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	09/13/2024

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 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. 40039 Based on observation and interview, it was determined that the facility failed to maintain resident dignity when staff were observed standing while feeding residents their meals on 1 of 2 Nursing units, 2nd floor, for 1 of 1 resident reviewed for dignity (Residents #20). This deficient practice was evidenced by the following: On 09/10/2024 at 12:13 PM, the surveyor observed a facility staff on the 2nd floor dining room at the lunch meal assisting Resident #20 to eat. The staff was standing next to the table to assist the Resident #20 to eat from a standing position. Resident #20 was seated in a wheelchair at a table in the center of the dining room facing the television. The staff did not attempt to get a chair while assisting Resident #20 to eat. The staff continued to feed Resident #20 from the standing position throughout the meal. On interview, the staff who identified herself as a Licensed Practical Nurse (LPN #1). The surveyor asked LPN #1 what the facility procedure is when assisting residents at meal time. LPN #1 stated to the surveyor, Should I be seated? According to the Admission Record, Resident #20 was admitted to the facility with the following but not limited to diagnoses: Dementia, and moderate calorie-protein malnutrition. According to section GG of the Minimum Data Set, an assessment tool, dated 6/12/2024, Resident #20 required partial/moderate assistance with eating. On 09/13/2024 at 09:53 AM, during an interview with the facility administration, which included the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor asked what the facility practice was for assisting residents who are unable to independently eat at mealtimes. The LNHA told the surveyors, Staff who assist residents who require assist with eating at meals should be seated at eye level. Thy surveyor then asked the LNHA why staff should assist residents seated at eye level. The LNHA responded, We do it that way because it is a dignity issue. A review of the facility provided policy titled Assistance with Meals, revised March 2022, revealed the following under Policy Interpretation and Implementation: Dining Room Residents: 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024

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

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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	a. not standing over residents while assisting them with meals. NJAC 8:39 - 4.1(a)12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34423 Based on observation, interview review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to report an injury of unknown origin, specifically a fracture of the right distal femur, as well as an allegation of staff to resident abuse to the New Jersey Department of Health (NJDOH) in a timely manner for 2 of 26 sampled residents, (Resident #13 and Resident #257). This deficient practice was evidenced by the following: 1. During the initial tour of the unit, Resident #13 told Surveyor #1 that he/she had pain due to a fracture of the hip. Resident #13 denied having fallen and said he/she will be following up with the orthopedic physician on Thursday. A review of the EMR was conducted on 09/09/2024 at 01:05 PM and included the following: According to the Admission Record Resident #13 was admitted to the facility with diagnoses including but not limited to: HIV (Human immunodeficiency virus) chronic pain syndrome and disorder of bone density and structure (osteoporosis). A review of a the most recent comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate care dated 09/02/2024, revealed Resident #13 had a Brief Interview for Mental Status score of 15/15 indicating intact cognition. A review of the Clinical Orders revealed a physician order dated 8/28/2024 for B/L (bilateral) hip x-ray to r/o (rule/out) fracture/dislocation. D/C (discontinue) when completed. A further review of the Order Summary Report revealed a physician order dated 8/30/2024 for Orthopedic eval (evaluation) and treat. On 09/10/2024 at 10:45 AM, a review of the EMR progress notes for 8/28/2024 through 8/31/2024 did not include documentation of what had occurred that the physician would have ordered the B/L hip x-ray on 8/28/2024 and the Orthopedic eval and treat on 8/30/2024. On 09/11/2024 at 09:19 AM, a review of x-ray dated 8/28/24 revealed a fracture of right distal femur relationship of the femoral head appears within acetabulum. Displaced femur noted superior lateral to the acetabulum. Degenerative changes hip joint noted. Under the impression section Fracture displacement involving the femoral neck and distal femur relationship of the femoral head. During an interview with Surveyor #1 on 09/11/2024 at 10:17 AM, the Director of Nursing (DON) was asked what had occurred with Resident #13 having sustained a fractured right femur. The DON replied I don't know how the fracture happened. The resident has a history of osteopenia and bone density disorder. The DON went on to say, I would say this is an injury of unknown origin and should have been reported to NJDOH. The DON said, I know there's no documentation in EMR regarding his/her c/o pain and follow up x-ray ordered and the fracture. Surveyor #1 requested any information including reporting of this to the NJDOH from DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Health Center at Galloway The		STREET ADDRESS, CITY, STATE, ZIP CODE 66 West Jimmie Leeds Road Galloway Township, NJ 08205	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/2024 at 01:00 PM, Surveyor #1 reviewed a type written document from the Licensed Nursing Home Administrator (LNHA) indicating the following; Resident name admitted A&O x3 8/28/24 Resident complained to family about hip pain. Family contacted Social Worker (SW) and informed of pain. SW communicated family concern to clinical team. 8/28/24 x-ray ordered. x-ray completed. x-ray results received. 8/29/24x-ray reviewed by NP documented on x-ray results 8/30/24 order received for ortho eval and treat. 9/11/23 Resident interviewed by Assistant director of Nursing (ADON). Resident noted sitting in wheelchair in his room. He is awake, alert and orientedx3 He shows no signs or symptoms of pain or discomfort at the time of the interview. Resident stated that he has had bilateral hip pain for years. He denies any falls while here in the facility. He denies anyone causing any injuries to him. He stated that he does not think he has ever had any studies or imaging previously on his hips. 9/11/24 Reportable called into the NJDOH. Notified Office of Ombudsman. The LNHA confirmed this was called into the NJDOH after surveyor inquiry. During an interview with Surveyor #1 on 09/11/2024 at 1:26 PM, the LNHA said the facility became aware of resident's fracture when the surveyor inquired about the investigation. The LNHA said the staff should have informed administration at the time they knew resident had a fracture. It was a communication problem. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Surveyor #1 on 09/12/2024 at 09:24 AM, the Registered Nurse/Unit Manager (RN/UM) was asked what her expectations were regarding being notified of allegations of abuse, resident altercations or injuries of unknown origin. She replied my expectations are when I come in, I ask what is going on and what is new from both nurses and aides. I call in on weekends and staff knows I am available by phone. RN/UM said staff knows to call me with resident-to-resident allegations, abuse or fractures. If I become aware of abuse allegation, resident to resident altercation, misappropriation of property or fracture it is instant call to DON (Director of Nursing), ADON (Assistant Director of Nursing) and Administrator. During an interview with Surveyor #1 on 09/12/2024 at 09:35 AM, Licensed Practical Nurse (LPN #1) was asked what the facility policy was when there was a resident-to-resident altercation, resident allegation of abuse, or a resident was found to have a fracture with no identified cause. LPN #1 replied we report to DON, MD (medical doctor), Family. We ask the resident what happened, risk management form on computer (incident report) we would make a note in medical record of the incident or allegation. We would call DON on her cell phone if she were not here. We would also notify supervisor on duty. We do have supervisors on and would tell them as well. We would write and get statements from assigned aides that day and nurse who had them as well as prior nurse and cnas. LPN #1 went on to say Yes, one of the first things we would do was assess the resident for pain, injury, and vitals. We would get statements from residents involved as well. We would do this immediately. On 09/12/2024 at 08:34 AM, a review of a facility policy titled Facility Responsibilities for Reporting Allegations with a revised date of September 2022 revealed the following addresses facility responsibilities for reporting allegations/occurrences involving staff to resident abuse; resident to resident altercations; injuries of unknown source; and misappropriation of resident property/exploitation. Under the Injuries of Unknown Source Required to report incudes but not limited to: Unobserved/unexplained fractures, sprains or dislocations The policy did not include timeframes for reporting or steps for facility to take once the allegation/injury. On 09/12/2024 at 09:48 AM, a review of the above facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating with a revised date of April 2021, revealed under the Policy Statement, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Under the Policy Interpretation and Implementation section Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to the other officials according to state law. 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; .3. Immediately is defined as: within 2 hours of the allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 40039 (continued on next page)

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Health Center at Galloway The	66 West Jimmie Leeds Road Galloway Township, NJ 08205

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

2. A review of a facility reported event involving an alleged incident of staff to resident abuse revealed that Resident #257 alleged that Certified Nursing Assistant (CNA #1) was talking to a co-worker on the 11 PM - 7 AM shift on 01/01/2024. Resident #257 alleged that CNA #1 was talking too loudly, and Resident #257 went to their door threshold and yelled at CNA #1 for being too loud. Resident #257 then slammed their door shut. According to Resident #257, who no longer resides at the facility, CNA #1 opened Resident #257's door and spoke to him/her in an aggressive manner telling Resident #257 that he/she could not keep their door closed and they could pull their privacy curtain for privacy before exiting the room. This event was noted to have occurred late on the 11 Pm - 7 AM shift, however the Reportable Event Record/Report indicated that the event occurred on 01/01/2024 at a11:45 PM.

Review of the facility investigation summary dated 1/3/2024 revealed that the facility Director of Nursing (DON) was not made aware of the alleged verbal abuse until 9:30 AM on 01/02/2024. The DON documented on the investigation summary that it was a presumed delay in reporting the matter to the appropriate management. The incident occurred on the evening of 1/1/24 but was not reported until the morning of 1/2/24. The reporting nurse will receive a 1:1 refresher education on reporting events in a timely manner.

On 09/12/2024 at 02:54 PM the surveyor conducted an interview with the 2nd Floor Registered Nurse/Unit Manager (RN/UM #1). The surveyor asked RN/UM #1 what the facility practice was when al alleged event of staff to resident abuse was alleged. RN/UM #1 told the surveyor, I would immediately report it to the Administrator, DON, and the ADON (Assistant Director of Nursing). I would then assist in getting any information that those people would require of me. I would also notify the physician and I would notify the family afterwards. I also assess the involved resident.

On 09/12/2024 at 03:22 PM the surveyor conducted an interview with the facility DON and Licensed Nursing Home Administrator (LNHA) concerning the alleged verbal abuse investigation of Resident #257. The surveyor asked the DON and LNHA what the facility practice was for alleged incidents of abuse. The DON told the surveyor, Nursing should report to the facility DON and LNHA any alleged incident of abuse. The surveyor asked what the time frame was for reporting an alleged incident of abuse to the New Jersey Department of Health. The DON stated, An alleged event of abuse should be reported to the NJDOH within 2 hours and for residents over the age of 60 it should also be reported to the ombudsman.

On 09/12/2024 at 09:48 AM, a review of the above facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating with revised date of April 2021.revealed under the Policy Statement, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.

Under the Policy Interpretation and Implementation section Reporting Allegations to the Administrator and Authorities

1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to the other officials according to state law.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; . 3. Immediately is defined as: within 2 hours of the allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. NJAC 8:39-9.4(f)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41442 Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives, timelines, and interventions to meet resident's medical and nursing needs specifically by failing to implement a care plan for an antibiotic that was infused through a Peripherally Inserted Central Catheter (PICC) used to deliver the antibiotic, and 2.) a resident diagnosed with PTSD (Post Traumatic Stress Disorder) on admission. The deficient practice was identified for 2 of 26 sampled residents, (Resident #86 and Resident #99). The deficient practice was evidenced by the following: 1.) On 09/09/2024 at 08:28 AM, during the initial tour, Resident #86 was identified by the nurse preparing an Intravenous Antibiotic (IV Antibiotic), as being ordered an IV antibiotic for an infection. A review of Resident #86's Admission Record revealed that he/she had a diagnosis that included but not limited to: Cutaneous Abscess of Buttock, and Local Infection of the Skin and Subcutaneous tissue. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 08/15/2024, under Section N-Medications: High-Risk Drug Classes: Use and Indication: indicated that Resident #86 is taking an Antibiotic; Under Section O-Special Treatments, Procedures, and Programs: IV Medications: Yes. A review of the Physician Orders revealed the following: Change PICC dressing on RUE (Right Upper Extremity) weekly every night shift every Tuesday; Eravacycline Dihydrochloride Intravenous Solution Reconstituted 50 MG, use 100 mg Intravenously two times a day for Acinetobacter infuse via pump. A review of Resident #86's Care Plan did not include a care plan that addressed that Resident #86 had a PICC line and was receiving IV Antibiotics. During an interview with the surveyor on 09/12/2024 at 3:15 PM, the Director of Nursing (DON) was asked what the expectations for a comprehensive person-centered Care Plan to include that a PICC line and Antibiotic should be included in the residents Care Plan. The DON said yes it should be included. 40039 2. On 09/09/2024 at 08:43 AM, the surveyor conducted an interview with Resident #99 on the initial tour of the facility. Resident #99 told the surveyor the he/she was a veteran and stated to the surveyor that he/she had PTSD (post traumatic stress disorder). Resident #99 was observed to be anxious on interview and told the surveyor that they were medicated for PTSD. On 09/09/2024 at 12:16 PM, the surveyor conducted a record review for Resident #99. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Admission Record, Resident #99 was admitted to the facility with the following but not limited to diagnoses: Post-traumatic stress disorder, depression, anxiety disorder, unspecified mood (affective) disorder. A review of the comprehensive Minimum Data Set (MDS) an assessment tool, dated 8/13/2024, revealed Resident #99 had a Brief Interview for Mental Status score of 15/15, indicating intact cognition. According to Section D of the MDS, Resident #99 had feelings of little interest or pleasure in doing things and feeling down, depressed, or hopeless on a frequency of 2-6 days. A review of Section I of the MDS revealed Resident #99 had active diagnoses of anxiety disorder, depression, and post traumatic stress disorder. Section N of the MDS revealed Resident #99 received daily antidepressant medication. A review of the Order Summary Report revealed Resident #99 had the following physician order: FLUoxetine HCl (hydrogen chloride) Oral Tablet 20 MG (milligram) (Fluoxetine HCl) Give 2 tablet by mouth one time a day for depression/anxiety/PTSD.: Order Date: 08/13/2024. A review of Resident #99's comprehensive care plan did not include a care plan for PTSD. On 09/12/2024 02:38 PM, the survey team conducted an interview with the facility Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). On interview both the facility LNHA and DON agreed that, PTSD is a diagnosis that should be care planned. On 09/13/2024 at 10:40 AM, the surveyor conducted an interview with the Licensed Practical Nurse/Unit manager (LPN/UM) of the 3rd floor. The LPN/UM was responsible for developing care plans for Residents on the third floor of the facility where Resident #99 resided. The surveyor then asked the LPN/UM if Resident #99 should have been care planned for a diagnosis of PTSD. LPN/UM told the surveyor, I'm really not sure if it should have been care planned, but yes, I should've care planned Resident #99 for PTSD. I have to be honest I never had anybody with a diagnosis of PTSD before. I'm glad that I know now. A review of a facility policy on 09/12/2024 at 12:10 PM, titled Care Plans, Comprehensive Person-Centered, with a revised date of March 2022, Policy Statement as follows: A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. Under #7, The Comprehensive, Person-Centered Care Plan: reflects currently recognized standards of practice for problem areas and conditions. a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; e. reflects currently recognized standards of practice for problem areas and conditions. NJAC 8:39-11.2(f)

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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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. 34423 C/O #NJ 174603 Based on observation, interview, review of the Electronic Medical Record (EMR) it was determined that the facility nursing staff failed to document in the progress notes (PN) unusual incidents, specifically regarding a.) a fracture found on x-ray, b.) staff to resident abuse allegation and c.) a resident-to-resident altercation. This deficient practice was identified for 4 of 26 sampled residents (Resident #13, Resident #5, Resident #48 and Resident #257) 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 stated, The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or 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 stated, The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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. 1. During the initial tour of the unit, Resident #13 told Surveyor #1 that he/she had pain due to a fracture of the hip. Resident #13 denied having fallen and said he/she will be following up with the orthopedic physician on Thursday. A review of the EMR was conducted on 09/09/2024 at 01:05 PM and included the following: According to the Admission Record Resident #13 was admitted to the facility with diagnoses including but not limited to: HIV (Human immunodeficiency virus), chronic pain syndrome and disorder of bone density and structure (osteoporosis). A review of the most recent comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate care dated 9/02/2024, revealed Resident #13 had a Brief Interview for Mental Status score of 15/15 indicating intact cognition. A review of the Clinical Orders revealed a physician order (PO) dated 8/28/2024 for B/L (bilateral) hip x-ray to r/o (rule/out) fracture/dislocation. D/C (discontinue) when completed. A further review of the Order Summary Report revealed a physician order dated 8/30/2024 for Orthopedic eval (evaluation) and treat. On 09/10/2024 at 10:45 AM, a review of the EMR progress notes for 8/28/2024 through 8/31/2024 did not include documentation of what had occurred that the physician would have ordered the B/L hip x-ray on 8/28/2024 and the Orthopedic eval and treat on 8/30/2024. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 09/11/2024 at 09:19 AM, a review of x-ray dated 8/28/24 revealed a fracture of right distal femur relationship of the femoral head appears within acetabulum. Displaced femur noted superior lateral to the acetabulum. Degenerative changes hip joint noted. Under the impression section Fracture displacement involving the femoral neck and distal femur relationship of the femoral head.

During an interview with Surveyor #1 on 09/11/2024 at 10:17 AM, the Director of Nursing (DON) was asked what had occurred with Resident #13 having sustained a fractured right femur. The DON replied I don't know how the fracture happened. The resident has a history of osteopenia and bone density disorder. The DON went on to say, I would say this is an injury of unknown origin and should have been reported to NJDOH. The DON said, I know there's no documentation in EMR regarding his/her c/o pain and follow up x-ray ordered and the fracture. Surveyor #1 requested any information including reporting of this to the NJDOH from DON.

On 09/12/2024 at 02:58 PM, a review of a facility policy titled Charting and documentation with a revised date of July 2017 revealed under the Policy Statement section All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.

Under the Policy Interpretation and Implementation section 2. d. any changes in the resident's condition; e. events, incidents or accidents involving the resident.

39460

2. On 9/10/2024 at 10:00 AM, the surveyor reviewed the facility provided Facility Reported Event (FRE) dated 2/22/24 which was an alleged verbal altercation involving two residents over the volume of the television, Resident #5 and Resident #48.

On 9/11/2024 at 1:45 PM, the surveyor interviewed Resident #5's and Resident #48's nurse, LPN #3, who stated she was unaware of any verbal altercations between the two residents. LPN #3 stated that Resident #5 could be argumentative at times but was easily redirected.

On 9/11/2024 at 1:51 PM, the surveyor interviewed LPN #3 regarding Resident #48, who stated the resident got along with both the staff and residents but would become easily agitated if he/she felt their needs weren't satisfied in a timely manner. When asked the facility process for reporting an altercation between two residents LPN #3 stated the residents would be separated, then she would let management either the unit manager or the Assistant Director of Nursing (ADON) or the DON know about the incident. Then there would be a risk management report entered into the resident's medical record including a Situation, Background, Assessment and Recommendation (SBAR) a tool used in nursing for communication with other healthcare professionals regarding patient information, notification to resident's physician, and family the incident would be discussed at a morning meeting of department heads

On 9/12/2024 at 12:24 PM, the surveyor reviewed the medical record for Resident #48.

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

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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 - Some	A review of the Admission Record reflected the resident was admitted to the facility with diagnoses which included hemiplegia and hemiparesis (paralysis on one side of the body), unspecified mood disorder, major depressive disorder and aphasia following cerebral infarction (a language disorder that can occur after a stroke that impairs the expression and understanding of language as well as reading and writing). A review of the most recent quarterly Minimum Data Set (MDS) an assessment tool dated 3/8/24, reflected the resident had a brief interview for mental status score of 14 out of 15, which indicated a fully intact cognition. A review of the individualized person-centered care plan reflected a focus area initiated 10/24/22, for a behavioral problem related to verbally abusing staff. Interventions included caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Educate [Resident #48] .on successful coping and interaction strategies . A review of the resident Progress Notes (PN) for February 2024 did not reveal any notes or references to the FRE incident reported to the New Jersey Department of Health (NJDOH) regarding the alleged event on 2/22/24. On 9/12/2024 at 2:28 PM, the surveyor reviewed the medical record for Resident #5. A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included dementia, major depressive disorder, anxiety and unspecified intellectual disabilities. A review of the most recent quarterly Minimum Data Set (MDS), and assessment tool dated 2/01/2024, reflected a brief interview for mental status (BIMS) score of 15 out 15, which indicated a fully intact cognition. A review of the individualized person-centered care plan reflected a focus area initiated 9/15/21, for mood distress related to his/her diagnosis of impulse control disorder and history of depression, and anxiety evident by occasional verbal outbursts (not directed at others), frustration, anger, tearfulness, perseveration on issues and expressions of sadness over past life events. Interventions included to allow time for verbalization of feelings/needs and attempt to resolve area of upset. Attempt to re-focus [Resident #5's] behavior to something positive when upset . A review of the resident Progress Notes (PN) for February 2024 did not reveal any notes or references to the FRE incident reported to the New Jersey Department of Health (NJDOH) regarding the alleged event on 2/22/24. 40039 (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

3. A review of a Facility Reported Event, dated 01/02/2024, revealed that Resident #257 alleged that Certified Nursing Aide (CNA #1) verbally abused him/her on the 11 PM - 7 AM shift on 01/01/2024. Resident #257 alleged that CNA #1 was talking loudly in the hallway. Resident #257 stated that he/she went to the threshold of their door and yelled at CNA #1 for talking loudly and then slammed the door shut. Resident #257 then stated that CNA #1 opened the door to the room and spoke to him/her in an aggressive manner. Resident #257 stated that CNA #1 told him/her that they could not have their door closed and that they could pull the privacy curtain if they wanted privacy.

According to Resident #257's Admission Record they were admitted to the facility with the following but not limited to diagnoses: Muscle weakness, cirrhosis of liver, morbid obesity, insomnia, and cognitive communication deficit.

According to a review of the Minimum Data Set (MDS) an assessment tool, Resident #257 had a Brief Interview for Mental Status score of 12/15, indicating mild cognitive impairment. According to Section D of the MDS, Resident #257 had trouble falling or staying asleep, or sleeping too much for several days in the observation period.

Review of the comprehensive care plan for Resident #257 revealed a care plan Focus: Adjustment to new environment & involvement in activity interests limited due to recent hospitalization . New admission. Date Initiated: 12/11/2023. The following was observed under Interventions/Tasks: My usual bed time is 12 AM. Date Initiated: 12/11/2023.

On 09/11/2024 at 02:34 PM, a review of the PN from 01/01/2024 through 01/03/2024 did not include documentation of the alleged incident between Resident #257 and CNA #1.

On 09/12/2024 at 02:40 PM the surveyor conducted an interview with the Certified Social Worker (CSW). The surveyor asked the CSW to briefly describe what she would do concerning a report of alleged abuse in the facility. The CSW stated, I would find out from the resident what the actual event was from their perspective and would meet in private with the resident. The surveyor then asked the CSW if she would document the interview/meeting in the EMR. The CSW responded, Of course, I would document the encounter with alleged victim in the social service progress notes in PCC (Point Click Care, an electronic medical record). The surveyor told the CSW that he was unable to find any documentation of the CSW's interview with Resident #257 concerning the alleged abuse. The surveyor asked if the encounter should have been documented in the EMR. The CSW responded, Yes, I would have documented and should have documented the event in the progress notes for the alleged event that occurred on 1/1/2024 with Resident #257.

On 09/12/2024 at 02:58 PM, a review of a facility policy titled Charting and documentation with a revised date of July 2017 revealed under the Policy Statement section All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record.

Under the Policy Interpretation and Implementation section 2. d. any changes in the resident's condition; e. events, incidents or accidents involving the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/13/2024 at 9:23 AM the survey team met with facility Administration. The DON told the surveyor's that a summary of the alleged incident would be expected to be documented in the resident's progress notes. The DON further acknowledged that an FRE should have been documented in the resident's progress notes. NJAC 8:39-11.2(b); 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. 40039 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 6 days of 10 weeks reviewed. This deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the weeks of 11/05/2023, 12/31/2023 thru 01/06/2024 revealed the facility had no RN coverage for 8 consecutive hours for all shifts on 11/05/2023, 11/08/2023, 11/11/2023, 12/31/2023, 01/01/2024, and 01/06/2024. On 09/12/2024 at 03:15 PM, the surveyors conducted an interview with the facility Director of Nursing (DON) and the surveyor said she reviewed the facility staffing sheets which indicated that the facility had days without a Registered Nurse (RN) for at least 8 consecutive hours. When asked should there be an RN on duty for at least 8 consecutive hours daily the DON replied, Yes, we should have 8 hours minimum for RN on duty per day. A review of the facility provided policy titled Staffing, revised October 2017, revealed the following under Policy Statement: Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. The following was revealed under the heading Policy Interpretation and Implementation: 5. Efforts are made to fill open shifts as well as call-outs utilizing incentive programs and agency. Staffing is monitored daily. NJAC 8:39-25.2(h)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34423 Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to follow up on a psychiatry recommendation to discontinue an antipsychotic medication, failed to monitor residents' behavior for the use of the antipsychotic, and failed to develop a care plan for the use of an antipsychotic. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications, (Resident #74) and was evidenced by the following: On 9/10/2024 at 08:58 AM, the resident was observed lying in bed with his/her eyes closed. On 9/10/2024 at 12:30 PM, the resident was observed in his/her room with a therapist eating lunch. There were no behaviors exhibited. On 9/11/2024 at 08:39 AM, the resident was observed lying in bed with his/her eyes closed. On 9/12/2024 at 12:00 PM, the resident was observed ambulating with therapy. Resident was smiling, replied fine when asked how he/she was today. No behaviors were exhibited. On 9/09/2024 at 12:19 PM, a review of the Electronic Medical Record was done and revealed the following: According to the Admission record, Resident #74 was admitted with diagnoses including but not limited to: traumatic hemorrhage of the cerebrum, and unspecified dementia without behavioral disturbance. A review of the most recent comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate care dated 7/25/2024 revealed Resident # 74 had a Brief Interview for Mental Status (BIMS) of 3/15 score indicating severe cognitive impairment. The MDS further revealed Resident #74 had no behavioral symptoms, and was taking an antipsychotic medication. A review of the Care Area Assessment (CAA's) revealed to proceed to care plan for psychotropic drug use. A review of the Order Summary Report with active orders as of 7/01/2024 revealed a physician order dated 7/19/2024 for quetiapine fumarate (Seroquel) oral tablet 25 MG (milligram) (quetiapine fumarate) (an antipsychotic medication used to treat several kinds of mental health conditions including schizophrenia and bipolar disorder.) Give 0.5 tablet by mouth at bedtime for altered mental status. A review of the Medication Administration Record (MAR) for July, August and September 2024 did not include monitoring for behaviors or the use of quetiapine. A review of a Progress note dated 7/29/2024 revealed a Psychiatric Progress Note which indicated a Chief Complaint: Pt (patient) was re-evaluated today for follow-up, and med (medication) management. Under the HPI (history of present illness): (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patient with dementia and depression seen for follow up, and med management. Per chart has a recent fall, admitted to the hospital for Subarachnoid hemorrhage and discharged on Seroquel. Patient seen in room, aaox1, calm, forgetful, confused at baseline, and in no apparent distress. Reports feeling alright. Under the MONITORED PSYCH MEDICATIONS (with DIAGNOSES) section .4. Seroquel 12.5mg QHS (every bedtime time) for Mood D/O (disorder). Under the PLAN section: 1. Always consider supportive and individualized non-pharmacologic interventions, including: redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement. Treat medical issues including pain, UTI, constipation, infection, physical issues, positioning, toileting. Encourage participation in activities, social engagement as tolerated and as possible for psychosocial well-being. 2. Recommend D/C (discontinue) Seroquel 12.5mg qHS for mood d/o; B>R (benefits>risk). A Dose Reduction (GDR) (gradual dose reduction) is: D/C Seroquel 12.5mg qHS. A review of Resident #74's progress Notes from 7/29/2024 thru 09/11/2024 did not include documentation that the physician was notified of the Psychiatric recommendation to discontinue the Quetiapine. A review of the care plan for Resident #74 did not include the care and monitoring for the use of Quetiapine. During an interview with the surveyor on 9/11/2024 at 12:37 PM, Licensed practical Nurse (LPN#3) was asked what the facility policy was regarding follow up by nurses with consultations. LPN #3 replied It depended on which physician. The dentist and eye doctor give us their orders. The psychiatrist gives us a paper for recommendations and once we get physician approval we put the new orders in the computer. We can read their (consultant's) notes but most of the time they give us a paper with the recommendations for all their residents on the unit. The surveyor questioned what the facility policy was on monitoring of psychotropic medications, and LPN #3 replied We do monitor for different s/s (signs/symptoms), any reactions, an increase in behaviors and we document that on the MAR. The surveyor asked if that was for all psychotropic medications, and she stated yes, for any antianxiety, antipsychotic, or antidepressant. We have to put in the monitoring of behavior on order sheets. The surveyor asked what was expected to be on a resident care plan and LPN #3 stated she was not too familiar with care plans. She stated she knew it would contain the resident's transfer requirements, their diet, and whatever assistance was needed to care for the resident. LPN #3 further stated that nurses didn't usually handle care plans. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 9/13/2024 at 9:18 AM, the Director of Nursing (DON) was asked what the facility's policy was regarding following-up on consultant recommendations by nurses. The DON stated that the nurses were to reach out to the physician, make them aware of the recommendation, and record their decisions whether they agree or disagree in the EMR. The DON was then asked what the facility's policy was on monitoring of psychotropic medications? The DON replied residents were supposed to be monitored for 14 days when a new medication was initiated. The surveyor then asked should there be behavior monitoring for a resident who was receiving quetiapine? The DON replied yes, they should have behavior monitoring documented in the EMAR (electronic medication administration record). The DON was then asked what was expected to be on a resident care plan and she replied things that were going on with them, what their goal would be, any falls, any skin issues, and use of any psychotropic medications. The surveyor questioned should there be a care plan for a resident on quetiapine and the DON confirmed, if a resident was on quetiapine there should be a care plan. The surveyor reviewed the following policies: On 9/12/2024 at 12:28 PM, a facility policy titled Guidelines for Notifying Physician of Clinical Problems with a revised date of September 2017 revealed under Non-immediate Notification Situations Non-immediate implies that the physician should be informed of the problem or event at the time of the next routine communication or the next time he/she is making rounds (whichever is sooner). Under 3. Other Consultant reports not involving a life-threatening or unstable medical or psychiatric situation. On 9/12/2024 at 12:45 PM, a facility policy titled Care Plans, Comprehensive Person-Centered with revised date of March 2022 revealed under the Policy Statement section A comprehensive, person-centered care plan that include measurable objectives and timetables to meet the residents psychosocial and functional needs is developed and implemented for each resident. Under the Policy Interpretation and Implementation section 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy also indicated 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychological well-being, e. reflects currently recognized standards of practice for problem areas and conditions. On 9/13/2024 at 10:37 AM, a facility policy titled Psychotropic Medication Use with revised date of July 2022 revealed under the Policy Interpretation and Implementation section 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Antipsychotics 3. Residents, families, and/or the representative are involved in the medication management process. Psychotropic medication management includes: .d. adequate monitoring for efficacy and adverse consequences. 10. Nonpharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 13. Residents receiving psychotropic medications are monitored for adverse consequences, including: anti cholinergic effects, flushing, blurred vision, dry mouth, altered mental status b. cardiovascualar {sic} [cardiovascular] effects-irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath .c. metabolic effects .d. neurologic effects-agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinson's, tardive dyskinesia, e. psychosocial effects-inability to perform ADL's or interact with others, withdrawal or decline from usual social patterns, . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:3927.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40039 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 09/09/2024 from 7:39 to 8:23 AM, the surveyors, accompanied by the cook and the Food Service Director (FSD), observed the following in the kitchen: 1. Prior to entering the walk-in refrigerator and freezer the surveyors reviewed the temperature logs. Review of the September 2024 Refrigerator Temperature log revealed that no AM or PM temperatures were recorded on 9/7, 9/8, and 9/9/2024. On interview the FSD stated that the aide was responsible for recording the refrigeration temperatures and that the aide had not worked on those days. 2. On a lower shelf in the walk-in freezer, a sheet pan contained frozen hamburger patties. The hamburger patties were covered with plastic wrap. There were no dates labeled on the pan or plastic wrap. 3. On a middle shelf in the walk-in refrigerator, a plastic milk crate contained [NAME] Ready Care supplements (A frozen nutritional supplement for people with unintended weight loss). Approximately 20 vanilla shakes were in the crate. No dates were observed on the crate or supplements. The FSD told the surveyor that the shakes are good for 14 days once pulled from frozen storage. 4. On a lower shelf in the kitchen prep area (under toaster) a clear plastic container contained cleaned and sanitized dessert plates. The plates were uncovered and were not in the inverted position leaving the eating surface exposed to contamination. 5. Four (4) pans and a colander on a middle shelf of the pot and pan drying/storage rack were not in the inverted position and were not covered. The food contact surface of the pans and colander were exposed, and the pan contained a clear liquid substance on the interior of the pan. FSD removed to be rewashed and sanitized. On 09/11/2024 from 08:58 to 09:12 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN #2), observed the following on the 3rd Floor resident pantry: 1. Observation of the temperature log revealed that the facility was only monitoring refrigerator temperatures and there was no monitoring of the freezer temperatures. 2. The lower glass shelf and lower storage drawers of the refrigerator were covered with an off white unidentified substance. All foods are labeled and dated, however sign on outside of refrigerator stated that all foods were to only be held for 24 hours after the labeled date and then would be discarded. A gray plastic bag on the lower shelf contained unidentified resident food. The bag was labeled Rec 9/9/24 Discard 9/15/24. In addition, on the same shelf a plastic Tupperware style container contained unidentified resident food. The container was labeled with resident name and room number. The container had no dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/11/2024 from 09:47 to 09:53 AM, the surveyor, accompanied by LPN #3, observed the following on the 2nd Floor resident pantry: 1. Observation of the temperature log revealed that temperatures were being recorded in the AM and PM for the refrigerator. No monitoring of freezer temperatures was conducted. On 09/11/2024 at 09:57 AM, the surveyor conducted an interview with the food service District Manager (DM). The surveyor asked the DM who was responsible for maintaining the facility resident pantries. The DM explained that It' a concerted effort between food service and nursing (no housekeeping). We (food service) are responsible for cleaning the refrigerator and freezer. The surveyor then questioned what the use by date should be when a food from out of the facility is stored in the pantry refrigerator. The DM told the surveyor the use by date should be 72 hours. 24 hours is too short. The DM further told the surveyor I will get with the DON (Director of Nursing) and get on the same page with dates today. The surveyor then asked the DM why there was no monitoring of freezer temperatures on the facility pantry's The DM stated, I might have to ask the FSD about freezer temps. The freezer temperatures on the pantry's should be monitored, yes. The DM agreed that the facility policy for food brought from family/visitors was inconsistent with the posted signage on the 3rd floor refrigerator door indicating that food was to be discarded after 24 hours and the dietary policy of 3 days. The DM assured the surveyor that they would meet with facility administration to establish a consistent policy for use by dating related to food brought by visitors/family. On 09/12/2024 from 10:33 to 10:57 AM, the surveyors, accompanied by the FSD and the DM, observed the following in the kitchen: 1. The surveyors requested to see the tray line temperature monitoring logs from the FSD. Observation of the TService Line Checklist (Food temp log) revealed that Item names and temperatures for all hot and cold foods should be taken prior to service and recorded in the boxes below. Review of the Service Line Checklists provided to the surveyor by the facility FSD revealed the following: On 8/17/2024 the cook failed to record hot and cold food temperatures at the breakfast and lunch meal, on 8/18/2024 the cook failed to record food temperatures for the breakfast, lunch, and dinner meals, on 8/22/2024 the cook failed to record hot and cold food temperatures for the lunch and dinner meals, on 8/25/2024 the cook failed to record hot and cold food temperatures for the dinner meal, on 8/26/2024 the cook failed to record hot and cold food temperatures at the dinner meal, On 9/2/2024 the cook failed to record hot and cold food temperatures at the lunch and dinner meal, on 9/3/2024 the cook failed to record hot and cold food temperatures at the dinner meal, on 9/4/2024 the cook failed to record hot and cold food temperatures at the dinner meal, on 9/5/2024 the cook failed to record hot and cold food temperatures at the dinner meal, and on 9/7/2024 the cook failed to record hot and cold food temperatures at the dinner meal. When interviewed the FSD and DM told the surveyor, It's our responsibility to make sure that the food temperatures are being done correctly. It's important to monitor to ensure that food is not in the danger zone (41-134 degrees Fahrenheit (F)). The surveyor asked why it was important to monitor food temperatures for hot and cold foods. The FSD and DM explained, People (residents) could potentially get food poisoning if food is in the danger zone. The surveyor asked who was responsible for taking food temperatures of hot and cold foods prior to meal service. The FSD stated, The cooks are in charge/responsible for checking temperatures prior to tray line. The surveyor reviewed the facility policy titled Food: Preparation, [company name] Policy 016, revised 2/2023. The following was revealed under the heading Procedures: (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F, or per state regulation. 13. All foods will be held at appropriate temperatures, greater than 135 F (or as state regulation requires) for hot holding, and less than 41 F for cold holding. 14. Temperature for TCS (time/temperature control for safety) will be recorded at time of service and monitored periodically during meal service periods. The surveyor reviewed the facility policy titled Receiving, [company name] Policy 017, revised 2/2023. The following was revealed under the heading Procedures: 5. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. The surveyor reviewed the facility policy titled Food Storage: Cold Foods, [company name] Policy 019, revised 2/2023. The following was revealed under the heading Procedures: 4. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. The surveyor reviewed the facility policy titled Warewashing, [company name] 022, revised 2/2023. The following was revealed under the heading Procedures: 4. All dishware will be air dried and properly stored. The surveyor reviewed the facility policy titled Foods Brought by Family/Visitors, revised March 2022. The following was revealed under Policy Interpretation and Implementation: 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. b. Perishable foods are stored in re-sealable containers with tight-fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. NJAC 18:39-17.2(g)