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	02/19/2026

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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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. NJ#2643473Based on observation, interview, and record review, it was determined that the facility failed to a.) Re-implement a comprehensive care plan (CCP) for a resident (Resident #72) who had a previously identified history of inappropriate sexual behaviors b.) implement a CCP for a resident (Resident #11) who was on psychotropic medications with behaviors, c.) develop a person-centered care plan for a resident who changed the setting on the oxygen concentrator (Resident #129) d.) develop a person-centered care plan for 1 of 5 residents (Resident #130) reviewed for unnecessary medications who was prescribed an anticoagulant (a medication used to prevent blood clots). This deficient practice occurred for 4 of 29 residents surveyed (Resident #11, #72, #129, and #130) and was evidenced by the following: 1. On 2/12/2026 at approximately 10:00 AM, the surveyor attempted to conduct an interview with Resident #72 during the initial tour of the facility. It was determined from interview with staff and review of the electronic medical record that Resident #72 no longer was a resident of the facility and had been discharged to an acute care facility. A review of the facility provided REPORTABLE EVENT RECORD/REPORT, revealed that on 10/14/2025 Resident #72 was observed by a physical therapist (PT) staff on the 2nd floor dining/day room. At approximately 2:50 PM, the PT observed Resident #72 with his/her hand inside the shirt/blouse of Resident #61 massaging the left breast. Resident #72 was observed to have their pants situated in a way that allowed for Resident #72 to have their genitalia (penis/vagina) exposed. The PT immediately removed Resident #61 from the dining room/day room and had them assessed by nursing. Resident #72 was moved to the third floor of the facility. No injuries were reported. The parties responsible were notified. Resident #72 was evaluated by psychiatry and care plans were updated. A review of the reportable event revealed that Resident #72 had a care plan with the following Focus: Inappropriate Sexual Behavior (Verbal and Physical) related to: resident exposes self, resident makes inappropriate remarks. Date Initiated: 06/03/2024 and Cancelled Date: 05/29/2025. The following Interventions/tasks were observed as CANCELLED: Avoid type of conversation that could encourage or initiate inappropriate behavior, Cancelled date: 05/29/2025. Encourage attendance at recreational/activation [sic] programs. Cancelled Date: 05/29/2025. Provide privacy. Cancelled Date: 05/29/2025. Remain calm and avoid angry reactions towards resident. Cancelled Date: 05/29/2025. On 2/13/2026 at 12:32 PM, the surveyor reviewed the closed medical record for Resident #72. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: infection and inflammatory reaction, muscle weakness, difficulty in walking, limitation of activities due to disability, and unspecified dementia. A review of the resident's significant change/comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/20/2026, revealed the resident (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated the resident's cognition was severely impaired. According to section E of the MDS, Resident #72 had no behaviors. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 10/15/2025, that the resident had Inappropriate Sexual Behavior (Verbal or Physical) related to the resident exposing self, the resident had one episode of touching another resident inappropriately. Interventions included: Avoid type of conversation that could encourage or initiate inappropriate behavior. Distract resident if possible. Monitor [resident name] frequently when out of bed. Remove resident from public areas when behavior is disruptive/unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity. A further review of the ICCP included an intervention dated 10/22/2025, for Provide privacy. Resident #72's care plan that addressed inappropriate sexual behavior was Cancelled on 5/29/2025. Upon return to the facility the facility failed to reimplement Resident #72's care plan addressing inappropriate sexual behavior, which was a known behavior prior to hospitalization dating back to 06/03/2024. On 2/18/2026 at 9:43 AM, the surveyor conducted an interview with Licensed Practical Nurse/Unit Manager (LPN/UM#2). The surveyor asked LPN/UM #2 if Resident #72 should have had their care plan that addressed inappropriate sexual behavior reimplemented upon readmission to the facility on 5/31/2025 after an acute care stay. LPN/UM #2 stated, I'm not going to lie; we should have put the care plan (inappropriate sexual behavior) back in place because it was a known behavior. LPN/UM #2 further stated that it just got dropped. On 2/28/2026 at 10:21 AM, the surveyor conducted an interview with the facility Assistant Director of Nursing/Infection Preventionist (ADON/IP) who had participated in the development of Resident #72's care plan on 10/15/2025. The surveyor asked the ADON/IP if she had been involved in Resident #72's care plan development and she stated, Yes. The ADON/IP told the surveyor that Resident #72 had a care plan when they were admitted to the facility that addressed inappropriate sexual behavior. The ADON/IP further stated that the inappropriate behavior mostly involved masturbation that would occur in the room or sometimes in the hallway. The ADON/IP also confirmed that the care plan for inappropriate sexual behavior had been discontinued during Resident #72's hospitalization.The surveyor asked the ADON/IP if the care plan for inappropriate sexual behavior should have been reimplemented upon their return to the facility. The ADON/IP stated Yes, It should have been reimplemented upon readmission to the facility. The ADON/IP then stated that the care plan was re-implemented and updated on 10/15/2025, after the incident with Resident #61 occurred. On 2/18/2026 at 2:11 PM, the surveyor conducted an interview with the facility administration, which included the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the ADON/IP. The surveyor asked if Resident #72 had a history of inappropriate sexual behavior and both the DON and the ADON/IP confirmed that Resident #72 did have a history of inappropriate sexual behavior. The surveyor pointed out that Resident #72's care plan for inappropriate sexual behavior was discontinued on 5/29/2025, during their acute care hospitalization. The facility DON and the ADON/IP confirmed that Resident #72 should have had the inappropriate sexual behavior care plan implemented upon return to the facility. They stated that Resident #72 should have been reassessed upon readmission, and the care plan should be updated as indicated. The surveyor asked how the facility ensured the safety of other residents from this type of inappropriate behavior. The acting DON stated that staff was familiar with the residents, and they would continue to oversee the resident's behavior. The surveyor then asked what if staff were not familiar with Resident #72, such as agency nursing staff. The LNHA told the surveyor that it would be definitely helpful to unfamiliar staff if there was a care plan in place that addressed the resident's inappropriate sexual behavior. (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 facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, included: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The following were revealed under Policy Interpretation and Implementation: .The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. .Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the quarterly MDS assessment. 2. A review of Resident #11's admission Record, an admission summary, indicated the resident was admitted to the facility with diagnoses which included, but were not limited to: dementia and diabetes mellitus (DM). A review of the resident's comprehensive Minimum Data Set (MDS), an assessment that facilitates a resident's care, dated 12/14/2025, included the resident had a Basic Interview for Mental Status (BIMS) score of 3 (three) out of 5 (five), which indicated the resident's cognition was severely impaired. The MDS also indicated that Resident #11 did not exhibit behaviors and required supervision and assistance with activities of daily living (ADLs). Further review of the MDS reflected that Resident #11 was on psychotropic (psychiatric) medications. On 2/12/2026 at 12:57 PM, the surveyor entered the resident's room, and the resident's responsible party (RP) was visiting with the resident. The surveyor interviewed the RP who explained that Resident #11 had fallen and was sent to an acute care facility a month and a half ago. Subsequently, the resident was admitted to this facility for rehabilitation. The RP explained that the resident had a diagnosis of dementia and would remain in the facility for long-term care. The RP further stated that she had no concerns related to the resident's care. On 2/13/2026 at 1:20 PM, the resident's RP was observed visiting Resident #11. The resident was sitting in a recliner chair with call light within reach. The resident was well-groomed, wore clean clothes and no complaints were offered from the resident or the RP. No behaviors were observed. The surveyor reviewed the resident's electronic medical record (EMR) which revealed the following: (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 Order Summary Report (OSR), dated as of 1/28/26, included the following physician's orders (PO): A PO, dated 1/28/26, for Haldol 1 mg (antipsychotic) one tablet by mouth three times a day for psychotic mood disorder. A PO dated 12/8/25, for Seroquel 100 mg (antipsychotic) one tablet by mouth at bedtime for psychosis. A PO dated 12/8/25, for Citalopram Hydrobromide 20 mg (antidepressant) give two tablets by mouth in the evening for depression. A review of the psychiatry progress note dated 1/29/26 at 1:27 PM, indicated that the resident had diagnoses of depression, anxiety, mood disorder, psychosis and dementia. The psychiatrist recommended continuation of all current psychoactive medications and for the staff to document any changes in mood or behavior. The psychiatrist also indicated that a gradual dose reduction (gdr) was contraindicated and that treatment was medically necessary at this time. On 2/18/2026 at 9:46 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that Resident #11 exhibited behaviors such as agitation, exit seeking and repeatedly expressed a desire to go home. CNA #1 reported using distraction and redirection interventions, including taking the resident for wheelchair rides throughout the building and engaging in one-to-one conversations. He stated that these interventions were generally effective in calming the residents. CNA #1 reported that the resident did not display verbal or physical aggression. CNA #1 further stated that the resident experienced sundowning, characterized by increased confusion, agitation and behavior changes during the evening hours beginning around 7:00 PM. CNA #1 indicated that offering peanut butter and jelly sandwiches and ice water had been effective in decreasing the residents' anxiety. CNA #1 also reported that the resident remained calm when the RP was present. A review of the resident's Individual Comprehensive Care Plan (ICCP) revealed that the resident was at risk of elopement related to dementia and interventions included encourage independence while in the building but ensure supervision while outside and utilize a security bracelet. There were no further interventions documented on the ICCP to manage the resident's behaviors associated with the resident's diagnoses of dementia. A review of Resident #11's progress notes revealed that there was no documentation to reflect that the resident was exhibiting sundowning at night, searching for the RP or threatening to call the police. There was also no documentation in the progress notes regarding redirection interventions that were provided when Resident #11 exhibited these behaviors. On 2/18/2026 at 10:02 AM, the surveyor interviewed the Licensed practical Nurse (LPN #2) who stated that behavior monitoring was ordered by the physician and conducted every shift. LPN #2 reported uncertainty regarding whether behaviors were required to be documented in the progress notes. He stated the resident had been adjusting since admission but continued to exhibit sundowning in the evening, including agitation, searching for the RP and threatening to call the police. LPN #2 reviewed the ICCP in the presence of the surveyor and confirmed that it was not resident specific and did not include individualized interventions to address agitation or sundowning behaviors during the evening shift. He further confirmed that an ICCP was not implemented for the use of psychotropic medications or interventions associated with the use of psychotropic medication use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/2026 at 10:35 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM#1) who also reviewed Resident #11's ICCP in the presence of the surveyor and confirmed that individualized interventions to address agitation or sundowning behaviors during the evening shift were not implemented for Resident 11's use of psychotropic medications. She further added that she was now aware of the discrepancy, since it was brought to her attention by the surveyor, but she stated that she would address the issue. A review of the facility's Behavior Assess, Intervention and Monitoring policy, dated March 2019, included: The Interdisciplinary Team (IDT) will evaluate behavior symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. The care plan will incorporate findings from the comprehensive assessment. The family or representative will be involved in the development and implementation of the care plan. A review of the facility's Care Plans, Comprehensive Person Centered policy, dated March 2022, included: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 3. On 2/12/26 at 10:58 AM, the surveyor observed Resident #129 sitting upright in bed. Resident #129 had a nasal cannula (clear plastic tubing used to deliver supplemental oxygen or air to a patient through the nostrils) delivering humidified oxygen via an oxygen concentrator (a medical device that provides purified oxygen) set at eight (8) liters. The humidification bottle connected to the oxygen concentrator contained only a small amount of liquid. On 2/13/26 at 8:46 AM, the surveyor reviewed Resident #129's electronic medical record (EMR). A review of the admission Record, an admission summary, revealed that the resident had diagnoses that included, but were not limited to: chronic obstructive pulmonary disease (COPD) [a progressive, incurable, yet treatable lung disease that causes chronic airflow restriction, often resulting from smoking, leading to severe breathing difficulties], anemia (a condition where low red blood cell or hemoglobin levels reduce oxygen delivery to tissues, causing fatigue, pale skin, dizziness, and shortness of breath), emphysema (a chronic, progressive lung disease and a form of COPD (chronic obstructive pulmonary disease) that destroys the alveoli (air sacs) in the lungs, making it difficult to breathe), morbid obesity, and atrial fibrillation (heart arrhythmia, characterized by a chaotic, an irregular heartbeat). A review of the admission Evaluation included that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the resident's cognition was intact. A review of the resident's individual comprehensive care plan (ICCP), which included a focus area initiated on 2/20/26, showed that the resident used oxygen therapy. The interventions included encouraging or assisting with ambulation as indicated. There were no other interventions. (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 Order Summary Report (OSR) included a physician order (PO) dated 2/10/26 for oxygen running at 5 (five) liters per minute via nasal cannula for 18-24 hours daily. A review of the Treatment Administration Record (TAR) did not include the oxygen setting. On 2/13/26 at 10:31 AM, the surveyor made a follow-up visit with Resident #129, who was observed sitting upright in their room. Resident #129 was receiving oxygen via the nasal cannula. The oxygen concentrator was set at nine (9) liters. The humidification bottle was empty. At that time, the surveyor interviewed the resident. When asked how long the humidification bottle had been empty, they replied, Since yesterday. On 2/13/26 at 10:50 AM, the surveyor interviewed Licensed Practical Nurse (LPN #3), who stated that she had administered Resident #129's medication that morning and the resident did not voice any concerns. When asked if she had checked to see what the oxygen concentrator was set on, she replied, No. She added that the oxygen concentrator setting should be checked every shift and maintained on the setting in accordance with the physician's order. On 2/13/26 at 11:00 AM, the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM #2), went to Resident #129's room. LPN/UM #2 confirmed that the oxygen concentrator was set at 9 (nine) liters per minute and the humidification bottle was empty. At that time, Resident #129 stated that they had turned up the oxygen setting to 9 (nine) liters. LPN/UM #2 then proceeded to adjust the setting on the oxygen concentrator and replaced the humidification bottle. At that time, The surveyor and LPN/UM #2 exited the resident's room to conduct an interview. LPN/UM #2 stated that prior to Resident #129 being admitted to the facility, the sending facility reported to her that when Resident #129 got out of bed, they would get anxious and increased the oxygen setting themselves. LPN/UM #2 further stated that both she or the admitting nurse was responsible for developing the care plan and updating it quarterly and as needed. LPN/UM #2 added that the care plan should have included that the resident increased their oxygen setting without the nurse's knowledge, so that the nurses would know what to watch for. LPN/UM #2 added that when the nurse comes in, they were supposed to do walking rounds to make sure that all oxygen was on the right settings, ensured that humidification was present, check the dates on the oxygen tubing, and make sure the resident was not in any respiratory distress. LPN/UM #2 further added that it was important for the setting to be correct because Resident #129 has COPD. LPN/UM #2 also stated that for a resident who has COPD, if the oxygen was set at 9 (nine) liters per minute, they could retain carbon dioxide and go into respiratory distress due to their inability to blow off the carbon dioxide. On 2/13/26 at 12:08 PM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP), who stated that if the resident increased the oxygen setting themselves, they should have a care plan that addressed that they were changing the settings. The ADON/IP stated that she would probably check on the resident more often to make sure that the oxygen was on the correct setting. The ADON/IP added that when the nurses first came in and during all interactions with the resident, they should check the physician's order versus the setting on the oxygen concentrator to ensure that it was on the correct setting. On 2/18/2026 at 10:16 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the admitting nurse or the unit manager developed the care plan and updated it as needed. The DON added that when the resident has a history of changing the oxygen setting, it should be included on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Complaint# NJ2699824 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, by failing to ensure that critical laboratory results obtained on 12/15/25 were immediately conveyed to the physician, which resulted in a three (3) day delay in notification on 12/18/25 and immediate transfer to the hospital for evaluation and treatment. This deficient practice was identified for 1 of 1 resident (Resident #123), reviewed for quality of care. This deficient practice 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 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 well-being, and executing medical regimes 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. The surveyor reviewed the electronic medical records for Resident #123. A review of Resident #123's admission Record, an admission Summary, reflected that the resident was admitted to the facility with diagnoses which included acute respiratory failure (a rapid-onset, life threatening condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide), heart failure (a chronic condition where the heart does not pump blood as well as it should), presence of an implanted cardiac defibrillator (a device implanted under the skin that constantly monitors the heart rate to detect irregular heartbeats and delivers electric shocks to restore normal heartbeat), chronic obstructive pulmonary disease (COPD) [progressive irreversible lung disease that restricts airflow, making it hard to breath], and type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel). A review of the progress notes included a physician's progress note (PPN) dated 12/7/25 at 10:17 AM, which included a history and physical for Resident #123. The note indicated that the resident had been admitted to the facility after being hospitalized for respiratory failure and was treated for pneumonia and was currently completing antibiotics. The physician evaluated the resident and identified prior medical history which included generalized weakness, and chronic back pain, with a treatment plan to provide physical, occupational therapy and physiatry per protocol, complete antibiotics, and trend labs. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/18/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident's cognition was moderately impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 11/12/25, that the resident was at risk for bleeding and bruising due to use of Plavix (a medication that prevents platelets from sticking together to form a blood clot). Interventions included labs as ordered and report abnormal results to physician asap (as soon as possible). A review of the Order Summary Report (OSR), included the following physician's orders (PO): A PO dated 12/8/25, for CBC (complete blood count; a blood test that measures the number and type of cells in the blood) and BMP (basic metabolic panel; a blood test that assesses overall health, kidney function and electrolyte levels) weekly, one time a day on Mon (Monday). A PO dated 12/18/25, reflected and order to send to ER (emergency room) for low platelet count. A review of the resident's laboratory report dated reported 12/8/25 2:45 PM, and collected 12/8/25 at 8:20 AM, included CBC, auto differential/basic metabolic panel, included, but (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the hospital for evaluation. Ph #1 stated that critical laboratory results must be called in to the physician emergently. If the nurse was unable to reach the physician, the nurse should contact the Medical Director. On 2/19/26 at 10:34 AM, Ph #1 called the surveyor in the presence of the survey team. He stated that during the earlier interview, he did not have Resident #123's chart open or accessible. After speaking with the surveyor, he reviewed the resident's medical chart and noted a substantial decline in renal function (kidney functions) as well, which had not been included in the initial text message and would have prompted emergency medical intervention. Ph #1 stated that when the nurse called on 12/18/25, he opened the resident's chart and personally reviewed the laboratory results. He emphasized that he was highly accessible and had received multiple phone calls regarding other residents. He further stated that Resident #123 had been seeing a nephrologist (kidney specialist), though he did not currently have access to the nephrology note. Ph #1 stated that once he was made aware of the critical laboratory results, he took immediate action and sent the resident to the hospital for evaluation. He then discussed the situation with the resident's responsible party, who agreed with the decision to transfer the resident to the hospital. On 2/19/26 at 10:52 AM, the surveyor attempted to interview the former Unit Manager Licensed Practical Nurse #3 (LPN/UM #3) via telephone in the presence of the survey team. However, LPN/UM #3 did not answer her phone. On 2/19/26 at 11:08 AM, the surveyor interviewed the Medical Director (MD) in the presence of the survey team. The MD stated that he expected all nurses, including night shift nurses, to communicate critical lab results by calling him directly. He emphasized that nurses may call him at any time, nights, weekends, or holidays. He further stated he informed the previous administration the nurses needed education, that critical labs required a phone call, not a text message. The MD cited a prior incident at the facility involving another physician which created a lot of mess, in the sense the physician texted the nurse back, the nurse thought the issue was addressed, and the resident did not do well. There was a delay in treatment. The MD further stated he held a meeting with the facility staff within the last few months and communicated that any critical results, including labs, radiology, or ultrasounds, must be communicated by phone rather than text message. As a result of this incident, we needed to change the policy to state that critical results required a phone call and not a text message. A text was just a short message and can create confusion. however, a phone call would allow for discussions, questions, and review of previous labs. When asked whether sending the resident to the hospital immediately would have made a difference, the MD stated he could not determine the outcome. However, he noted that investigation of the labs at the hospital was the appropriate course of action. He further stated that the resident's condition could have continued to decline, so transferring the resident to the hospital was the right decision. On 2/19/26 at 12:36 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Assistant Director of Nursing/Infection Preventionist (ADON/IP). The LNHA stated that he was unable to locate an investigation regarding Resident #123's critical laboratory results. The ADON/IP stated that when Resident #123 was sent to the hospital, it was considered an acute discharge, and the facility reviewed all acute discharges. The ADON/IP further stated that she had reviewed all of the resident's medical records and had looked into the incident, which was how she was able to provide the surveyor with a copy of the text messages between LPN #4 and Ph #1. The ADON/IP acknowledged that there had been a delay in care. The DON also acknowledged that there was a delay in treatment. The LNHA stated that the ADON/IP's work represented a follow-up on the acute transfer and was not necessarily a formal, required investigation. A review of the facility Lab and Diagnostic Test results- Clinical Protocol policy, revised November 2018, included:. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results.whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). Direct voice (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification. A physician should respond within one hour regarding a lab result requiring immediate notification. If the attending or covering physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. Physician decisions. When responding to notification of test results, the physician and staff will discuss the implications of the test results for the resident, as well as subsequent actions; for example, obtaining additional tests, new or modified medication orders, additional monitoring, etc. A review of the Acute Condition Changes- Clinical Protocol policy, revised March 2018, included: . The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications. the nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less).The attending physician (or practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. The nurse and the physician will discuss and evaluate the situation. The physician should request information to clarify the situation; for example, vital signs, physical findings, a detailed sequence of events and description of symptoms. NJAC 8:39-27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review and review of other pertinent facility documentation, it was determined that the facility failed to a.) prevent the potential for cross contamination by not initiating and implementing Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms) for a resident with a wound in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. b.) follow appropriate infection control practices in a manner to prevent the potential spread of infection and/or cross-contamination during the provision of a wound care treatment and c.) transport linen in a manner that prevents the spread of infection for 1 (one) of 1 resident (Resident #11) reviewed for pressure ulcers d.) maintain the feeding tube pump pole, overbed table, and wall in a sanitary manner, for 1 of 2 residents (Resident #2) reviewed for tube feeding e.) implement Enhanced Barrier Precautions (EBP) in accordance with the facility policy, physician orders, and the resident's care plan to prevent the potential spread of infection for 1 of 1 resident reviewed for tracheostomy/laryngectomy (a surgically created hole in the throat) care (Resident #14) f.) follow appropriate infection control practices for 1 of 3 nurses observed during the medication pass observation for 1 of 3 residents (Resident #92). This deficient practice was evidenced by the following: 1.On 2/12/2026 at 12:57 PM during a tour of the facility, the surveyor entered the resident's room and observed that the responsible party (RP) was visiting with the resident. The surveyor interviewed the RP at that time who explained that Resident #11 had fallen and was sent to an acute care facility a month and a half ago. Subsequently, the resident was admitted to this facility for rehabilitation. The RP explained that the resident had a diagnosis of dementia and would remain in the facility for long-term care. The RP added that the resident enjoyed sitting in the reclining chair and had an open area on the buttocks that he had developed while at home. The RP stated that she had no concerns related to the resident's care. The surveyor observed that there was no signage posted on the resident's door that indicated Resident #11 was on Enhanced Barrier Precautions (EBP) for a previously identified wound. The surveyor also did not observe any personal protective equipment (PPE) readily available outside of the resident's room. On 2/13/2026 at 1:20 PM, the resident's RP was observed visiting Resident #11. The resident was sitting in a recliner chair with the call light within reach. The resident was well-groomed, wore clean clothes and no complaints were offered from the resident or the RP. The surveyor again did not observe any signage that the resident was on EBP and there was also no PPE readily available outside of the resident's room. The surveyor reviewed the electronic medical records (EMR) which revealed the following: A review of the admission Record (AR) an admission summary revealed the resident had diagnoses which included, but were not limited to unspecified dementia (a brain sickness that makes it hard for a person to remember things, think clearly, or control their feelings; Muscle weakness (generalized); type 2 Diabetes Mellitus (a chronic condition where the body cannot properly manage blood sugar (glucose) for energy, leading to high sugar levels in the blood.); Essential (Primary) Hypertension (Long-term high blood pressure that does not have one specific, identifiable cause); Cognitive communication deficit (difficulty with speaking, listening, reading, or writing caused by brain-based thinking problems); Atherosclerotic Heart Disease (the buildup of fats, cholesterol and other substances in and on the artery walls); heart failure (the heart is not pumping blood as well as it should, making it harder to supply oxygen to the body); history of falling. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facilitate the management of care, dated 12/14/2025, included the resident had a brief interview for mental status (BIMS) score of 3 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident was occasionally incontinent of urine and frequently incontinent of bowel. A review of the physician Order Summary Report (OSR) revealed an order dated 2/6/26, to cleanse the left buttocks with normal saline solution (NSS) and apply Santyl (an enzyme (protein) that breaks down collagen in damaged or dead skin) cover with a clean dry dressing (CDD) one time a day on the day shift. A review of the wound care Nurse Practitioner (NP) Note dated, 2/11/26 at 1:24 PM, indicated that Resident #11 had a wound on the left buttocks since December 2025. A review of the Individual Comprehensive Care Plan (ICCP) dated 12/16/2025, indicated that Resident #11 had actual skin breakdown and a history of previous pressure ulcer. There was no documented evidence that indicated EBP was implemented at the time the wound was discovered. On 2/17/2026 at 10:20 AM, the surveyor observed the Licensed Practical Nurse (LPN#1) perform a treatment to Resident #11's left buttocks. LPN #1 was observed performing hand-hygiene using alcohol-based hand sanitizer and then donned (put on) clean gloves. She then cleaned the bedside table with a disinfectant and retrieved one package of 4 x 4 gauze dressings, a four-ounce bottle of normal saline solution (NSS), a tube of Santyl ointment in the original box, and a bordered gauze in a pre-wrapped plastic packaging from the treatment cart and placed them directly on the bedside table. LPN #1 did not place a clean barrier on the table before she placed the treatment supplies on the table. LPN #1 then assisted the resident to a standing position to perform a wound treatment and instructed the resident to hold onto the bedside table, where all the treatment supplies had been placed. Upon observation, the resident was noted to be incontinent of urine. The nurse then proceeded to provide incontinence care. During this time, the nurse placed the soiled washcloth and the resident's soiled garment on the bedside table, which interminged with the clean treatment supplies. Following incontinence care, the nurse seated the resident on the bedside and exited the room with the soiled garments in her gloved hand and walked down the hallway. The nurse did not remove her gloves or perform hand hygiene after completing incontinence care and then proceeded to continue the wound treatment wearing the same soiled gloves. The nurse reached into the package of clean gauze with contaminated gloves and removed some gauze pads, and then applied the NSS to the gauze pads, and cleansed the wound without changing the gloves or performing hand hygiene. LPN #1 then applied the Santyl ointment to the dressing using her gloved finger to spread the ointment and then applied the dressing on the resident's wound. Without changing her gloves or washing her hands, the nurse attempted to return the opened package of 4 x 4s and bottle of NSS to the treatment cart. The surveyor intervened and informed the nurse that contaminated treatment supplies could not be returned to the cart. LPN #1 stated she intended to place the items on top of the cart and further stated, Oh yeah, I was not supposed to bring the treatment supplies into the resident's room. LPN #1 then discarded the contaminated supplies into the trash receptacle. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/17/2026 at 10:40 AM in a later interview with LPN #1, LPN #1 acknowledged that she should have placed a clean barrier on the table prior to setting up the treatment supplies. LPN #1 further acknowledged that she should have removed her gloves and performed hand hygiene after providing incontinence care, before initiating a wound treatment, and after the wound treatment. LPN #1 confirmed that soiled washcloths and garments should not be placed in the treatment area. LPN #1 stated that she could not recall if she received education in the facility regarding hand hygiene or infection control practices specific for wound care. LPN #1 also confirmed that EBP should have been implemented; however, she reported she was unaware that the resident had a wound until the surveyor requested to observe the wound treatment. On 2/17/2026 at 11:01 AM, the surveyor interviewed the Licensed Practical Nurse/ Unit Manager (LPN/UM #1) who explained that EBP was utilized to protect the residents from infections. LPN/UM #1 explained that EBP was to be implemented for any resident with an identified wound. LPN/UM #1 stated staff were responsible for donning appropriate PPE, including gloves and gown for any direct physical contact with the residents. LPN/UM #1 stated that a physician's order was required for EBP and that once Resident #11 was identified with a wound, EBP should have been ordered. LPN/UM #1 confirmed that LPN#1 should have disinfected the resident's bedside table and placed a clean barrier on the table prior to setting up the treatment supplies. LPN/UM #1 further stated that LPN #1 should have doffed (removed) her gloves, performed hand hygiene, and donned clean gloves after completing incontinence care and before resuming the wound treatment. LPN/UM #1 also confirmed that hand hygiene should have been performed after cleaning the wound with NSS and prior to applying a clean dressing. LPN/UM #1 stated that Santyl ointment should not have been applied directly to the dressing using a gloved finger and that a sterile applicator should have been utilized. Additionally, LPN/UM #1 confirmed that walking in the hallway while carrying unbagged soiled linen and garments posed an infection control risk and increased the potential for cross contamination. On 2/17/2026 at 11:55 PM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) who stated that for any resident with a wound the staff was required to obtain a treatment order, an order for EBP to include signage outside the resident's door and PPE in an isolation cart readily available, and a designated trash receptacle, initiate a ICCP, and weekly skin checks. The surveyor explained the wound care observation that provided to Resident #11 by LPN #1. The ADON/IP confirmed that LPN #1 breached infection control during the treatment. The ADON/IP also confirmed that LPN #1 should not have walked through the hallways with gloves on, with unbagged soiled linen and soiled resident garments as it was also a breach in infection control. A review of facility's policy dated October 2023 and titled, Handwashing/Hand Hygiene indicated that hand hygiene was the primary means to prevent the spread of healthcare-associated infections. All personnel are trained and regularly in serviced on the importance of hand hygiene in preventing the transmission of health-associated infections. 2.) All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infection to other personnel, residents, and visitors. The policy specified that hand hygiene was indicated after contact with blood, bodily fluids, or contaminated surfaces, after touching a resident, after touching the resident's environment, before moving work on a soiled body site to a clean body site on the same resident, immediately after glove removal, use an alcohol-based hand rub containing 60% alcohol for most clinical situations, wash (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hands with soap and water, when hands are visibly soiled ., single-use disposable gloves should be used, before aseptic procedures, when anticipating contact with blood or body fluids .The use of gloves does not replace hand washing. A review of facility's policy dated December 2024 and titled Enhanced Barrier Precautions indicated 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 2. EPBs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gowns are applied to performing high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. C. Face protection may be used if there is also a risk of splashes. 3. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and /or indwelling medical devices regardless of MDRO colonization. 7. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. A review of the facility policy dated January 2014 and titled, Department (Environmental Services)-Laundry and Linen indicated that the facility was to provide a process for safe and aseptic handling, washing and storage of linen. The policy indicated that staff were to consider all soiled linen to be potentially infectious and handle with standard precautions. 2. On 2/12/26 at 11:34 AM, the surveyor observed Resident #14 in bed awake. The dressing that surrounded the resident's tracheostomy tube (a surgically created hole in the front of the neck into the windpipe, or trachea) was soiled. On 2/13/26 at 12:35 PM, the surveyor reviewed the Electronic Medical Record (EMR) of Resident #14 which revealed the following: A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: malignant neoplasm of the esophagus (a disease where the tissues of the tube-like structure that connects the throat to the stomach (esophagus) becomes malignant (cancer), tracheostomy status, and gastrostomy status (a surgical procedure that creates an opening (stoma) into the stomach through the abdomen, allowing for the direct insertion of a feeding tube, known as a PEG-Tube (percutaneous endoscopic gastrostomy) or G-Tube for long-term nutritional support, hydration, and medication delivery for individuals who cannot eat by mouth). A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/30/2025, included the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident was occasionally incontinent of both bowel and bladder. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 11/11/2025, for Enhanced Barrier Precautions (an infection control intervention designed to reduce the transmission of multi-drug resistant organisms (MDROs) and involves the use of gowns and gloves during high-contact resident care activities for resident's with indwelling devices such as a breathing tube regardless of MDRO colonization status) r/t (related to) Peg tube, and laryngostomy (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tube (a short, soft, flexible tube inserted into the stoma (neck opening) after total laryngectomy (surgery to remove the larynx (voice box))to keep the airway open and prevent the stoma from shrinking). Interventions included: Hand hygiene before and after care, and Maintain precautions as ordered. A review of the Order Summary Report (OSR), included the following physician's orders (PO): A PO, dated 11/11/2025, for Enhanced Barrier Precautions due to Peg/laryngostomy every day and night shift for Infection Prevention. On 2/17/26 at 11:17 AM, the surveyor observed Resident #14 lying in bed awake. The resident did not speak when spoken to and instead nodded their head yes or no to communicate. The dressing that surrounded the resident's laryngectomy tube was clean, dry and intact. At that time, the surveyor noted that there was no signage outside of the resident's room to instruct those who entered to perform hand hygiene prior to entry, and to donn (put on) Personal Protective Equipment (PPE) (equipment such as gloves, gowns, goggles, or face shield worn to protect one from injury or infection) prior to resident care. On 2/17/26 at 11:59 AM, the surveyor observed Licensed Practical Nurse (LPN #6) as she knocked on Resident #14's door and then proceeded to enter the resident's room without first performing hand hygiene. LPN #6 then proceeded to look in the residents' drawers and closets reportedly to find an Ambu bag (a device used to provide respiratory support to patients in emergency and non-emergency situations). LPN #6 then proceeded to leave the resident's room without first performing hand hygiene and she then proceeded to access the emergency cart at the nurse's station to reveal that there was an Ambu bag available if it were required. When interviewed, LPN #6 stated that she had worked at the facility for six years and she was scheduled to work again tomorrow. On 2/18/26 at 9:44 AM, the surveyor observed that there was no signage outside of Resident #14's room to indicate that the resident was ordered EBP and there was no PPE cart outside of the resident's room for PPE equipment storage. On 2/18/26 at 9:49 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #2 who stated that Resident #14 had a trach, and since she had not provided any trach care, she just used standard precautions to care for the resident. CNA #2 identified as an agency aide and further stated that LPN #6 informed her that she only needed to donn a gown if she had gotten close to the resident's trach. CNA #2 stated that while the resident was on hospice care, she had not seen anyone from the hospice agency provide care to the resident yet today. CNA #2 further stated that the resident was able to stand and fed themselves. On 2/18/26 at 9:49 AM, the surveyor interviewed LPN #6 outside of Resident #14's room. When the surveyor asked LPN #6 what type of precautions were required to enter the resident's room she stated that she thought the resident was on EBP, and there was supposed to be a sign posted outside of the resident's door. LPN #6 then proceeded to explain that the signage described how you must garb up (what type of PPE to donn prior to entry) to go into the resident's room. LPN #6 further explained that the resident was on EBP due to their laryngectomy. When the surveyor asked LPN #6 who was responsible to ensure that EBP precaution signage, and equipment were readily available outside of the resident's door she stated that the Infection Preventionist (IP) was responsible, but she was not here anymore. LPN #6 stated that it was important to ensure that EBP precautions were adhered to because the resident was very vulnerable and if the proper PPE were not worn by staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and visitors during care they could bring contaminants into the room. At that time, LPN #6 stated that the hospice nurse had already rendered all care to the resident today including the resident's laryngectomy care. LPN #6 stated that if she had to suction the resident thereafter, she would first wash her hands, donn a mask, and gown, and gloves before she suctioned the resident. LPN #6 further stated, she would then have to doff (remove) her PPE and place it in the trash before she washed her hands for 20 seconds and left the resident's room. At that time, the surveyor asked LPN #6 where she obtained the PPE to provide Resident #14's care as described and she stated, I was used to snatching PPE from across the hall, so I should have noticed the PPE cart was not outside of the resident's room. LPN #6 stated she thought there was a sign outside of the resident's room, but she did not know what happened to it. On 2/18/26 at 10:16 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #2) who stated Resident #14 should have been on EBP because the resident had a laryngectomy that was opened, and the resident had a previous infection too. LPN/UM #2 stated she expected to see a sign outside of the resident's room to indicate EBP was required and a cart with gowns, goggles, face shields, and gloves. LPN/UM #2 stated that you must also clean your hands before entering the resident's room and after resident care. LPN/UM #2 stated there was a concern for the spread of infection to the resident if the EBP protocol were not followed. LPN/UM #2 stated that the facility educator was responsible for ensuring the sign for EBP and cart were placed outside of the resident's room. LPN/UM #2 further stated but since the educator did not do it, both she and all the nurses were responsible for the omission of the EBP signage and PPE cart. On 2/18/26 at 11:38 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) who stated that EBP were needed for someone with a laryngectomy tube and a gown, gloves, and mask were needed for direct care to prevent the spread of infection. The ADON/IP further stated that there should have been signage outside of the resident's room with instructions to enter and the PPE bin should have been in close proximity to the resident's door with all necessary supplies. The ADON/IP further stated that EBP should have been included in both the residents' physician's orders and care plan. The ADON/IP further stated that both the resident and the staff could get sick if they were exposed if they had not adhered to EBP. On 2/18/26 at 12:53 PM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #14 should have been on EBP as we did not want to transmit infection to the resident or the staff. The DON stated that she would have expected to have seen a sign outside of the resident's room and the supplies should have been available in a cart near the entrance to the room. The DON further stated that if there were a physician's order for EBP and the Care Plan illustrated the resident was on EBP the IP should have ensured that there was both a sign and a cart that contained PPE at the entrance to the resident's room. The DON further stated that the nurse and the unit manager also should have made rounds and made sure the sign and the cart were there for communication purposes and to prevent contamination as the resident was on hospice and was compromised. The DON further stated that it was for both the safety of the patient and the staff to adhere to EBP precautions. On 2/18/26 at 2:42 PM the surveyor, in the presence of the survey team, informed the Licensed Nursing Home Administrator (LNHA) of the concerns related to EBP. A review of the facility's Enhanced Barrier Precautions policy, (dated December 2024), included: Enhanced barrier precautions (EBPs) are recommended by the Centers for Disease Control (CDC) to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent the spread of multi-drug-resistant organisms (MDROs) to residents. .EBPs employ targeted gown and glove use during high contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDROs colonization. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs included: Dressing, bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; .device care or use of the following are some examples: .feeding tube, tracheostomy. .EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at risk. .Staff are trained on EBPs. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is accessible in the resident care area and bins are not required to be in front of each door of an EBP room. A review of a facility provided Enhanced Barrier Precaution signage revealed: Everyone must: Clean their hands including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities: .Device care or use: .feeding tube, tracheostomy tube. 3. On 2/12/26 at 11:19 AM, the surveyor observed Resident #2 resting in bed and a feeding pump pole was observed next to the resident's bed. The resident was receiving nutritional formula via (by way of) a tube feeding pump (Pump designed to deliver formula through a tube placed in a stomach). The pumps electronic display showed the formula was being delivered at 65 milliliters per hour (ml/hr.). On 2/13/26 at 10:01 AM, the surveyor reviewed Resident #2's electronic medical record which revealed the following: A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to gastrostomy (the surgical creation of an opening into the stomach to insert a feeding tube for direct nutrition), gastritis (inflammation of the stomach lining), and anemia. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 12/19/25, included a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated that the resident had severe cognitive impairment. Further review of the MDS revealed the resident was receiving nutritional formula via a feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 9/10/25, that Resident #2's nutrition/hydration was at risk related to the feeding tube dependency. Interventions included but were not limited to: Glucerna 1.5 at 65 ML/hr. A review of the Order Summary Report (OSR), included the following physician orders (PO): A PO, dated 12/8/25, for nothing by mouth (NPO). A PO, dated 12/7/25, for Glucerna 1.5 via a peg tube (a tube inserted through the skin directly into the stomach to provide long-term nutrients) at 65 ML/hr. On 2/13/26 at 11:27 AM, the surveyor conducted a follow-up visit to Resident #2's room and Resident #2 was observed lying in bed with the head of the bed elevated and nutritional formula infusing at 65 ml/hr. The surveyor observed several small black insects crawling on the nutritional formula bottle, pump, and tubing. The surveyor also noted dried tan colored substance on the lower part of the tube feeding pole and on Resident #2's wall. On the same day at 11:34 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #2) walked into Resident #2's room. When asked to look at the tube feeding, she stated, I see ants. LPN/UM #2 pointed at the ants crawling on the tube feeding pole, floor, and overbed table. She further stated that the tan colored stain on the wall looked like the resident's tube feeding. On 2/13/26 at 11:45 AM, the surveyor interviewed Housekeeper #1, who stated, that she had already cleaned the Resident #2's room. On 2/13/26 at 11:48 AM, the surveyor interviewed the Director of Housekeeping (DOH) who stated that any surfaces that were not cluttered, including high-touched areas, bed rails, phones, call bells, TV remotes, overbed tables, and light switches and bathroom were cleaned daily. She also stated that the tables should be cleaned from the top down on a daily basis and as needed. The DOH further added that the walls were spot cleaned during general cleaning, and as needed and that the tube feeding poles were wiped down daily. On 2/13/26 at 11:58 AM, the surveyor, accompanied by the DOH, went to Resident #2's room and confirmed the findings. On 2/13/26 at 12:16 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) who stated that the resident's room should be kept clean, and it was a team effort to maintain a clean and sanitary environment. She stated that any spillage should be cleaned right away and that anyone could report a resident's area that was not cleaned. On 2/17/26 at 11:35 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the walls, overbed tables, and tube feeding poles should be cleaned daily and as needed. On 2/18/26 at 10:34 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident's environment should be maintained in a clean a sanitary manner. A review of the facility's Infection Prevention and Control Program, revised June 2023 included, An infection prevention and control program (IPCP) is established and maintained to provide a safe, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, record review, and review of facility documents, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman's Office of a resident transfer to an acute care hospital in a timely manner.This deficient practice was identified for 1 of 2 residents (Resident #123) reviewed for hospitalization and was evidenced by the following: On 2/17/26 at 10:20 AM, the surveyor reviewed the closed medical record of Resident #123.A review of the admission Record, an admission summary, revealed the resident was admitted to the facility with diagnoses which included but were not limited to: acute respiratory failure, chronic obstructive pulmonary disease (COPD) (a condition which makes it difficult to breathe), heart failure, unspecified, and Type 2 (two) diabetes mellitus (a condition in which the body does not produce enough insulin or use it effectively).A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/18/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident's cognition was moderately impaired.A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 11/12/25, which indicated that the resident was at risk for easy bleeding and bruising due to the use of Plavix (a medication that prevents platelets in your blood from sticking together). Interventions included: .Labs as ordered. Report abnormal result to physician asap (as soon as possible), and monitor for active bleeding, i.e. hematuria (blood in the urine), bruising, nose bleeds, rectal bleeding, blood in stool, bleeding gums.A review of the Order Summary Report (OSR), dated as of 12/18/2025, included the following physician orders (PO):A PO, dated 12/18/2025, for Send to ER (emergency room) for low platelet (cell fragments that compose the smallest component of blood and are responsible for stopping bleeding) count.A review of a Progress Notes (PN) dated 12/18/25 at 2:19 PM, revealed, Spoke with MD (Medical Doctor). Discussed [name redacted] concern and questioning lab work. Compared labs over last 2 (two) draws. MD stated send to ER due to drop in Platelet Count (measures the platelet count in a person's blood and if high or low platelet counts, can increase the risk of clotting or excessive bleeding). Call placed to [name redacted] and informed of order to send to ER. [name redacted] is agreeable. Resident care rendered. [Name redacted] called for transport. Awaiting pickup. No distress at this time.A further review of a Progress Note (PN) dated 12/19/25 at 12:56 AM, revealed that the resident was admitted to the hospital [name redacted] with an admitting diagnosis of septic shock (a condition in which the blood pressure fails, and the organs of the body fail to receive sufficient oxygen) and PNA (pneumonia). MD notified. Will endorse the incoming nurse and staff.On 2/17/26 at 12:24 PM, the surveyor requested and received a copy of Resident #123's Notice of Emergency Transfer from the Licensed Nursing Home Administrator (LNHA) that was dated 12/18/25. When the surveyor requested confirmation of notification to the Office of the State Long-Term Care Ombudsman's Office the LNHA stated that when he spoke with the Director of Social Services (DSS) and questioned the process, he learned that the current DSS did not realize that he was required to notify Ombudsman. The LNHA stated the DSS then proceeded to send the notifications for both November and December 2025 to the Ombudsman's Office on 2/13/26. The LNHA confirmed that the resident's responsible party was notified of the Notice of Bed Hold on 12/18/25, however, the Office of the State Long-Term Care Ombudsman's Office was not notified of the resident's acute hospitalization at that time as required.On 2/18/26 at 9:28 AM, the surveyor interviewed the DSS who stated that he just received notification of the need to notify both the family member and the Ombudsman of hospital transfer. The DSS stated that he notified the Ombudsman via fax either at the very end of the month, or the very beginning of the following month. The DSS stated that he received education on the process late last month related to the notification and he did not know that the notices needed to be faxed. The DSS further stated that the previous DSS was doing it prior, but it was a miscommunication on my end.A review of the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Transfer or Discharge Notice policy, (Revised March 2021), included:Residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge.Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: .An immediate transfer or discharge is required by the resident's urgent medical needs;.A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.NJAC 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to: a.) properly store a bi-level positive airway pressure (BiPAP), machine [helps breathing by delivering air through a face mask), in a bag when not in use, b.) ensure that oxygen was being administered as per physician's orders, and c.) ensure that oxygen was humidified in accordance with professional standards of practice. This deficient practice was identified for 2 of 2 residents (Resident #116 and Resident # 129) reviewed for respiratory care and was evidenced by the following:1.On 2/12/26 at 10:58 AM, the surveyor observed Resident #129 sitting upright in bed. Resident #129 had a nasal cannula (clear plastic tubing used to deliver supplemental oxygen to a patient through the nostrils) that delivered humidified oxygen via an oxygen concentrator set at eight (8) liters. The humidification bottle connected to the oxygen concentrator contained a small amount of liquid. On 2/13/26 at 8:46 AM, the surveyor reviewed Resident #129's electronic medical record (EMR). A review of the admission Record, an admission summary, revealed that the resident had diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD) [a progressive, incurable, yet treatable lung disease that causes chronic airflow restriction, often resulting from smoking, leading to severe breathing difficulties], anemia (a condition where low red blood cell or hemoglobin levels reduce oxygen delivery to tissues, causing fatigue, pale skin, dizziness, and shortness of breath), emphysema (a chronic, progressive lung disease and a form of COPD (chronic obstructive pulmonary disease) that destroys the alveoli (air sacs) in the lungs, making it difficult to breathe), morbid obesity, and atrial fibrillation (heart arrhythmia, characterized by a rapid, chaotic, and irregular heartbeat). A review of the admission Evaluation included that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the resident's cognition was intact. A review of the resident's individual comprehensive care plan (ICCP), which included a focus area initiated on 2/20/26, showed that the resident used oxygen therapy. The interventions included encouraging or assisting with ambulation as indicated. No additional interventions related to oxygen therapy were identified in the care plan. A review of the Order Summary Report (OSR) included a physician order (PO) dated 2/10/26 for oxygen running at 5 liters per minute via nasal cannula for 18-24 hours daily. A review of the Treatment Administration Record did not include the oxygen setting. On 2/13/26 at 10:31 AM, the surveyor made a follow-up visit with Resident #129, who was observed sitting upright in their room. Resident #129 was receiving oxygen via the nasal cannula. The oxygen concentrator was set at nine (9) liters. The humidification bottle was empty. At that time, the surveyor interviewed the resident. When asked how long the humidification bottle had been empty, the resident replied, Since yesterday. On 2/13/26 at 10:50 AM, the surveyor interviewed Licensed Practical Nurse (LPN #3), who stated that she had administered Resident #129's medication that morning and that the resident did not voice any concerns. When asked if she had checked the oxygen concentrator setting, she replied, No. LPN (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#3 confirmed that the oxygen concentrator setting should be checked every shift and maintained according to the physician's order. On 2/13/26 at 11:00 AM, the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM #2) and proceeded to Resident #129's room. LPN/UM #2 confirmed that the oxygen concentrator was set at 9 liters per minute and the humidification bottle was empty. At that time, Resident #129 stated that they had turned up the oxygen setting to 9 liters. LPN/UM #2 adjusted the setting on the oxygen concentrator and replaced the humidification bottle. The surveyor and LPN/UM #2 exited the resident's room to conduct an interview. LPN/UM #2 stated that when the nurse comes in, they are expected to complete walking rounds to ensure that all oxygen equipment is set to the correct flow rate, confirm that humidification is present, check the dates on the oxygen tubing, and assess that the resident is not experiencing any respiratory distress. She further stated that maintaining the correct oxygen setting was important because Resident #129 had COPD. She explained that if the oxygen liters were set at nine (9) liters per minute for a resident with COPD, the resident could retain carbon dioxide and potentially go into respiratory distress due to an inability to adequately expel the carbon dioxide. LPN/UM #2 further stated that she or the admitting nurse was responsible for developing the care plan and updating it quarterly and as needed. She confirmed that the care plan should have included documentation indicating that the resident independently increased the oxygen setting, so nursing staff would be aware of this behavior and monitor accordingly. On 2/13/26 at 12:08 PM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP), who stated that the nurses should verify the physician's order against the oxygen concentrator setting to ensure it was set correctly. The ADON/IP explained that this should be done at the beginning of each shift and during any subsequent interactions with the resident. The ADON/IP further stated that nurses should check the humidification bottle to ensure it contained water and confirmed during rounds that humidification was in place, as non-humidified oxygen can dry the mucous membranes. The ADON/IP further stated that for a resident with COPD, higher oxygen levels could place the resident at risk for respiratory distress and potentially cause them to stop breathing. Th ADON/IP also noted that if a resident independently increased the oxygen setting, the care plan should have addressed this behavior. The ADON/IP stated that in such a situation, she would likely monitor the resident more frequently to ensure the oxygen remained at the prescribed setting. On 2/18/2026 at 10:16 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated that the nurse should check each shift to ensure the oxygen was set at the correct flow rate and that humidification was in place. The DON further stated that the nurse should contact the physician to obtain an order for humidified oxygen, as high-flow oxygen without humidification can cause dryness and irritation for the resident. The DON further stated that the admitting nurse or unit manager was responsible for developing the care plan and updating it as needed. The DON added that if the resident had a history of independently changing the oxygen setting, this information should have been included in the care plan. The DON further stated that all staff involved in the resident's care should be aware of the plan of care and understand what to monitor for in order to ensure the resident's safety. On 2/18/2026 at 11:43 AM, the surveyor made a follow-up visit to see Resident #129. They were observed sitting in their wheelchair, receiving humidified oxygen at 5 (five) liters via nasal cannula. Resident #129 stated that their nose was awfully dry and felt much better now that the oxygen was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	humidified. A review of the facility's Oxygen Administration policy, revised 10/23, included Review the physician's orders or facility protocol for oxygen administration . Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. 2. On 2/12/26 at 11:33 AM, during the initial facility tour, the surveyor observed Resident #116 lying in bed receiving three liters per minute (3LPM) of humidified oxygen (Oˆ) via an oxygen concentrator (a medical device that filters and delivers oxygen from the air). The surveyor also observed that the Resident's BiPAP (a type of noninvasive ventilation that helps you breathe) machine was not in use and was not stored in a protective, labeled plastic bag. A review of the admission Record, an admission summary, indicated that Resident #116 was admitted to the facility with diagnoses that included, but were not limited to: acute and chronic respiratory failure with hypoxia (lung disease with low oxygen levels in the blood) and obstructive sleep apnea (OSA), [a condition where airway obstruction causes repeated pauses in breathing during sleep]. A review of the quarterly Minimum Data Set (MDS), an assessment that guides a resident's care, dated 12/13/25, indicated that Resident #116 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the Resident's cognition was intact. Further review of Section O: Special Treatments, Procedures, and Programs of the MDS, revealed the Resident was receiving Oˆ. On 2/13/26 at 11:08 AM, the surveyor observed the BiPAP machine placed in an open area on the Resident's bedside table, exposed and not maintained in a protected, labeled bag. On 2/13/26 at 11:08 AM, the surveyor observed the BiPAP machine placed in an open area on the resident's bedside table. The machine was exposed and not maintained in a protected, labeled bag when not in use. On 2/13/26 at 11:18 AM, the surveyor reviewed the medical record for Resident #116. A review of the Resident's Individual Comprehensive Care Plan (ICCP) included a focus area, dated 10/20/25, indicating that Resident #116 was receiving Oˆ therapy related to (r/t) ineffective gas exchange and using BiPAP. Interventions included ensuring that the BiPAP was placed as ordered. However, the ICCP did not specify how the BiPAP machine should be stored when it was removed from the Resident. A review of the Order Summary Report (OSR) dated as of 2/12/26, included the following physician orders (POs) for Resident #116: A PO, dated 11/18/25, to place the BiPAP at night and remove after sleep. A PO, dated 11/18/25, for Oˆ at 3 LPM via nasal cannula to maintain Oˆ of 92% or greater every day and night shift for hypercapnic respiratory failure (inability of the lungs to remove carbon dioxide from the blood, causing high levels in the body). A PO, dated 1/20/26, for overnight sleep study evaluation for OSA. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/26 at 11:25 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who confirmed that the Resident's BiPAP machine should not be placed on the bedside table but should be cleaned and stored in a labeled bag upon removal in the morning. On 1/21/26 at 11:36 AM, the surveyor interviewed the (Licensed Practical Nurse/Unit Manager (LPN/UM #1), who stated that all devices with masks, including the BiPAP machine, should be cleaned, placed in a protective bag, and labeled when not in use. The LPN/UM #1 further stated that proper storage of respiratory equipment was important for infection control. On 2/18/26 at 2:16 PM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP), who stated that staff were expected to clean, bag, and label respiratory equipment, including BiPAP machines, when not in use. The ADON/IP confirmed that proper storage was important for infection control purposes. A review of the facility's CPAP/BiPAP Support policy, revised March 2015, included that the purpose 3). was . to promote resident comfort and safety. Additionally, review of the facility's Departmental (Respiratory Therapy) - Prevention of Infection policy, revised November 2011, indicated that the purpose of this procedure was to guide prevention of infection associated with respiratory therapy tasks and equipment.among residents and staff. NJAC 8:39-27.1(a)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on record review and interview, it was determined that the facility failed to ensure physician supervision and oversite of medical care for 1 of 2 residents (Resident #11) reviewed for pressure ulcer management and was evidenced by the following:The surveyor reviewed Resident #11's Electronic Medical Records (EMRs) which revealed the following information:A review of the admission Record, an admission summary, indicated that Resident #11 was admitted to the facility with diagnoses that included but were not limited to dementia: (a loss of mental functioning that affects thinking, memory, mood, and behavior) and diabetes mellitus (a condition in which the body is unable to properly regulate blood sugar due to problems with insulin production or use).A review of the admission Minimum Data Set (MDS), an assessment that facilitates a resident's care, dated 12/14/2025, indicated that the resident scored 3 (three) out of 5 (five) on the Basic Interview for Mental Status (BIMS), which indicated that the resident had severe cognitive impairment. Further review of the MDS also indicated that Resident #11 did not exhibit behaviors and required supervision and assistance with activities of daily living (ADLs). The MDS further reflected that Resident #11 was on psychotropic medications.A review of the Wound Care Practitioner (WCP) notes dated 2/11/2026 at 1:24 PM, indicated that Resident #11 had a wound on the left buttocks that had been present since December 2025. According to the Resident Representative (RP), the resident had a history of multiple wound sites while residing in the community. The wound on the left buttocks was identified as unstageable and measured 2.5 cm x 4.5 cm x 0.3 cm. The documentation further indicated the presence of moisture-associated skin damage (MASD) to the scrotal area.A review of the Medication Administration Record (MAR) reflected ongoing treatment orders beginning in December 2025 for the left buttock wound. The MAR further indicated treatment orders initiated in February 2026 for MASD to the scrotal area.A review of the Comprehensive Care Plan (CCP) dated 12/16/25, indicated that the resident had actual skin breakdown on the buttocks with a previous history of pressure ulcers. Preventative protective skin care interventions were in place.A review of the primary care physician (PCP) documentation dated 12/17/25, 12/29/25, 1/5/26, 1/8/26, 1/13/26, 1/20/26, 1/27/26, 2/26, 2/6/26, and 2/10/26 revealed no evidence that the physician addressed the residents' medical condition related to the wounds, awareness of the wounds, or demonstrated medical supervision of the resident's wound.On 2/19/2026 at 9:18 AM, the surveyor telephone interviewed Resident #11's PCP who stated that she was aware that the resident had a wound on the buttocks, however, did not document an assessment of the wound because the wound care Nurse Practitioner (NP) in the facility performed the assessments. The provider stated, I'm sorry, I should have mentioned assessing wound care in my note, moving forward, I will mention the wound care in my notes.The facility policy dated February 2021 and titled Physician Services indicated that the medical care of each resident was supervised by the licensed physician. The policy specified that the supervision of the medical care of the residents included participating in the resident's assessment and care planning, monitoring changes in the resident's medical status, providing consultation or treatment when called by the facility, prescribing medications and therapy, ordering transfers to the hospital, conducting routine required visits, delegating and supervising follow-up visits by non-physician practitioners (NPs, PA, CNS); and overseeing a relevant plan of care for the resident. NJAC 8:39-11.2 (a)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to a.) develop an individualized Comprehensive Care Plan (ICCP) with specific interventions to address dementia care, and b.) follow the facility policy for dementia care. This deficient practice was identified for 1 of 2 residents (Resident #11) reviewed for dementia care and was evidenced by the following: A review of the admission Record (admission summary) indicated that Resident #11 was admitted to the facility with diagnoses that included but were not limited to dementia and diabetes mellitus.A review of the comprehensive Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, dated 12/14/2025, indicated that the resident scored 3 (three) out of 15 (fifteen) on the Basic Interview for Mental Status (BIMS) assessment which indicated that the resident had severe cognitive impairment. The MDS also indicated that Resident #11 did not exhibit behaviors and required supervision and assistance with activities of daily living (ADLs). The MDS further reflected that Resident #11 was on psychotropic medications.On 2/12/2026 at 12:57 PM, the surveyor entered the resident's room, and the responsible party (RP) was visiting with the resident. The surveyor interviewed the RP who explained that Resident #11 had fallen and was sent to an acute care facility a month and a half ago. Subsequently, the resident was admitted to this facility for rehabilitation. The RP explained that the resident had a diagnosis of dementia and would remain in the facility for long-term care. The RP stated that she had no concerns related to the resident's care.On 2/13/2026 at 1:20 PM, the resident's RP was observed visiting Resident #11. The resident was sitting in a recliner chair with call light within reach. The resident was well-groomed, wore clean clothes and no complaints offered from the resident or the RP. No behaviors observed.The surveyor reviewed the resident's electronic medical record (EMR) which revealed the following information:A review of the psychiatry notes dated 1/29/26 at 1:27 PM, indicated that Resident #11 had diagnoses of dementia and had clinical signs such as forgetfulness, memory loss, confusion, anxiety, depression, delusions and mood swings.A review of the Order Summary Sheet ([NAME]) contained an order for Namenda 10 mg one tablet by mouth two times a day for dementia.On 2/18/2026 at 9:46 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that Resident #11 exhibited behaviors such as agitation, exit seeking and repeatedly expressed a desire to go home. The CNA #1 reported using distraction and redirection interventions, including taking the resident for wheelchair rides throughout the building and engaging in one-to-one conversations. He stated that these interventions were generally effective in calming the resident. The CNA #1 reported that the resident did not display verbal or physical aggression. The CNA #1 further stated that the resident experiences sundowning, characterized by increased confusion, agitation and behavior changes during the evening hours beginning around 7:00 PM. He indicated that offering peanut butter and jelly sandwiches and ice water had been effective in decreasing the residents' anxiety. The CNA #1 also reported that the resident remained calm when the RP was present.A review of the Individual Comprehensive Care Plan (ICCP) revealed that the resident was at risk of elopement related to dementia and interventions included encourage independence while in the building but ensure supervision while outside and utilize a security bracelet. There were no further interventions documented on the ICCP to manage the residents' behaviors associated with the residents' diagnosis of dementia.A review of Resident #11's progress notes revealed that there was no documentation that the resident was exhibiting sundowning at night, searching for the RP or threatening to call the police. There was also no documentation in the progress notes regarding redirection interventions that were provided when the resident exhibited these behaviors.On 2/18/2026 at 10:02 AM, the surveyor interviewed the Licensed practical Nurse (LPN #2) who stated that behavior monitoring was ordered by the physician and conducted every shift. LPN #2 reported (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uncertainty regarding whether behaviors were required to be documented in the progress notes. He stated the resident had been adjusting since admission but continued to exhibit sundowning in the evening, including agitation, searching for the RP and threatening to call the police. LPN #2 reviewed the ICCP in the presence of the surveyor and confirmed that it was not resident specific and did not include individualized interventions to address agitation or sundowning behaviors during the evening shift. He further confirmed that the ICCP did not include a resident specific dementia-focused care area with related goals and interventions to address the resident's dementia care needs.On 2/18/2026 at 10:35 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM#1) who also reviewed Resident #11's ICCP in the presence of the surveyor and confirmed that individualized interventions to address agitation or sundowning behaviors during the evening shift. She further confirmed that the ICCP did not include a resident specific dementia-focused ICCP. She further added that she was now aware of the discrepancy, since brought to her attention by the surveyor, and would address the issue.A review of the facility policy dated 11/2018 and titled, Dementia-Clinical Protocol indicated individuals with dementia can have personality disorders, mental illness, psychosis, delirium, depression, adverse drug reactions or conditions contributing to impaired cognition and problematic behaviors. The policy further indicated that for individuals with confirmed dementia, the Interdisciplinary Team (IDT) would identify a resident-centered care plan to maximize remaining function and quality of life. The IDT would identify and document the residents' condition and level of support needed during care planning and review changing needs as they arise. Resident needs would be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses notes and documentation tools). The IDT will adjust interventions and overall plan depending on the individuals' responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors.N.J.A.C 8:39-45.1 (a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the pharmacy consultant conducted a monthly review of each resident's medication regimen b.) to clarify a physician's order, c.) address a pharmacy consultant recommendation for one (1) of five (5) residents reviewed for unnecessary medications (Resident #113). This deficient practice was evidenced by the following:On 2/12/26 at 11:20 AM, the surveyor observed Resident #113 lying in bed.On 2/13/26 at 1:40 PM, the surveyor reviewed the electronic medical record for Resident #113.A review of the admission Record, an admission summary, revealed that the resident had diagnoses which included, but were not limited to: type 2 diabetes mellitus (a chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly) and rheumatoid arthritis (a chronic autoimmune disorder where the immune system attacks joint linings (synovium), causing painful, stiff, and swollen joints, primarily in the hands and feet).A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/12/26, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated that the resident's cognition was severely impaired.On 2/13/26 at 9:45 AM, the surveyor requested the pharmacy consultant recommendations for August 2025 through January 2026.A review of Resident #113's pharmacy consultant recommendations did not include the month of August 2025.A review of the pharmacy consultant recommendation for the month of September 2025 revealed 9/29/25. Patient is receiving Prednisone (a fast-acting corticosteroid used for inflammatory, allergic, and autoimmune conditions) 15 mg QD (every day) for CHF (7/6/25 order). Instructions read: ?MD will taper med (medication) Is taper appropriate at this time?There was no evidence that the 9/29/25 pharmacy consultant recommendation was addressed.A review of the Order Summary Report (OSR) included the following physician orders (PO):A PO, dated 7/5/25, for prednisone 5 milligrams (mg), one time a day for congestive heart failure (CHF). Give 3 tablets by mouth and MD (provider) will taper med (medication). The physician's order did not include a stop date.A PO, dated 11/17/26, for Prednisone 5 mg, give 2 tablets, one time a day for CHF.A PO, dated 11/19/26, for Prednisone 5 mg tablet, give one tablet by mouth for CHF.A review of the Medication Administration Record (MAR) revealed that Prednisone 15 mg was administered daily during the entire month of July (as of July 6, 2025), August, September, and October 2025.A review of the MAR for the month of November revealed that Resident #113 was administered Prednisone 15 mg from 11/1/25 through 11/16/25, Prednisone 10 mg from 11/17/25 through 11/19/25, and prednisone 5 mg from 11/20/25 through 11/22/25.On 2/18/26 at 12:57 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #2), who stated that the pharmacy consultant recommendations were sent to the facility monthly. She also stated that she was unaware of what happened to the August 2025 pharmacy consultant recommendation for Resident #113. She further stated that when a PO indicated that a medication would be tapered, the nurse should have called the physician to clarify the order to ensure that the resident received the correct dose. LPN/UM #2 stated that she was not working at the facility on 9/25, so she was not sure why the pharmacy consultant recommendation was not addressed. She also noted that when the provider was made aware of the pharmacy recommendations, the provider would sign the recommendation, and it would be placed in the resident's paper chart. At that time, LPN/UM #2 looked in the resident's hard chart and did not see a signed pharmacy consultant report for 9/29/25, regarding the prednisone.On 2/18/26 at 10:27 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the pharmacy consultant conducted monthly reviews of each resident's medication regimen. She added that the pharmacy recommendations were given to the DON and followed up and addressed as soon as they were received. The DON stated that the facility received the recommendations as early as 24 hours after the medication regimen review had been conducted. The DON stated that the ADON would give the recommendations to the unit manager and (continued on next page)

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	315210	A. Building B. Wing	02/19/2026

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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the unit manager would address the pharmacy consultant recommendations. Each unit manager was responsible to address their units' recommendations. She added that if the provider wrote an order to taper a medication, it should be clarified right away or as soon as it was noted because prednisone was not to be given for an extended period of time. On 2/18/2026 at 1:25 PM, the surveyor interviewed Nurse Practitioner #1, who stated that the facility had a communication binder in which the pharmacy consultant recommendations were placed in for the provider to review. She further stated that there was a box on the pharmacy consultant recommendation that was to be circled to indicate if she had accepted or declined the recommendations and the rationale; then the form was placed back in the communication binder, and the nurse would be notified to review the response.A review of the Pharmacy Services - Role of the Consultant Pharmacist dated revised April 2019 included, The Consultant Pharmacist will provide specific activities related to medication regimen review including a. A documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines; b. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services .e. Providing the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review.N.J.A.C. 8:39-27.1 (a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, it was determined that the facility failed to administer medication with an error rate of less than 5%. The surveyor observed 3 nurses administer medications for 3 residents with 26 opportunities for error. There were 2 errors resulting in an error rate of 7.6% as evidenced by the following: During the medication pass observation on 2/13/2026 from 8:27 AM until 8:35 AM, the surveyor observed the following: At 8:27 AM, the surveyor observed Licensed Practical Nurse #8 (LPN #8) prepare five medications for Resident #100 including Coreg tablet 25 mg (milligram) (carvedilol); give one tablet by mouth two times a day for HTN (hypertension) take with food, and Metformin HCL tablet 1000 mg; give one tablet by mouth two times a day for DM (diabetes mellitus) with a pharmacy cautionary label indicating to take this medication with food. At the time of the medication administration, the facility breakfast trays had not been delivered, and LPN #8 had not provided, offered, or instructed the resident to take the medication with food. At that time. the surveyor stopped LPN #8 and reviewed the electronic medical record (EMR) with LPN #8 who acknowledged the two medications should have been given with food. LPN #8 stated that usually breakfast had been served by then, she should have offered food with the medications such as applesauce, a sandwich or crackers. LPN #8 then proceeded to provide Resident #100 with a cup of applesauce. On 2/18/26 at 12:12 AM, the surveyor interviewed the Assistant Director of Nursing/ Infection preventionist (ADON/IP) who stated if medication should be taken with food, then a cup of pudding, a cup of applesauce or a half sandwich should have been given. If breakfast had not been served, then the nurse should have provided food to the resident before administering the medication. The ADON/IP stated it was important to follow the instructions to take with food because some medications could have side effects if not taken with food. On 2/18/26 at 11:40 AM, the surveyor interviewed the third floor Licensed Practical Nurse/ Unit Manager #1 (LPN/UM #1) who stated take with food meant a meal, or some type of snack, a sandwich, a pudding or applesauce cup, or a banana usually to prevent stomach upset. LPN/UM #1 acknowledged LPN #8 should have administered medications to Resident #100 with food or waited until they had been served their breakfast. On 2/18/26 at 1:40 PM, the pharmacist attempted to interview the facility's Consultant Pharmacist (CP) via telephone, but the call went directly to voicemail. On 2/18/26 at 2:56 PM, the surveyor interviewed the Director of Nursing (DON) who stated LPN #8 should have followed the pharmacy cautionaries and given the medications with food. The DON further stated food would be considered sandwiches, applesauce, or pudding. A review of the Administering Medications policy, revised October 2023, included Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescribers orders. The policy did not address cautionaries or the definition of food during medication pass. NJAC 8:39-29.2(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to secure a treatment cart during a wound treatment observation that was conducted on 2/17/2026. This deficient practice occurred with 1 of 1 nurse observed for the provision of a wound treatment and was evidenced by the following:On 2/17/2026 at 10:20 AM, the surveyor conducted a wound treatment observation on the third floor nursing unit with the Licensed Practical Nurse (LPN #1). LPN#1 was observed gathering treatment supplies from the treatment cart. LPN #1 then proceeded to put the treatment supplies on top of the treatment cart. She then entered a resident's room, and left the treatment cart with the treatment supplies on top of the cart unlocked, unattended and out of her line of sight. LPN#1 returned to the cart to obtain additional supplies, then re-entered the resident's room, again leaving the cart unlocked, unsecured, and unattended.The treatment supplies left on top of the treatment cart consisted of one bottle of normal saline solution (NSS), one tube of Santyl ointment (a topical medicine used to help clean and remove dead tissue from long-lasting skin wounds).During the observation, LPN#1 exited the resident's room carrying soiled garments and walked past the unlocked and unattended treatment cart without securing it. LPN #1 placed trash bags on top of the cart, re-entered the resident's room to obtain a trash bag, and again left the treatment cart unlocked, unsecured and out of her view. There were no residents in the hallway at the time; however, the treatment cart remained accessible and unsecured.On 2/17/2026 at 10:40 AM, the surveyor interviewed LPN #1 who stated that she should have locked and secured the cart when not in sight and she should not have left the cart unattended as a resident could have gained access to the treatment supplies.On 2/17/2026 at 11:01 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) who confirmed that the treatment cart should be kept secured and locked when not in sight as a resident could gain access to the treatment supplies. LPN/UM #1 also indicated that the ointments and creams in the treatment cart were considered medications.The facility policy dated November 2020 and titled, Storage of Medications indicated that the facility stored all drugs and biologicals in a safe, secure and orderly manner.NJAC 8:39-29.2(d)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, it was determined that the facility failed to offer snacks to residents between meals and at bedtime. This deficient practice was identified for 2 of 4 residents (Resident #80, Resident #83,) who attended a resident's group meeting and for an additional two residents interviewed for the provision of snacks, (Resident #5, Resident #130).This deficient practice was identified on 2 of 2 nursing units (Second and Third Floor) and was evidenced by the following:On 2/13/2026 at 10:31 AM, the surveyor conducted a meeting with four alert and oriented residents. When asked about bedtime snacks, two residents stated that snacks were not passed out at night. Resident #83 stated that they did not receive snacks and worried about their blood sugars as a diabetic. Resident #83 further stated that they had spoken to the Dining Director (DD) previously about it and they had agreed to look into it.On 2/17/2026 at 11:47 AM, the surveyor observed Resident #5 seated in a wheelchair in their room eating lunch. When the surveyor asked if they received a snack at night the resident stated no, but they wished they would.On 2/17/2026 at 12:31 PM, the surveyor interviewed Resident #130 at their bedside who stated that they had not received a snack last night but would have liked to.On 2/17/2026 at 12:35 PM, the surveyor interviewed Certified Nurse Aide (CNA #3) who stated that snacks came up from the kitchen at every meal and some were assigned to specific residents with their name attached and some additional snacks were provided for the general census. CNA #3 stated that the aides must go around and offer snacks, but they were not required to sign the snacks out to demonstrate resident receipt. CNA #3 further stated that he knew his residents and offered them snacks even if they were not on the list.On 2/17/2026 at 12:39 PM, the surveyor interviewed Licensed Practical Nurse (LPN #5) who stated that snacks were offered at 10 AM, 2 PM and between 5 and 6 PM from the kitchen. LPN #5 stated that the snacks were labeled with the residents' names, and we passed them out and we had extras for residents who may want snacks. LPN #5 stated if the resident had a physician's order and were ordered a sandwich, health shake, or bedtime snack, the order was reflected on the Medication Administration Record (MAR) and nursing was required to sign the snack out on the MAR. LPN #5 stated that diabetics should have that process in place. LPN #5 stated that if there were extra snacks that came up from the kitchen, then they were passed out. LPN #5 further stated we let the kitchen know to put the resident on the list for snacks if they had requested.On 2/18/26 at 9:37 AM, the surveyor interviewed the Dining Director (DD), who stated that bulk snacks were delivered to the nursing units at 7:00 PM with assigned snacks for residents with orders with their name, consistency, and room number. The DD stated that snacks were also delivered at breakfast, lunch, dinner, and at 7:00 PM. The DD stated that we send unlabeled crackers, cookies, chips and sugar free items. At that time, the surveyor requested a list of residents who had snack orders and any documented evidence that the staff had signed for receipt of the snacks as described.On 2/18/26 at 9:46 AM, the DD provided the surveyor with a blank Food and Nutrition Services Meal Service Delivery Log that failed to have illustrated the delivery confirmation of snacks to the nursing units.On 2/18/2026 at 9:49 AM, the surveyor interviewed CNA #2 who stated the residents had two meals served during the day shift and if residents asked for snacks during that time, then she could call the kitchen for it. CNA #2 further stated that snacks were then offered before bedtime thereafter.On 2/18/2026 at 10:00 AM, the surveyor interviewed LPN #6 who stated that she only had to sign out the provision of a health shake on the MAR. LPN #6 stated diabetics did not have to ask for a snack, because they were provided with snacks on their meal trays. LPN #6 further stated the snacker's families brought snacks into the facility from home. On 2/18/2026 at 10:31 AM, the surveyor interviewed Licensed/ Practical Nurse/Unit Manager (LPN/UM #2) who stated that snacks were delivered to the nurse's station around 5:30 PM or 6:00 PM and the nurse had to sign receipt. LPN/UM #2 stated the aides then passed the snacks out and the nurses had snacks (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on their carts that they passed out when they gave their medications. LPN/UM #3 further stated that staff did not have to sign the snacks out as administered, and she would have to ask the resident if they received them to verify receipt.At that time, LPN/UM #3 reviewed the electronic medical record (EMR) and stated that none of the residents (Resident #80, Resident #83, and Resident #130) the surveyor inquired about had orders for snacks. At that time, the surveyor heard an unsampled resident call out at the nurse's station, I want my sandwich. LPN/UM #3 confirmed that the resident was requesting to have their snack provided to them.On 2/18/2026 at 11:56 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) who stated some patients were ordered scheduled snacks if they were diabetic and other residents were offered snacks at HS (hours of sleep). The ADON/IP stated that the nurses and aides handed them out and signed for them if the snacks were dietician assigned and there was a physician's order.On 2/18/2026 at 12:30 PM, the surveyor interviewed the Lead Dietician (LD) who stated not every resident required an HS snack. The LD explained that if the doctor felt it necessary due to low blood sugar in the morning or a hefty dose of insulin at night, then we will add something. The LD stated that snacks came up to the nursing units on a snack tray and nursing handed them out. The LD further stated that only supplements and fortified foods were required to be signed out as administered by nursing.On 2/18/2026 at 1:04 PM, the surveyor interviewed the Director of Nursing (DON) who stated the facility did bring snacks for everybody. The DON stated that the snacks should be offered in the afternoon and at night. The DON further stated, except for residents with orders, then the nurses passed them out and signed them out on the MAR.On 2/18/2026 at 2:05 PM, the surveyor in the presence of the survey team, informed the Licensed Nursing Home Administrator (LNHA) of the resident's allegation that they had not been offered snacks in between meals and at bedtime.A review of the Snacks (Between Meal and Bedtime) , Serving policy, (Revised September 2010), included: The purpose of this procedure is to provide the resident with adequate nutrition.The person performing this procedure should record the following in the resident' s medical record:The date and time the snack was served, The name and title of the individual (s) who served the snack. The amount of snack eaten by the resident (i.e., 50%, 75%, etc.).The signature and title of the person recording the data.NJAC 8:39-17.2(f) 1 (ii)