transported from one area of the unit to another in a dignified manner for 1 of 28 sampled residents, (Resident #84). This deficient practice was evidenced by the following: On 12/04/2024 at 11:37 AM, the surveyor observed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) to pull a resident (Resident #84) backward in his/her wheelchair (w/c) from the nurse's station to the dining/recreation room. Resident #84's feet on which he/she was wearing slippers, were dragging on floor. There were no foot rests observed on the w/c for the resident to put his/her feet on. The surveyor reviewed the EMR on 12/04/2024 11:54 AM, as follows: According to the Admission Record Resident #84 was admitted to the facility with diagnoses including but not limited to: Alzheimer's disease. A review of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care dated 11/2/2024, revealed a Brief Interview for Mental Status score of 4/15 indicating Resident #84 has severe cognitive impairment. The MDS further indicated that resident uses a w/c but not attempted for resident to wheel (self) due to medical condition or safety concern. During an interview with the surveyor on 12/04/2024 at 11:39 AM, the surveyor asked LPN/UM #1 if it was appropriate to pull a resident backwards in the w/c. LPN/UM #1 replied he/she (resident) put his/her feet down and resident is not capable of following instructions. Again, the surveyor questioned was it appropriate to pull a resident backwards in the w/c. LPN/UM #1 replied I would have to say probably not. A review of a facility policy titled Safe Resident Handling/Mobility/Transfers with implemented date of 11292023 did not include documentation of how to transport a resident from one area of the facility to another. During an interview with the surveyor on 12/06/2024 at 01:56 PM, the Director of Nursing (DON) was asked how a resident should be transported in a w/c. The DON replied they should be pushed moving forward. If (resident) unable to lift feet for any reason we would have to get leg rests for the resident. (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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(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	NJAC 8:39-4.1(a)(12)

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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 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. 40039 Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents reviewed for SNF (Skilled Nursing Facility) Beneficiary Protection Notification (SNF BPN), (Resident #9 and #22). This deficient practice was evidenced by the following: On 12/04/2024 at 09:35 AM, the surveyor presented the facility certified social worker (CSW) with three (3) SNF BPN, one (1) resident discharged to home and two (2) residents that remained in the facility with Medicare A time remaining. The CSW explained to the surveyor that she just started issuing the SNF BPN forms in October after her predecessor left the facility. The CSW further told the surveyor on 12/04/2024 at 10:28 AM, I was unable to find the other form for the residents that went home (NOMNC CMS 10123). In my previous experience it just used to be a verbal conversation. The surveyor explained to the CSW that residents discharged to the facility with Medicare A time remaining required two (2) forms, Notice of Medicare Non-Coverage/NOMNC -Form CMS 10123 and SNF ABN (Skilled Nursing Facility Advanced Notice of Non-Coverage)- Form CMS-10055. The CSW told the surveyor, I agree that two (2) forms should be issued when a Medicare A resident is discharged to the facility with Medicare A time still remaining. On 12/04/2024 at 01:41 PM, the surveyor reviewed the following Residents for SNF BPN: 1. Resident #9's Medicare A start date was 10/17/2024 and last day covered was 11/26/2024. Resident #9 remained in the facility. Resident #9 did not receive CMS Form 10055 (SNFABN), as required. A review of the form SNF BPN revealed under Section 1 Other explain: Facility did not provide. 2. Resident #22 had a Medicare A start date was 8/6/2024 and last day covered was 9/19/2024. Resident #22 remained in the facility. The facility did not provide Resident #22 with SNFABN Form 10055 as required. A review of the SNF BPN Section 1 under Other explain: revealed that Facility did not provide. NJAC 8:39-4.1(a)(7)

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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** 34423 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean, safe, and sanitary environment. This deficient practice was identified for 2 of 2 units (1st floor and 2nd floor) and was evidenced by the following: On 12/03/2024 at 11:22 AM, Surveyor #1 observed the wheels on 2 East and 2 [NAME] medication carts. There was hair and strings wrapped around the wheels. On 12/03/2024 at 11:26 AM, Surveyor #1 observed hair and debris wrapped around the wheels of the Hoyer lift on 2nd floor. On 12/03/2024 at 11:33 AM, Surveyor #1 observed 1/2 PB&J sandwich under the bed of room [ROOM NUMBER]. On 12/03/2024 at 11:42 AM, Surveyor #1 observed the 1 west treatment cart with hair wrapped around the wheels. On 12/03/2024 at12:16 PM, Surveyor #1 observed the wheels on 1 [NAME] with large amount dark hair wrapped around the wheels. 40039 On 12/06/24 at 11:18 AM Surveyor #2 observed the interior of Resident #260's room. Resident #260 had there bed against the wall on the (L) side of the room. The bed rail was disattached from the wall. The end of the chair rail was noted to have a nail protruding out of the chair rail pointing towards resident#260's bed, which would be in the area where Resident #260's head would be while lying in bed. On 12/06/2024 at 11:24 AM during an interview with the facility Director of Maintenance (DOM) the surveyors asked the DOM if weekly tours of the facility included visiting resident rooms. The DOM told the surveyors that weekly rounds would include observations of residene rooms. Surveyor #2 then made the DOM aware of the chair rail observation in Resident #260's room. The DOM replied this was the first time that I'm hearing of that. I must have missed it on my rounds. How long has it been like that? The surveyor told the DOM that it was observed on the initial tour of the facility on 12/02/2024. The DOM went on to say that it was a common occurrence in the facility with residents who have had their beds placed against the wall. 51232 On 12/02/2024 at 11:11 AM, Surveyor #3 observed the following: a black trashcan in the shower room on the second floor, containing trash but lacking a liner. Additionally, trash, including a used incontinent brief, a white sock, and a clear plastic cap, was found in the linen cart inside the same shower room. The cart also did not have a liner. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/2024 at 9:08 AM, Surveyor #3 observed floor tiles missing around the shower drain exposing a dark brown sunstance, hanging air vent with brown particles, wall tiles stained brown inside the shower room on the 1st floor. On 12/05/2024 at 9:16 AM, Surveyor #3 observed a missing baseboard on the 1st floor wall near room [ROOM NUMBER]. On 12/05/2024 at 9:24 AM, Surveyor #3 observed a drop ceiling tile with brown stains and bulging in the bathroom inside the shower room on the 1st floor. During an interview with Surveyor #3 on 12/06/2024 at 2:08 PM, Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), were made aware of the identified environmental concerns. The DON explained that housekeeping is responsible for cleaning the shower rooms during the day, while Certified Nursing Assistants (CNAs) clean after each resident use. Nurses are responsible for cleaning the medication and treatment carts, and housekeeping performs deep cleaning and power washing as necessary. The DON noted that there is no formal cleaning schedule currently in place. A review of a facility provided policy undated, titled Routine Cleaning and Disinfection revealed that, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. A review of a facility provided policy undated, titled Cycle Cleaning revealed that, It is the policy of this facility to identify the functional areas in the facility that require cleaning and to use cycle cleaning schedules to outline the frequencies and maintain regularly scheduled environmental service task. 8:39-31.4 (a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34423 Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to ensure that an accurate Minimum Data Set (MDS), an assessment tool, was completed. This deficient practice was identified for 6 of 28 residents reviewed (Residents #35, Resident #107, Resident #99, Resident #67. Resident #102, and Resident #1). and was evidenced by the following: 1.During the initial tour of the facility on Resident #35 was observed lying in bed using a cell phone with his/her left hand. Resident #35's right hand was observed to be contracted. A review of the Electronic Medical Record (EMR) on 12/02/2024 at 2:14 PM revealed the following: According to the Admission Record, Resident #35 was admitted to the facility with diagnoses including but not limited to: Cerebral Infarction due to Thrombosis (stroke due to a blood clot). A review of the most recent comprehensive MDS dated [DATE], revealed that Resident #35 had impaired mobility on one side of both upper and lower extremities. A further review of section O did not indicate that Resident #35 used a splint. A review of the Order summary Report (OSR) with active orders as of 12/05/2024 revealed a physician order dated 7/18/2024 to Apply resting hand splint on right hand when out of bed during daily functional acts. Remove during bathing/shower. Check for skin integrity before and after splint application. During an interview with the surveyor on 12/5/2024 at 12:56 PM, the MDS Coordinator (MDSC) was asked who was responsible to complete the MDS. The MDSC replied I have to look at all components to make sure it is filled out by the interdisciplinary team. I am responsible to make sure of the accuracy of each block especially section GG. I do nursing parts. The surveyor asked where you get the information from. The MDSC replied I get the information from the medical and hospital record. I also interview the patient and assess their needs. On 12/05/2024 at 01:09 PM, the surveyor reviewed with the MDSC that Resident #35 had a splint to his/her right upper extremity. The surveyor asked would this be coded on the MDS. The MDSC replied braces are in section O O500. The MDSC look at section O and confirmed it was not coded and should have been coded. 2. A review of the EMR for Resident #107 on 12/02/2024 revealed the following: According to the Admission Record Resident #107 was admitted with diagnoses including but not limited to: Non traumatic Intracerebral Hemorrhage (is a type of stroke caused by bleeding within the brain tissue.), and Hemiplegia (a symptom that involves one-sided paralysis). A review of a MDS section A 2000 discharge date revealed Resident #107 was discharged on [DATE]. A review of section A2105 Discharge Status was coded as 01. Home /community. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Progress Notes for Resident #107 dated 11/20/2024 16:10 4:10 PM), that at 3:45 pm resident was noted to be sitting in the hallway in the west wing crying and saying don't let me die and c/o (complained of) falling. Denies any pain or discomfort at this time. 911 contacted and sent to emergency room . Physician aware. A further review of the progress notes indicated that on 11/20/2024 at 16:14 (4:14 PM) Resident #107 left facility via 911 and stretcher at 4:10pm. According to a progress note dated 11/20/2024 at 20:46 (8:46 PM) Resident admitted to hospital with Dx (diagnosis) of knee pain. During an interview with the surveyor on 12/05/2024 at 01:05 PM, the surveyor reviewed with the MDSC that Resident #107 was sent to the hospital on 11/21/2024. The surveyor asked how the discharge was coded. The MDSC said it was coded went to home. The surveyor asked was this correct. The MDSC said no that should have been to the hospital that date. 3. During the initial tour of the facility on 12/02/2024 at 10:35 AM, Resident #99 was observed ambulating independently in the hallway talking to him/herself. The surveyor observed a wander alarm bracelet on each ankle. A review of the EMR for Resident #99 on 12/02/2024 at 11:01 AM revealed the following: According to the Admission Record, Resident #99 was admitted with diagnoses including but not limited to: Unspecified Dementia and Memory Deficit. A review of the most recent comprehensive MDS dated [DATE] revealed under section E wandering behavior occurred daily. Under section P alarms wander/elopement coded as not used. A review of the OSR with Active orders as of 12/09/2024 revealed a physician order dated 06/16/2024 to Monitor skin under left ankle wander bracelet every shift for skin integrity. The OSR also included an order dated 06/16/2024 [company name for wander alarm] left ankle- check placement and function q (every) shift for safety. During an interview with the surveyor on 12/5/2024 at 12:56 PM, the MDS Coordinator (MDSC) was asked who was responsible to complete the MDS. The MDSC replied I have to look at all components to make sure it is filled out by the interdisciplinary team. I am responsible to make sure of the accuracy of each block especially section GG. I do nursing parts. The surveyor asked where you get the information from. The MDSC replied I get the information from the medical and hospital record. I also interview the patient and assess their needs. On 12/05/2024 at 01:07 PM, the surveyor said to the MDSC, Resident #99 has a wander alarm bracelet. Please show me where this would be documented on the MDS. The MDSC said I don't remember. The surveyeyor again asked was this documented on the MDS. The MDSC said no he/she is not coded as having one. I should look under orders and he/she should have been coded as having one as of 6/16/2024. 51232 4.) On 12/02/2024 at 10:49 AM, Surveyor #2 observed Resident #67 sitting in a Merry [NAME] (an adaptive device to allow independent and safe walking) with the gate closed and a loose black nylon adjustable safety belt secured between his/her legs, positioned next to the nursing station. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/03/2024 at 10:16 AM, Surveyor #2 observed Resident #67 sitting in a Merry [NAME] with the gate closed and a loose black nylon adjustable safety belt secured between his/her legs, positioned next to the nursing station. The surveyor asked the resident if he/she could open the gate on the Merry [NAME] and remove the adjustable safety belt. The resident responded with a smile. Surveyor #2 reviewed the EMR on 12/02/2024 at 2:00 PM as follows: According to the Admission Record, Resident #67 was admitted to the facility with diagnoses including but not limited to: muscle wasting and atrophy, dementia, and Alzheimer's disease. A review of the MDS dated [DATE] for Resident #67 revealed under section E Wandering-Presence and Frequency was coded as 0 indicating Resident #67 did not exhibit wandering behavior. Section P-Physical Restraints and Alarms was coded as 0 indicting Resident #67 does not use a physical restraint. A review of the physician orders included the following: a physician order dated 04/07/2024, for the use of a Merry [NAME] to promote independence and mobility. A physician order dated 04/07/2024 directing staff to assist the resident in exiting the Merry [NAME] and walking with assistance every 2 hours during each shift. a physician order dated 06/20/2024, specifying the use of the Merry [NAME] when the resident is out of bed for safety and independence, with the requirement to release the resident and ambulate for 10 minutes every 2 hours. During an interview with Surveyor #2 on 12/05/2024 at 1:00 PM, with the MDSC regarding Resident #67's QMDS from 11/04/2024 not being coded for wandering said, the resident does wander and should have been coded for wandering. He/she also considers the merry walker a restraint if the resident is unable to release it on his/her own, and in that case, it should be coded as a restraint. 5.) On 12/03/2024 at 10:21 AM, Surveyor #2 observed Resident #102 lying in bed with a black splint on his/her left lower arm and wrist area. He/she stated that the orthopedic doctor provided the black arm splint and a black cam boot due to a broken left arm and ankle, but he/she no longer wears the cam boot. He/she puts the splint on his/her left lower arm and wrist at night and removes it when he/she chooses. On 12/03/2024 at 9:00 AM, Surveyor #2 reviewed the EMR for Resident #102 as follows: According to the Admission Record Resident #102 was admitted to the facility with diagnoses including but not limited to: fracture of shaft of left radius, and injury left ankle. A review of the most recent comprehensive MDS dated [DATE] for Resident #102 revealed under section O-Restorative Nursing Programs, it was coded as 0, indicating that Resident #102 does not use a splint or brace assistance, nor does the resident receive range of motion therapy. A review of the physician orders for Resident #102 did not include current or discontinued orders for a cast on the right lower extremity, a cast on the left upper extremity, a splint, or a cam boot. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Nurse notes from 10/06/2024, indicated that Resident #102 was admitted with a cast on the right lower extremity and left upper extremity. On 10/23/2024, the nurse noted that the resident returned from an orthopedic appointment with a brace on the left arm, and on 10/25/2024, the nurse noted that the cast had been removed and replaced with a cam boot. A review of the Orthopedics notes dated 10/23/2024, recommended initiating physical therapy with weight-bearing as tolerated while using a cam boot. A follow-up note on 10/25/2024 outlined a treatment plan that included active range of motion, assisted active range of motion, passive range of motion, and the use of a splint for a left distal radius fracture. During an interview with Surveyor #2 on 12/05/2024 at 1:00 PM, the MDSC was questioned regarding Resident #102 from 10/09/2024 not being coded for wearing a splint. MDSC said, the resident should have been coded for wearing a splint if he/she is wearing one. 6.) On 12/02/2024 at 10:29 AM, Surveyor #2 observed the Resident #1 sitting in a wheelchair in the hallway on the second floor near the nursing station. Resident #2 was not wearing a handroll or splint on the right hand. A review of the EMR for Resident #1 on 12/03/2024 at 12:35 PM, revealed the following: According to the Admission Record Resident #1 was admitted to the facility with diagnoses including but not limited to: Cerebral Palsy. A review of the most recent MDS dated [DATE], revealed under section O-Restorative Nursing Programs, it was coded as 0, indicating that Resident #1 does not use a splint or brace assistance. A review of the physician orders included the following: a physician order dated 05/12/2022, instructing the use of a right hand roll as tolerated, with skin checks every shift when in use; and a physician order dated 07/02/2024, directing the resident to wear a right hand comfy splint during functional activities out of bed, remove it at night during bathing and exercise, and check for skin redness and irritation every shift. During an interview with Surveyor #2 on 12/05/2024 at 1:05 PM, the MDSC was questioned regarding Resident #1 not being coded for wearing a handroll and splint. MDSC said, that the resident should be coded for wearing a handroll and splint if he/she is using them. NJAC 8:39-11.1

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 51232 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 develop and implement a baseline care plan (BCP) within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident. This deficient practice was identified for 1 of 28 sampled residents (Resident #102) and was evidenced by the following: On 12/03/2024 at 10:21 AM, Surveyor #1 observed Resident #102 lying in bed with a black splint (medical device used to immobilize, support, or protect a body part) on his/her left lower arm and wrist area. He/she said that the orthopedic doctor (medical professional who specializes in the musculoskeletal system) provided the black arm splint and a black Controlled Ankle Motion boot (CAM) boot (medical boot used to immobilize and protect the foot, ankle, and lower leg following an injury or surgery) due to a broken left arm and ankle, but he/she no longer wears the CAM boot. He/she puts the splint on his/her left lower arm and wrist at night and removes it when he/she chooses. On 12/03/2024 at 9:00 AM, Surveyor #1 reviewed the EMR for Resident #102 as follows: According to the Admission Record Resident #102 was admitted to the facility with diagnoses including but not limited to: fracture of shaft of left radius, and injury left ankle. A review of the physician orders for Resident #102 did not include current or discontinued orders for a cast, splint, or a CAM boot. A review of the Nurses note dated 10/06/2024, indicated that Resident #102 was admitted with a cast on the right lower extremity and left upper extremity. A further review of the Nurses note dated 10/23/2024, indicated that the resident returned from an orthopedic appointment with a brace on the left arm. A Nurses note dated 10/25/2024, the nurse noted that the cast had been removed and replaced with a CAM boot. A review of the care plan for Resident #102 did not address or include specific instructions for the care of a cast, splint, or a CAM boot. During an interview with the surveyor on 12/05/2024 at 10:25 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1), said resident should have had a care plan for a cast, splint, or a CAM boot. NJAC 8:39-11.2(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41442 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 develop a person-centered comprehensive care plan to address the use of A. an anticoagulant (blood thinner) medication, B. oxygen therapy, C. a splint used to prevent further contracture, and D. a wander alarm used to prevent elopement. This deficient practice was identified for 4 of 28 sampled residents, (Resident #8, Resident #18, Resident #35, and Resident #99) and was evidenced by the following: A.) On 12/2/2024 at 11:01 AM, during the initial tour, Resident #8 was identified as being on an anticoagulant. A review of Resident #8's EMR on 12/02/2024 at 02:11 PM, revealed the following: A review of Resident #8's Admission Record revealed that he/she had diagnoses that included but were not limited to: Acute Embolism (a blockage of a pulmonary artery) and Thrombosis of Deep Veins of the Upper Extremity (a blood clot forms in a vein deep inside a part of the body). A review of the (OSR) with an active date as of 12/05/2024, revealed the following: Eliquis Oral Tablet 2.5 milligrams; Give 1 tablet by mouth every 12 hours for Deep Venous Thrombosis. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care dated 09/10/2024, revealed under section N Resident #8 was on an anticoagulant. A review of Resident #1's care plan on 12/02/2024 at 02:11 PM, did not include documentation that Resident #8 was on an anticoagulant. During an interview with the Surveyor #1 on 12/03/2024 at 10:10 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1) agreed that anticoagulants, including Eliquis should be care planned. During an interview with the Surveyor #1 on 12/06/2024 at 01:51 PM, the Director of Nursing (DON) agreed that an anticoagulant should be care planned. 51232 B.) During the initial tour of the facility on 12/02/2024 at 10:18 AM, Resident #18 was observed in his/her room sitting on the side of the bed with oxygen on via nasal cannula (n/c) (a device used to deliver supplemental oxygen or increased airflow to a patient in need of respiratory help). On 12/03/2024 at 10:30 AM, Surveyor #2 observed Resident #18 in their room, lying in bed with oxygen on via nasal cannula. On 12/04/2024 at 10:33 AM, the Surveyor #2 observed Resident #18 in their room sitting on the side of his/her bed with oxygen on via n/c. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the EMR on 12/03/2024 at 12:45 PM, revealed the following: According to the Admission Record, Resident #18 was admitted to the facility with diagnoses including but not limited to: Heart Disease. A review of the most recent MDS dated [DATE] revealed under section O: no oxygen therapy. A review of the OSR with Active Orders as of 12/05/2024, revealed a physician order dated 11/20/2023, Oxygen at 2 liters via nasal canula as needed (PRN) for SOB (shortness of breath). A review of Resident #18's care plan on 12/03/2024 at 1:00 PM, did not include that Resident #18 used oxygen therapy. During an interview with Surveyor #2 on 12/05/2024 at 11:00 AM, LPN/UM #1 was questioned regarding the resident's PRN oxygen. LPNUM #1 said that the oxygen tubing should be dated weekly to indicate when it was changed. The resident should have oxygen care planned, and if nursing staff administer PRN oxygen, it should be documented in the Treatment Administration Records (TAR). 34423 C.) During the initial tour of the facility on 12/02/2024 at 10:45 AM, Resident #35 was observed lying in bed using a cell phone with his/her left hand. Resident #35's right hand was observed to be contracted. A review of the Electronic Medical Record (EMR) on 12/02/2024 at 2:14 PM, revealed the following: According to the Admission Record, Resident #35 was admitted to the facility with diagnoses including but not limited to: Cerebral Infarction due to Thrombosis (stroke due to a blood clot). A review of the most recent comprehensive MDS dated [DATE], revealed that Resident #35 had impaired mobility on one side of both upper and lower extremities. A review of the OSR with active orders as of 12/05/2024, revealed a physician order dated 7/18/2024 to Apply resting hand splint on right hand when out of bed during daily functional acts. Remove during bathing/shower. Check for skin integrity before and after splint application. A review of the care plan for Resident #35 did not include documentation that he/she used a splint as per the physician order. During an interview with Surveyor #3 on 12/05/2024 at 10:19 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) was asked who was responsible for completing the care plan. LPN/UM #1 replied between the Unit Manager (UM) and DON we are responsible for the care plan. LPN/UM #1 went on to say the nurses initialize the care plan upon admission and UM/DON finalize them. Surveyor #3 questioned what is expected to be on the care plan for residents. LPN/UM #1 said I would say elopement risk 2 goals and at least 3 nursing interventions per goal. We review and adjust quarterly and as needed based on resident status. We look at skin, diet/weights, medications such as psych meds, falls, and Activities of Living. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/2024 at 10:23 AM, Surveyor #3 questioned if a splint would be care planned. LPN/UM #1 stated Yes, I would expect a brace/splint to be care planned. We would also monitor the skin for staying intact or protect as needed. On 12/05/2024 at 10:49 AM, the Surveyor #3 requested LPN/UM #1 to review Resident #35's care plan on the EMR for the splint. LPN/UM #1 said No, I don't see a care plan for resident's splint. LPN/UM #1 confirmed that yes, there should be one. During an interview with Surveyor #3 on 12/06/2024 at 01:50 PM, the DON was asked, what are your expectations as to what should be on a resident care plan. The DON replied Specific for patient with dx (diagnoses) condition, situation. They would include pain risk or actual skin issues, Activities of Daily Living, code status. The DON confirmed this would include a brace/splint. D.) During the initial tour of the facility on 12/02/2024 at 10:35 AM, Resident #99 was observed ambulating independently in the hallway talking to him/herself. The surveyor observed a wander alarm bracelet on each ankle. A review of the EMR for Resident #99 on 12/02/2024 at 11:01 AM, revealed the following: According to the Admission Record, Resident #99 was admitted with diagnoses including but not limited to: Unspecified Dementia and Memory Deficit. A review of the most recent comprehensive MDS dated [DATE] revealed under section E wandering behavior occurred daily. Under section P alarms wander/elopement coded as not used. A review of the OSR with Active orders as of 12/09/2024 revealed a physician order dated 06/16/2024 to Monitor skin under left ankle wander bracelet every shift for skin integrity. The OSR also included an order dated 06/16/2024 [company name for wander alarm] left ankle- check placement and function q (every) shift every shift for safety. A review of Resident #99's care plan on 12/02/2024 at 11:01 AM, revealed a focus area care plan as follows: Resident #99 is an elopement risk/wanderer r/t (related to) dementia with an initiated date of 04/05/2024. Under the goal section The resident will not leave facility unattended through the review date. A further review of the care plan revealed that there were no interventions noted on the care plan for elopement risk/wanderer. During an interview with Surveyor #3 on 12/05/2024 at 10:19 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #1) was asked who is responsible for completing the care plan. LPN/UM #1 replied between the Unit Manager (UM) and DON we are responsible for the care plan. LPN/UM #1 went on to say the nurses initialize the care plan upon admission and UM/DON finalize them. Surveyor #3 questioned what is expected to be on care plan for residents. LPN/UM #1 said I would say elopement risk 2 goals and at least 3 nursing interventions per goal. We review and adjust quarterly and as needed based on resident status. We look at skin, diet/weights, medications such as psych meds, falls, and Activities of Living. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/2024 at 10:27 AM, Surveyor #3 requested LPN/UM #1 look at Resident #99's care plan. She stated, I don't see any interventions for the elopement care plan. LPN/UM #1 confirmed Yes, there should be interventions. During an interview with Surveyor #3 on 12/06/2024 at 01:50 PM, the DON was asked, what are your expectations as to what should be on a resident care plan. The DON replied Specific for patient with dx (diagnoses) condition, situation. They would include pain risk or actual skin issues, Activities of Daily Living, code status. The DON confirmed he would expect interventions for a wander alarm to be on a care plan. On 12/05/2024 at 11:41 AM, a review of a facility policy titled Comprehensive Care Plans with an implemented date of 06012024 revealed under the Policy section: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Under the Policy explanation and Compliance Guidelines section: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. 3. The comprehensive care plan will describe at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident highest practicable physical, mental, and psychosocial well-being. f. Resident specific interventions that reflect the resident's needs and preferences . NJAC 8:39-11.2 (e)(1), (f)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 39460 Based on the interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to document a discharge summary which included a recapitulation of the resident's stay and a final summary of the resident's status for 1 of 1 resident reviewed for hospitalization , (Resident #109). This deficient practice was evidenced by the following: On 12/4/2024 at 1:49 PM, the surveyor reviewed the closed medical record for Resident #109 which revealed the following: Resident #109's Admission Record indicated the resident had been admitted to the facility with medical diagnoses that included myocardial infarction (heart attack), anxiety and adult failure to thrive (a syndrome in older adults characterized by a significant decline in physical and mental health). A review of the resident's Discharge assessment- return not anticipated Minimum Data Set (DRNAMDS), an assessment tool used to facilitate the management of care, reflected the resident had a planned discharge to short-term general hospital. A review of the resident's Progress Notes did not reflect any documentation or note that the resident had been hospitalized or discharged from the facility. A review of the electronic medical record (EMR) did not reveal any additional information regarding the resident being hospitalized or discharged and did not include a discharge summary. On 12/5/2024 at 2:26 PM, the surveyor interviewed the facility Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) (via telephone), together reviewed the resident's EMR and both acknowledged the nurse, or social worker should have entered progress notes in the EMR regarding the discharge/hospitalization of the resident. The Administrative team both acknowledged there was also no discharge summary as required. The facility did not provide additional information. A review of the facility Discharge Summary policy dated implemented 10/01/2023 included the following: It is the policy of this facility to ensure that a discharge summary is provided upon a resident's discharge which addresses each resident's discharge goals and needs, including caregiver support and referrals to local agencies. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plan for care after discharge. It must contain an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another . NJAC 8:39-35.2(d)(16)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51232 Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure that treatment for range of motion limitations were provided for 3 of 3 residents (Resident #102, Resident #1, and Resident #35) reviewed for limited range of motion. This deficient practice was evidenced by the following: 1. On 12/03/2024 at 10:21 AM, Surveyor #1 observed Resident #102 lying in bed with a black splint on his/her left lower arm and wrist area. He/she stated that the orthopedic doctor provided the black arm splint and a black cam boot due to a broken left arm and ankle, but he/she no longer wears the cam boot. He/she puts the splint on his/her left lower arm and wrist at night and removes it when he/she chooses. On 12/03/2024 at 9:00 AM, Surveyor #1 reviewed the EMR for Resident #102 as follows: According to the Admission Record Resident #102 was admitted to the facility with diagnoses including but not limited to: fracture of shaft of left radius, and injury left ankle. A review of the most recent comprehensive MDS dated [DATE] for Resident #102 revealed under section O-Restorative Nursing Programs, it was coded as 0, indicating that Resident #102 does not use a splint or brace assistance, nor does the resident receive range of motion therapy. A review of the physician orders for Resident #102 did not include current or discontinued orders for a cast on the right lower extremity, a cast on the left upper extremity, a splint, or a Cam boot (Controlled Ankle Motion boot (CAM) boot (medical boot used to immobilize and protect the foot, ankle, and lower leg following an injury or surgery). The review of the care plan for Resident #102 did not address or include specific instructions for the care of a splint or a CAM boot. A review of the Nurse notes dated 10/06/2024, indicated that Resident #102 was admitted with a cast on the right lower extremity and left upper extremity. On 10/23/2024, the nurse noted that the Resident #102 returned from an orthopedic appointment with a brace on the left arm, and on 10/25/2024, the nurse noted that the cast had been removed and replaced with a CAM boot. A review of the Orthopedics notes dated 10/23/2024, recommended initiating physical therapy with weight-bearing as tolerated while using a CAM boot. A follow-up notes on 10/25/2024, outlined a treatment plan that included active range of motion, assisted active range of motion, passive range of motion, and the use of a splint for a left distal radius fracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Surveyor #1 on 12/05/2024 at 10:25 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1), explained that the Resident #102 is supposed to wear the splint daily on the left arm and wrist. Resident #102 follows up with an orthopedic provider and the facility's therapy department for adjustments and evaluation of the splint. 2.) On 12/02/2024 at 10:29 AM, Surveyor #1 observed the Resident #1 sitting in a wheelchair in the hallway on the second floor near the nursing station. Resident #2 was not wearing a handroll or splint on the right hand. A review of the EMR for Resident #1 on 12/03/2024 at 12:35 PM, revealed the following: According to the Admission Record Resident #1 was admitted to the facility with diagnoses including but not limited to: Cerebral Palsy. A review of the most recent MDS dated [DATE], revealed under section O-Restorative Nursing Programs, it was coded as 0, indicating that Resident #1 does not use a splint or brace assistance. A review of the physician orders included the following: a physician order dated 05/12/2022, instructing the use of a right hand roll as tolerated, with skin checks every shift when in use; and a physician order dated 07/02/2024, directing the resident to wear a right hand comfy splint during functional activities out of bed, remove it at night during bathing and exercise, and check for skin redness and irritation every shift. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 12/2024, indicated that nurses are documenting the application of the resident's right-hand roll. Surveyor #1 did not observe Resident #1 wearing the right-hand roll on 12/02/2024, 12/03/2024, 12/04/2024, and 12/05/2024. Additionally, the order for the right-hand splint was not reflected in either the MAR or TAR. During an interview with Surveyor #1 on 12/05/2024 at 10:12 AM, LPN/UM #1, explained that Resident #1 wears the hand roll and splint daily, and both certified nurse assistants (CNAs) and nurses are responsible for putting them on and removing them. LPN/UM #1 confirmed that the resident should be care planned for the hand roll and splint, and a physician's order is required. The resident follows up with in-house therapy for adjustments and evaluation of the hand roll and splint. 34423 3. On 12/02/24 at 10:45 AM, Surveyor #2 observed Resident #35 lying in bed while using her phone. A contracture was noted in her right hand, but no splint or brace was observed. A review of the EMR for Resident #35 on 12/02/2024 at 11:16 AM, revealed the following: According to the Admission Record Resident #35 was admitted to the facility with diagnoses including but not limited to: Cerebral Infarction. A review of the most recent MDS dated [DATE], revealed under section O-Restorative Nursing Programs, it was coded as 0, indicating that Resident #35 does not use a splint or brace assistance. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the physician orders revealed the following: apply a resting hand splint to the right hand when the resident is out of bed and during daily functional activities. The splint should be removed during bathing or showering. Skin integrity should be checked before and after applying the splint. A review of the MARs/TARS for July revealed no documentation regarding the times the splint was applied or removed. Additionally, there was no indication that the skin was checked before or after the splint was applied. The review of the care plan for Resident #35 did not address or include specific instructions for the care of a splint. A review of the Occupational Therapy (OT) (healthcare professional who helps individuals maintain the skills needed for daily activities, also known as occupations.) notes from 07/18/2024 indicated that Resident #35 received passive range of motion (PROM) exercises to the right upper extremity (RUE), including the shoulder, elbow, wrist, and fingers, to promote continued normal tone and reduce the risk of contracture. An OT note dated 07/18/2024 also indicated that nursing staff was informed about the splint and provided with a storage bin for it, along with the wearing schedule for the splint. During an interview with Surveyor #2 on 12/05/2024 at 10:17 AM, LPN/UM #1 regarding Resident #35 splint. LPN/UM #1 said, initially, Physical Therapy (PT) (healthcare professionals who helps individuals improve their movement) will provide the devices and conduct an in-service for nurses and CNAs on how to properly apply and remove the brace or splint. LPNUM #1 confirmed that staff members are required to sign off after receiving the in-service training. She also stated that the use of a brace or splint should be included in the resident's care plan. Additionally, there will be a wearing schedule, and physician orders will specify details, such as applying the splint in the morning and removing it at bedtime, or adjusting the schedule based on the resident's needs. The morning application would be done during the day shift. During an interview with the surveyors on 12/06/2024 at 01:50 PM, the Director of Nursing (DON) was asked if a resident has physician order for a splint/brace, where would the staff document the application/removal and skin checks before and after. The DON replied, It should be on the TAR. 12/06/24 02:01 PM DON AND LNHA agreed yes would expect the brace to be coded on MDS. The facility was unable to provide a policy regarding therapy services and treatment for range of motion limitations. NJAC 8:39 - 27.1 (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** 39460 Based on observation, interviews, record review and review of other facility documentation, it was determined that the facility failed to obtain a physician's order for supplemental oxygen and not replacing and properly storing a nasal cannula (tube used to deliver oxygen to a person) in accordance with facility policy. This deficient practice occurred for 3 of 3 residents (Resident #54, Resident #261, and Resident #18) reviewed for respiratory care. The deficient practice was evidenced by the following: 1. On 12/3/2024 at 1:38 PM, Surveyor #1 observed Resident #54 in their room sitting on their bed and was being administered oxygen via nasal cannula. The resident informed the surveyor they had COPD (chronic obstructive pulmonary disease) and would use the oxygen concentrator when in their room but when they wanted to go outside their room, they used the portable canister. The surveyor reviewed the medical record for Resident #54 and the following was revealed: A review of the Admission Record reflected the Resident #54 was admitted to the facility with diagnoses including COPD. A review of the most recent Minimum Data Set (MDS), an assessment tool dated 11/28/2024, reflected that the resident had a brief interview for mental status (BIMS) score of a 15 out 15, which indicated a fully intact cognition. A further review reflected the resident received oxygen (O2) while in the facility. A review of the Order Summary Report (OSR) from 11/1/2024 until 12/09/2024 did not include a physician's order (PO) for the resident to receive oxygen via nasal cannula. A review of the corresponding November 2024 Medication Administration Record (MAR) included a PO dated 10/12/2024 and discontinued 11/2/2024, for O2 3liters at (specify rate) L/min via (specify type) to keep sats > 90% as needed for monitoring. A review of the corresponding December 2024 Medication Administration Record (MAR) did not include a PO for oxygen use. A further review of the resident's Electronic Medical Record (EMR) revealed an O2 sat summary report (a report where nurses would document the oxygen saturation in a resident's blood) indicating the resident had used oxygen and revealed the following: 11/27/2024 O2 sat =61.0% on 2L/min (liters per minute) oxygen via nasal cannula 11/27/2024 O2 sat =92.0% on 3L/min oxygen via nasal cannula 11/27/2024 O2 sat =95.O% on 2L/min oxygen via nasal cannula (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the individualized person-centered care plan included a focus area initiated 2/13/2024, for resident's resistance to care by increasing the liters per minute on his/her concentrator with a history of COPD. Interventions were to educate the resident/family/care givers of the possible outcomes of not complying with treatment of care. A further review of the care plan included a focus area initiated 12/12/2022, for COPD. Interventions included to give aerosol or bronchodilators (medications inhaled to the treatment of COPD) as ordered. Monitor/document any side effects and effectiveness. It did not indicate the use of oxygen for treatment of COPD. During an interview with Surveyor #1 on 12/6/2024 at 12:12 PM, Licensed Practical Nurse/Unit Manager (LPN/UM#2) stated resident #54 was on oxygen. At that time the Surveyor #1 and LPN/UM #2 reviewed the resident's EMR and confirmed the resident did not have an active PO to receive oxygen via nasal cannula. LPN/UM #2 further confirmed the resident should have had a PO for the use of oxygen. During an interview with Surveyor #1 on 12/6/2024 at 1:50 PM, the Director of Nursing (DON) confirmed Resident #54 did not have a current order for oxygen use as required. 40039 2. On 12/03/2024 at 08:27 AM, Surveyor #2 observed an oxygen concentrator (a medical device that gives you extra oxygen) in the room near the head of the bed. The oxygen concentrator was observed to be on and the nasal cannula (n/c), (a lightweight tube which fits in the nostrils from which a mixture of air and oxygen flows) and tubing were draped over the top of the resident's mattress and were not being utilized by Resident #261. The surveyor did not observe a date on the tubing and Resident #261 stated he/she does not wear the oxygen when asked by the surveyor. On 12/03/2024 at 11:59 AM Resident #261 was observed lying in bed with the head of bed slightly elevated. Resident #261 complained that the room was too hot and wanted the surveyor to turn the heat down. The surveyor explained he could not do that. Resident #262 was observed with an O2 concentrator at the head of the bed on the floor. The oxygen concentrator was set at two (2) liters per minute (2L/min) and was turned on. The surveyor observed the n/c draped over the top corner of the mattress and the n/c was in contact with the floor. In addition, close observation of the oxygen tubing determined that the tubing was not dated. On 12/04/2024 at 08:57 AM Resident #261 was observed lying in bed and in no distress. No shortness of breath (SOB) was noted. The oxygen concentrator was against the wall at the head of the bed. The oxygen concentrator was turned off and not in use on this observation. The nasal cannula was observed coiled up on the floor of the room without protection and no date was observed on the tubing. The n/c was exposed to contamination. On 12/05/2024 at 08:59 AM Resident #261 was observed lying in bed with supplemental oxygen via n/c at 2L/min. Resident #261 stated he/she was SOB. Resident #261 had no order for supplemental O2 at the time of administration. A review of the Admission Record revealed that Resident #261 was admitted to the facility with the following but not limited to diagnoses: hemiplegia (a condition that causes paralysis or weakness on one side of the body), nontraumatic intracerebral hemorrhage (a type of brain bleed). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the MDS dated [DATE], Resident #261 had a Brief Interview for Mental Status score of 13, indicating intact cognition. Section I indicated that Resident #262 had an active diagnosis of asthma, chronic obstructive pulmonary disease, or chronic lung disease. According to Section O of the MDS, Resident #261 did not receive any respiratory treatments, including oxygen therapy. A review of the Order Summary Report with Active Orders As of: 12/06/2024 did not reveal a physician order for the use of supplemental oxygen. A review of Resident #261's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the periods of 11/01/2024 through 11/30/2024 and 12/01/2024 through 12/09/2024 did not reveal an order for supplemental oxygen for Resident #261. A review of Resident #261's comprehensive care plan did not indicate a care planned focus for oxygen for Resident #261. During an interview with the surveyor on 12/05/2024 at 12:53 PM, Licensed Practical Nurse (LPN #3) assigned to Resident #261 was asked if residents who receive supplemental oxygen require a physician order. LPN #3 told the surveyor, 'Yeah. The surveyor then asked LPN #3 to check Resident #261's electronic medical record (EMR) for a supplemental oxygen order. LPN #3 went into the EMR of Resident #261 and told the surveyor that there was no order for supplemental oxygen. The surveyor then asked LPN #3 if Resident #261 should have an order. LPN #3 told the surveyor, Yeah. The surveyor asked LPN #3 what the facility practice was for storage of oxygen equipment (n/c) when not in use. LPN #3 responded that the nasal cannula and tubing is supposed to be protected from contamination when not in use. During an interview with the surveyor on 12/05/2024 at 01:24 PM, LPN/UM #2 was asked if residents receiving oxygen required a physician order. LPN/UM #2 told the surveyor, yes. The surveyor then asked LPN/UM #2 what the facility practice was for oxygen equipment when not in use. LPN/UM #2 told the surveyor it should be in a bag for sanitary reasons while not in use. In addition, the surveyor asked LPN/UM #2 what the facility practice was for oxygen tubing for residents receiving supplemental oxygen. LPN/UM #2 explained oxygen tubing is changed on the 11-7 shift I think every Thursday, once a week. The surveyor asked LPN/UM #2 the importance of changing oxygen tubing and LPN/UM #2 said to ensure the patency of the tubing and sanitary reasons. The surveyor then asked if Resident #261 had an order for supplemental oxygen and LPN/UM #2 stated that Resident #261 never had oxygen and she didn't know why he/she had it right now. During an interview with the surveyor on 12/06/2024 at 01:54 PM, the DON was asked if the use of supplemental oxygen by a resident required a physician order. The DON told the surveyor that resident's receiving supplemental oxygen via an oxygen concentrator required a physician order unless it was an emergency, and an order would be obtained after the emergency was resolved. The surveyor then asked what the facility practice was for oxygen when not in use. The DON explained that the equipment should be bagged when not in use. The DON also stated that oxygen tubing is to be changed once per week on 11-7 shift on Sundays and that it should be dated on that date. 51232 3.) During the initial tour of the facility on 12/02/2024 at 10:18 AM, Resident #18 was observed in his/her room sitting on the side of the bed with oxygen on via n/c. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/03/2024 at 10:30 AM, Surveyor #2 observed Resident #18 in their room, lying in bed with oxygen on via n/c. On 12/04/2024 at 10:33 AM, the Surveyor #2 observed Resident #18 in their room sitting on the side of his/her bed with oxygen on via n/c. A review of the EMR on 12/03/2024 at 12:45 PM, revealed the following: According to the Admission Record, Resident #18 was admitted to the facility with diagnoses including but not limited to: Heart Disease. A review of the most recent MDS dated [DATE] revealed under section O no oxygen therapy. A review of the OSR with Active Orders as of 12/05/2024, revealed a physician order dated 11/20/2023, Oxygen at 2 liters via nasal canula as needed (PRN) for SOB (shortness of breath). A review of the TAR for 12/2024, Surveyor #3 noted that nurses were not documenting the administration of oxygen to the resident. During an interview with Surveyor #3 on 12/05/2024 at 11:00 AM, LPN/UM #1 was questioned regarding the resident's PRN oxygen. LPN/UM #1 said that the oxygen tubing should be dated weekly to indicate when it was changed. The resident should have oxygen care planned, and if nursing staff administer PRN oxygen, it should be documented in the Treatment Administration Records (TAR). During an interview with the surveyor on 12/06/2024 at 01:54 PM, the Director of Nursing (DON) was asked if the use of supplemental oxygen by a resident required a physician order. The DON told the surveyor that resident's receiving supplemental oxygen via an oxygen concentrator required a physician order unless it was an emergency, and an order would be obtained after the emergency was resolved. The surveyor then asked what the facility practice was for oxygen when not in use. The DON explained that the equipment should be bagged when not in use. The DON also stated that oxygen tubing is to be changed once per week on 11-7 shift on Sundays and that it should be dated on that date. A review of a facility policy titled Oxygen Administration; date reviewed/revised: 01082024, revealed under Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The following was revealed under Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. e. Keep delivery devices covered in a plastic bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-27.1(a)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 51232 Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 2 of 14 days reviewed 11/17/2024 through 11/30/2024. Based on interview and review of Nurse Staffing Report sheets, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 2 of 14 days reviewed. This deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the week of 11/17/2024 through11/23/2024, revealed the facility had no RN coverage for all shifts on 11/18/2024 and 11/23/2024. During an interview with the surveyor on 12/06/2024 at 2:06 PM, the Director of Nursing (DON) expressed that staffing needs are met to some extent but not fully. When an RN is unavailable to work the required 8 consecutive hours, the DON steps in as a supervisor, rather than fulfilling the DON role. At that time, the Licensed Nursing Home Administrator confirmed that the DON can not be counted as the RN on duty. A review of a facility provided policy undated titled, [facility name] Staffing revealed that, To ensure there are a sufficient number of staff members (RN, Licensed Practical Nurse, Certified Nursing Assistant) with the appropriate competencies and skill sets necessary to care for its residents' needs requirements eight (8) hours per day for RN is required daily. NJAC 8:39-25.2(h)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39460 Based on interview and record review it was determined that the facility failed to address recommendations made by the Consultant Pharmacist (CP) in a consistent and timely manner. This deficient practice was identified for 2 of 5 residents reviewed for medication management (Resident #22 and Resident #90) and was evidenced by the following: The deficient practice was evidenced by the following: 1. On 12/2/24 at 10:28 AM, during initial tour the Surveyor #1 observed Resident #22 in their room seated in a chair dressed and well-groomed. When asked if the staff took good care of them the resident responded by shaking their head yes then proceeded to get up from the chair and walk out of the room and down the hallway. Surveyor #1 reviewed Resident #22's medical record on 12/03/2024 at 09:51 AM as follows: A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included dementia, multiple fractures of the bones in the fingers, wrist and arms, and depression. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/19/24, reflected that the Resident #22's Brief Interview for Mental Status (BIMS) score was 13 out of 15, which indicated that the resident's cognition was fully intact. A further review of the MDS revealed Resident #22 was taking antipsychotic, antianxiety and antidepressant medication during the last seven days or since admission. A review of the Order Summary Report (OSR) (physician's order sheet) dated August 2024 revealed a Physician order (PO) dated 8/9/24 for Ativan (lorazepam) (medication for anxiety) 0.5 mg (milligrams), give 1 tablet by mouth every 4 hours as needed for Anxiety. A review of the August 2024, September 2024 and the October 2024, Medication Administration Record (MAR) revealed an order dated 8/9/24, for Lorazepam 0.5 mg tablet, give 1 tablet by mouth every 4 hours as need for anxiety with a discontinued date of 10/16/24. A review of the Consultant Pharmacist (CP)- Pharmacist's Consult to Physician revealed the following recommendations: On 9/3/24 the CP recommended D/C (discontinue current order for PRN (as needed) Ativan. May renew PRN Ativan with a stop date exceeding 14 days if clinical rationale and anticipated during (sic)[duration] of therapy are documented in the resident's medical record. As per new CMS requirement for initial antipsychotic and psychoactive PRN medication, orders are to be limited to 14 days. Requirements for renewal of PRN psychoactive drugs after physician review and reason for continuation must be documented by the medical practitioner ordering PRN use of the psychoactive medication in the resident's chart. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/2024 the CP made the following recommendation assigned to: Nursing. Nursing: If not already done, please contact and document physician's response to my previous recommendation. recommended D/C (discontinue current order for PRN (as needed) Ativan. May renew PRN Ativan with a stop date exceeding 14 days if clinical rationale and anticipated during (sic)[duration] of therapy are documented in the resident's medical record. As per new CMS requirement for initial antipsychotic and psychoactive PRN medication, orders are to be limited to 14 days. Requirements for renewal of PRN psychoactive drugs after physician review and reason for continuation must be documented by the medical practitioner ordering PRN use of the psychoactive medication in the resident's chart. During an interview with Surveyor #1 on 12/6/2024 at 10:45 AM, Licensed Practical Nurse/Unit Manager #2 (LPN/UM #2) who stated nursing was responsible for ensuring the pharmacy consultant recommendations were addressed within 10 days of receiving them. Once the recommendations were completed, they were returned to the Director of Nursing (DON). During an interview with Surveyor #1 on 12/6/24 at 2:10 PM, in the presence of the survey team, the DON stated the CP recommendations should be addressed as soon as possible, and before the next month's pharmacy consultant review. Both the DON and the Licensed Nursing Home Administrator (LNHA) acknowledged the CP report and recommendations should have been addressed prior to the next CP review. 40039 2. Surveyor #2 reviewed the medical record for Resident #90 on 12/03/2024 at 08:37 AM as follows: A review of the Admission Record revealed that Resident #90 was admitted to the facility with the following but not limited to diagnoses: type 2 diabetes mellitus, major depressive disorder, anxiety disorder, and psychoactive substance dependence. A review of the comprehensive MDS dated [DATE], revealed Resident #90 had a BIMS score of 15/15, indicating he/she was cognitively intact. Section N revealed that Resident #90 received insulin daily, as well as antianxiety medication daily, antidepressant daily, opioid daily and anticonvulsant daily. On 12/04/2024 at 09:54 AM, Surveyor #2 reviewed the consultant pharmacist (CP) monthly medication regimen review (MRR) for the past 6 months as provided by the facility Director of Nursing (DON). The following recommendations were revealed: 1. On 08/02/2024, the CP made the following recommendation for Resident #90: Please clarify Glucagon (a medication to increase blood glucose) order as needs specific instructions when to give- add order to PRN (as needed) hypoglycemia (low blood sugar) if blood sugar is < 60? A review of the 9/1/2024 - 9/30/2024 Medication Administration Record (MAR) for Resident #90 revealed that the recommendation was addressed by the facility on 09/13/2024 and discontinued the Glucagon order 40 days after the CP recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 08/02/2024, the CP recommended Prostat (a liquid protein supplement) is missing an amount to administer on the MAR please clarify and update order. According to the 09/01/2024-09/30/2024 MAR the facility responded on 09/13/2024 and discontinued the order for ProStat. The follow up occurred 40 days after receiving the CP recommendation. 3. On 08/02/2024, the CP made the following recommendation: Change medication Coreg (Carvedilol) (a drug to treat heart failure) to plot at time to take with food. BID (twice daily) = 8 AM and 5 PM? The facility responded on 09/13/2024 and discontinued Carvedilol. The facility did not respond to the CP recommendation for a period of 40 days. On 09/03/2024, the CP made the following recommendations: 1. Nursing Recommendation: Please clarify Glucagon order as needs specific instructions when to give - add to order PRN hypoglycemia if blood sugar is < 60. Facility responded on 9/13/2024 by discontinuing Glucagon order, however CP made the same recommendation on 08/02/2024 MRR and facility failed to respond until 09/13/2024 as described previously. 2. Nursing Recommendation: Prostat is missing an amount to administer on the MAR please clarify and update order. Facility responded on 09/13/2024 and discontinued the Prostat order as described previously. On 11/01/2024, the CP made the following Physician recommendation: 1. Patient is receiving 1 patch Lidoderm (helps reduce itching and pain from certain skin conditions) q 12H. Lidoderm cannot be applied for more than 12 hours per manufacturer as medication can be systematically absorbed and will lead to site irritation. Recommend change to QD - apply daily and remove 12 hours later. Also please indicate if 4% or 5% patches should be used (current order does not specify)> The facility failed to respond to CP recommendation until 12/07/2024, 35 days after recommendation, by discontinuing the order the order for the Lidoderm patch. During an interview with Surveyor #2 on 12/06/2024 at 10:45 AM, Licensed Practical Nurse/Unit Manger (LPN/UM #2) was asked to briefly describe the facility process for addressing the CP MRR recommendations. LPN/UM #2 told the surveyor that the recommendations are distributed to the appropriate units. Nursing is responsible for following through on the recommendations. If it is a physician recommendation, we will call the physician and get their response. Nursing recommendations are handled by the nursing staff on the unit. For the most part I am responsible for making sure it is done. Surveyor #2 then asked LPN/UM #2 what the expected timeframe for nursing staff was to complete the MRR recommendations made by the CP. LPN/UM #2 explained that the recommendations were to be completed within 10 days of receiving the report. She further stated that we document on the CP recommendation sheet and once they are completed, we return them to the Director of Nursing (DON). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Surveyor #2 on 12/06/2024 at 02:19 PM, the DON was asked what the facility process was for responding to the CP monthly MRR recommendations. The DON told the surveyor's that the CP recommendations are emailed to the DON and unit managers (UM) or I make a copy of it and give it to them. The UM is responsible for carrying out the recommendations for nursing and to call the physician for physician recommendations. The surveyor asked the DON what the expected timeline was for completion. The DON stated the timeline is quickly as possible. I would expect the recommendations to be completed before the next month's visit. The surveyor then asked the DON who was responsible for ensuring that the recommendations were completed in a timely manner. The DON replied he would be responsible to ensure that all recommendations are completed and done in a timely manner. The DON further explained that the nurse (s) should document on the recommendation sheet to indicate that the recommendation was addressed. A review of a facility policy titled Addressing Medication Regimen Review Irregularities (Pharmacist recommendations) dated 11/11/2024 revealed . It is the policy of this facility to provide a Medication Regimen review (MRR) for each resident to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event . An irregularity refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services . the report should be submitted to the DON within 10 working days of the review and subsequent follow-up should occur by next MRR. A review of a facility policy titled Consultant Pharmacist Services, undated, revealed under Procedures: F. The consultant pharmacist documents activities performed and services provided on behalf of the residents and the facility. 1) A written or electronic report of findings and recommendations resulting from the activities as described above is given to the, attending physician, director of nursing, medical director, administrator, and others as may be appropriate at least monthly. The facility has a process to ensure that the findings are acted upon. 2) Resident-specific recommendations are documented by nursing when completed. NJAC 8:39-29.3(a)(1)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40039 Repeat deficiency from recertification survey of 09/23/2023 Based on observations, interviews, and review review of other facility documentation, it was determined that the facility failed to follow the planned, written menu and ensure residents were notified in advance of menu changes for 3 of 3 meals observed. This deficient practice was evidenced by the following: 1. On 12/03/2024 at 12:12 PM, the surveyor observed the lunch meal on the 2nd floor dining/activity room. The surveyor observed Resident #48 and seven (7) additional residents at the lunch meal. All eight (8) residents were observed to have received diced peaches in a clear plastic portion control cup for dessert at the lunch meal. According to the 12/3/2024 Week 4 cycle menu provided to the surveyor on entry to the facility, residents were to receive yellow cake for the dessert at the lunch meal on 12/03/2024. There was no yellow cake observed. When interviewed the Food Service Director (FSD) told the surveyor that they (kitchen staff) didn't make any. In addition, the lunch menu also included that a dinner roll was to be served. Observation of the 8 residents at the lunch meal revealed that 8 of 8 residents did not receive a dinner roll at the lunch meal. When interviewed the FSD told the surveyor on interview that the facility had run out the previous Friday (11/29/2024) and that they only received a delivery once a week. 2. On 12/04/2024 at 12:07 PM, the surveyor observed the lunch meal on the 2nd Floor dining room. The surveyor observed Resident #84 at the lunch meal being assisted by a staff nurse. Resident #84 received the following menu items: Salisbury steak with gravy, white rice, and mixed vegetables that contained peas, carrots, corn, and green beans (same vegetable that was served on 12/3/2024 at the lunch meal). There was no scalloped corn and there were no dinner rolls served. In addition, the menu revealed that residents were to receive a baked apple as dessert. There were no baked apples. On 12/04/2024 at 12:15 PM, the surveyor went to the kitchen and interviewed the FSD and cook. The surveyor asked the cook why residents had no received scalloped corn at the lunch meal as listed on the menu. The cook told the surveyor that they only had a few cans of corn, so she mixed it with the other vegetables, so we had enough. According to the FSD he did not contact the Registered Dietitian/Nutritionist (RDN) to obtain an approval of menu substitution prior to the lunch meal that day. The FSD told the surveyor that there were no dinner rolls in the facility and told the surveyor that they did not make yellow cake yesterday and substituted diced peaches. When asked if the FSD contacted the RDN for approval of menu substitutions prior to the meal the FSD stated he did not contact the RDN for approval prior to the lunch meal and that he had not contacted her at the time of interview. The surveyor asked the FSD if the facility process was to contact the RDN prior to making menu substitutions. The FSD agreed that he should contact the RDN for menu substitutions and document the substitutions in the meal substitution log. (continued on next page)

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On 12/05/2024 at 11:47 AM, during observation of tray line temperatures in the presence of the FSD, the surveyor observed that the vegetable to be served at the lunch meal on 12/5/2024 was a mixed vegetable that consisted of peas, carrots, corn, and green beans. This was the same vegetable that was observed to be served at the lunch meal on 12/3 and 12/4/2024 lunch meals. The surveyor asked the FSD if he realized that they had served the same vegetable at the lunch meal 3 days in a row. The FSD stated, Well, the menu said mixed vegetable. The FSD responded by saying that he would change the menu. A review of the Week 4 menu provided to the surveyor upon the initial tour revealed that the following vegetable was to be served at lunch meals: On 12/3/2024 the vegetable to be served according to the Week 4 menu was seasoned green peas. Residents received a mixed vegetable as described previously. On 12/4/2024 the Week 4 lunch menu revealed that residents were to receive scalloped corn at the lunch meal. Residents received the same mixed vegetable that they had received at lunch on 12/3/2024. On 12/5/2024 according to the week 4 lunch menu, residents were to receive vegetable blend. The FSD stated to the surveyor that the vegetable served was a mixed vegetable and agreed that the kitchen had served the same mixed vegetable at lunch for 3 days consecutively. On 12/05/2024 at 12:09 PM, the surveyor interviewed the facility Registered Dietitian/Nutritionist (RDN). The surveyor asked the RDN if she had been contacted by the FSD for any menu substitutions. The RDN told the surveyor that yesterday was supposed to be corn. The surveyor corrected the RDN and told her it was supposed to be scalloped corn. The RDN further stated she called yesterday (the FSD), right around 12:30 PM and she asked the FSD if there were any substitutions and he said that he made a substitution for the corn. I called earlier in the week, and I was told that there were no substitutions for the week. I was not contacted for a substitution for the yellow cake on Tuesday 12/3/2024. The surveyor asked if the FSD contacted her before or after the lunch meal to get approval for the corn substitution. The RDN told the surveyor that it was after the lunch meal. 4. On 12/06/2024 at 12:06 PM, the surveyor observed the meal delivery cart outside the 2nd floor dining room prior to the lunch meal. The surveyor observed diced fruit in a clear plastic portion control cup on resident trays. The dessert to be served according to the week 4 menu on 12/0/2024 was sherbet. On 12/06/2024 at 12:40 PM, the surveyor interviewed the facility FSD. The surveyor asked the FSD if he had completed a menu substitution for the lunch meal because the residents received diced, canned fruit as dessert and not sherbet as the menu had indicated. The FSD stated, I'm going to do it right now. The surveyor asked the FSD when the substitution should have been completed and approved. The FSD stated that it should have been done prior to the lunch meal. The surveyor asked the FSD if he had sherbet and the FSD stated, No. The facility was unable to provide the surveyor with a facility policy and procedure for menu substitutions. NJAC 8:39-17.2(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manahawkin Health and Rehabilitation Center	1211 Rt 72 West Manahawkin, NJ 08050

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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 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 there 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 12/02/2024 at 9:23 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. On the top shelf of a multi-tiered rack in the dry storage area, a previously opened pack of coffee filters were removed from their original packaging and left uncovered. The usable surface was exposed to contamination. 2. On a middle shelf of the walk-in freezer contained frozen pizza box previously opened. The lids to the box were open and the plastic bag inside that contained the pizza was opened and the pizza was exposed to the air and contamination. 3. The surveyor observed the kitchen staff operating the high temperature dish machine after the breakfast meal. The staff were actively washing dishes during this observation. The surveyor asked the FSD what the facility process was for operation of the dish machine. The FSD told the surveyor, First we check to assure proper temperatures (wash and final rinse) and record those temperatures on the temperature log prior to initiating dish washing. The surveyor then asked the FSD to provide the surveyor with the December 2024 dish machine temperature log. A review of the December dish machine temperature log revealed that no temperatures had been recorded for the month of December 2024 for the breakfast, lunch, and dinner meals for the dates 12/01/2024 up to and including breakfast on 12/02/2024. On interview the FSD agreed that dish machine temperatures must be at the required minimum temperatures and recorded on the temperature log prior to initiating dish washing. The surveyor attempted to interview the kitchen staff that was observed operating the dish machine, however the staff failed to provide the surveyor with an explanation when asked why the temperatures for the wash and final rinse had not been recorded. 4. A stack of three (3) quarter pans on a middle shelf of the pot and pan storage rack were observed to have a wet liquid substance on the interior and exterior of the pans when the surveyor lifted the top pan on the stack. On the same shelf next to the three quarter pans, a stack of four (4) half pans were observed to have a wet, clear liquid substance on the interior and exterior of the pans when the surveyor picked up the top half pan. On an adjacent rack on the middle shelf, the surveyor observed a sheet pan that was not inverted and was facing in the upward position. The pan was observed to have a clear liquid substance on the food contact surface. On interview, the FSD agreed that all pans should be air dried prior to stacking on top each other. The FSD further stated, That's wet nesting (occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating a condition that is ripe for microorganisms to grow). (continued on next page)

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	315206	A. Building B. Wing	12/09/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. An industrial can opener was attached to the end of the prep table in the center of the kitchen. The can opener was not currently in use, according to the FSD. When removed out of its receptacle the surveyor observed a brown/black sticky substance on the cutting blade and on the stem of the can opener. The FSD removed the can opener to the dish room to be cleaned and sanitized in the presence of the surveyor. The FSD told the surveyor that he did not have the can opener on the cleaning schedule and stated, I screwed up. On 12/03/2024 at 01:09 PM, the surveyor observed the first floor resident/dietary nourishment room. The surveyor reviewed the November 2024 and December 2024 Nourishment Room Refrigerator Temperature Log for the first floor nourishment room.A review of the temperature logs revealed that refrigerator temperatures had not been recorded from 11/27/2024 up to and including 12/3/2024. The temperature log also revealed that the facility was only monitoring temperatures for the refrigerator and no monitoring of the freezer temperatures was being conducted. observation of the interior of the freezer revealed that there was no internal thermometer present. The surveyor interviewed Licensed Practical Nurse (LPN #2) who told the surveyor that the 11-7 shift was responsible for the recording of refrigeration temperatures on the first floor unit pantry. On 12/05/2024 at 09:35 AM, the surveyor observed the 2nd floor nourishment room/resident pantry, accompanied by the staffing coordinator (SC). On an upper shelf, a clear plastic portion control cup contained what appeared to be apple sauce and a second portion control cup contained what appeared to be diced fruit. The portion control cups had no dates. The SC indicated that it was sent from the kitchen. When interviewed the SC agreed that all foods require dates. On interview with the facility FSD the surveyor was told that staff on the unit must have removed the portion control cups of applesauce and diced fruit from resident trays and placed them in the nourishment refrigerator because all foods that come from the kitchen are dated using a labeling gun. On 12/05/2024 at 11:24 AM, the surveyor, accompanied by the FSD, observed the following in the kitchen: (continued on next page)

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	315206	A. Building B. Wing	12/09/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. The surveyor told the FSD upon entry to the kitchen that they needed to observe tray line food temperatures for the lunch meal. The FSD told the surveyor that he would be conducting the food temperatures and proceeded to obtain a red digital thermometer and a brown paper hand towel from the hand towel dispenser wall mounted in the designated hand washing area. The FSD then approached the steam table where the lunch meal was waiting to be served from their respective pans. The FSD set the brown paper hand towel on the steam table ledge, proceeded to turn on the digital thermometer and inserted the thermometer into the first food item which was described as baked chicken. The FSD obtained a temperature of 160 F (Fahrenheit). The FSD then removed the digital thermometer from the baked chicken and proceeded to grab the brown paper hand towel. At this point the surveyor told the FSD that they needed to obtain an alcohol wipe to disinfect the probe before taking the temperature of the next food item. The FSD responded, I don't have any and proceeded to wipe the probe of the thermometer in then insert the thermometer into the next food item which was fried rice. After obtaining a temperature of 160.3 F, the FSD removed the thermometer from the rice and proceeded to wipe the probe with the brown paper hand towel previously used to clean the thermometer after the chicken. The FSD repeated this pattern for six additional food items. The digital thermometer probe was never cleaned with an approved sanitizer between foods, presenting a risk of contamination. The surveyor then conducted an interview with the facility Registered Dietitian/Nutritionist (RDN). The surveyor explained the process that the FSD utilized to sanitize the digital thermometer during the observation of lunch tray line temperatures. The RDN told the surveyor, I agree that the thermometer probe should have been cleaned with an appropriate sanitizer between foods. Using a paper towel is unacceptable. The surveyor reviewed the facility policy titled Record of Food Temperatures, undated, revealed under the heading Policy Explanation and Compliance Guidelines: Food temperatures will be verified using a thermometer which is both clean, sanitized and calibrated to ensure accuracy. The surveyor reviewed the facility policy titled Use and Storage of Food Brought in by Family and Visitors, undated, revealed under Policy Explanation and Compliance Guidelines: 2. All food items brought in that are already prepared by the family or visitor brought in must be labeled with content and dated. a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. The surveyor reviewed the facility policy titled Dishwasher Temperature, undated, revealed under Policy Explanation and Compliance Guidelines: Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes. The facility failed to provide the surveyor a policy/procedure related to wet nesting. NJAC 18:39-17.2(g)