STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315210	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Center at Galloway The	66 West Jimmie Leeds Road Galloway Township, NJ 08205

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint 2579597Based on interviews, medical record review, and other pertinent facility documentation on 08/07/25, it was determined that the facility failed to obtain a physician's order (POs) for the resident's (Resident #7) oxygen in accordance to professional standards of practice. This deficient practice was identified for 1 of 14 residents and was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.A review of Resident #7's closed Electronic Medical Record (EMR) was as follows:According to the admission Record (AR) face sheet, Resident #7 was admitted to the facility with diagnoses which included but were not limited to fibromyalgia (widespread musculoskeletal pain), difficulty walking, Type 2 Diabetes, Chronic Obstructive Pulmonary Disease (lung and airway diseases that restrict your breathing), and Dysphagia (difficulty swallowing).A review of the Minimum Data Set (MDS), an assessment tool dated 07/30/25, Resident #7 had a Brief Interview of Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. The MDS also indicated that Resident #7 was admitted with intermittent oxygen use on admission and while a resident at the facility.A review of Resident #7's Order Summary Report (OSR), included POs dated 07/25/25, such as, change oxygen tubing weekly on Sundays, 6 Min rest/walk test on room air and an order to monitor pulse oximetry Q Shift. The OSR did not include PO for the administration of oxygen.A review of Resident #7's care plan (CP) initiated on 07/25/25, did not include the resident received oxygen.A review of Resident #7's Progress Note (PN) dated 08/04/25 at 09:45 A.M, revealed Resident was walking all over the facility and going out to smoke and never observed with oxygen as well as when visited in her room, she did not have oxygen on.During an interview on 08/07/25 at 11:30 A.M the surveyor interviewed the Social Worker (SW), who had discharged Resident #7, and she stated that she did remember Resident #7 and stated that the resident was awake, alert, oriented and up walking. The SW also stated that Resident #7 used oxygen one day and then no longer utilized it.During an interview on 08/07/25 at 12:53 P.M, the surveyor interviewed a Licensed Practical Nurse (LPN) at the facility who stated, If a resident has an order for oxygen I would make sure the resident was receiving it and receiving the correct amount. The LPN further stated that he remembered Resident #7, that Resident #7 did not wear oxygen, and that the oxygen order for Resident #7 was an as needed order.During an interview on 08/07/25 at 01:04 P.M, the surveyor interviewed the Unit Manager (UM) of the third floor, who stated that the expectation for her nursing staff regarding a resident with oxygen, would to make sure that the resident had an order for oxygen and to notify the doctor if there wasn't and to ensure that oxygen tubing was dated and changed weekly.During an interview on 08/07/25 at 01:22 P.M., the surveyor interviewed Director of Nursing (DON) and Assistant Director of Nursing (ADON) together. The DON stated that residents who were on oxygen should have an oxygen order and when they were no longer on oxygen, that order should be changed. The ADON stated that Resident #7 was admitted on 2 liters of oxygen and that Resident #7 was not on oxygen upon discharge. The ADON stated that Resident #7 should have had the oxygen concentrator removed from their room if there was no order for oxygen.During an interview on 08/07/25 at 01:46 P.M., the surveyor interviewed the ADON, DON, and Licensed Nursing Home Administrator (LNHA) together regarding Resident #7's oxygen needs. The ADON confirmed that there was no oxygen order for Resident #7, but that there should have been one while Resident #7 was using oxygen. The DON confirmed there was no oxygen CP for Resident #7 and that there should have been one.A review of the facility's policy Oxygen Administration dated revised 10/23, under Preparation revealed: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 360598Based on observations, interviews, and record reviews on [DATE], it was determined that the facility failed to ensure infection control guidelines were followed for a resident who had a sick cat visiting the facility to prevent infection. This deficient practice was identified for 1 of 14 residents reviewed for infection control (Resident #6). This deficient practice was evidence by the following:A review of the Electronic Medical Record (EMR) was as follows:According to the admission Record (AR) face sheet, Resident #6 was admitted to the facility with diagnoses which included but were not limited to Spondylosis (degenerative changes in the spine), expressive language disorder, dysphagia (difficulty swallowing), sepsis, and muscle weakness.A review of the Minimum Data Set (MDS), an assessment tool, dated [DATE], Resident #6 had a Brief Interview of Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact.A review of Resident #6's Order Summary Report (OSR), did not include an order for Resident #6 to have a pet at bedside in the facility.A review of Resident #6's care plan (CP) initiated on [DATE] did not include a focus including a pet as therapy for Resident #6.A review of Resident #6's Progress Note (PN) dated [DATE] at 05:31 A.M, written by a Licensed Practical Nurse (LPN#1) revealed Resident #6 had a cat on the bed and lying on Resident #6. LPN #1 noted there were feces and urine stains on the bed and documented that the Power of Attorney (POA) for Resident #6 stated that the stains were from the cat. A second PN from [DATE] at 11:31 A.M., by LPN #2, revealed that the family pet had expired.During an interview on [DATE] at 11:06 A.M., the surveyor interviewed a Certified Nursing Assistant (CNA) who worked at the facility for over 30 years. The CNA stated that the facility did allow pets but that the pets paperwork and temperament must be reviewed and the paperwork for the pet needs to be brought to the front desk. During an interview on [DATE] at 11:06 A.M the surveyor interviewed LPN #3 who stated that she had never experienced personal pets on her unit which was considered the rehabilitation unit.During an interview on [DATE] at 11:50 A.M., the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated, We do have a policy on pets for the facility. The receptionist keeps a file of the pets' vaccinations. She handles all that. Residents are admitted and pets visit but that is usually managed by the Receptionist and activities has pet therapy. We did have a complaint regarding a cat. Resident was here short term and resident had a cat who had chemotherapy. The agreement was that the cat could stay with the resident in the room. We had to make sure the cat was staying in the cage. There was noncompliance. A staff member did complain. Staff wanted me to tell her (the staff member) the issues with a cat on chemotherapy being near the staff and what kind of issues they may have dealing with the cat. I sent an email to all staff after Googling.The surveyor requested a copy of this email along with immunizations for this pet. No immunizations were able to be retrieved. The Surveyor received an electronic medical record system communication dated [DATE], that stated, The family of Resident #6 is aware that the cat must be transported by crate and no litter box in the room. The patient can have the cat on the bed with him while the cat is in the harness. Cat is not to come out of the room during visits. A secondary electronic medical record system communication was also received dated [DATE], that stated, No pregnant or nursing mothers can have contact with Resident #6's cat.During an interview on [DATE] at 02:37 P.M., the surveyor interviewed the LNHA and ADON together. The LNHA stated that Resident #6's friend was responsible for bringing the cat back and forth in the crate into the facility since September of 2024. The LNHA stated that she was not aware of the cat defecating or urinating in the room and stated that once a litter box was brought but Resident #6 and the friend were instructed that this was not allowed. A review of the facility's policy Pets, Animals, and Plants revised 05/17 under Policy Statement revealed: Animals allowed in the facility will be monitored and managed in order to prevent the spread of microorganisms/infections resulting from contact with animals. Under the same policy, under Personal Pet Visits stated: 2c. The resident's physician and primary care nurse must approve the visit.A review of the facility's policy Infection Prevention and Control Program revised 06/23 under 6. Policies and Procedures revealed, a. Policies and procedures are utilized as the standards of the infection prevention and control program. b. Policies and procedures reflect the current infection prevention and control standards of practice. N.[NAME].C.: 8:39-19.4