STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Springs Rehabilitation and Healthcare Ctr	1049 Burnt Tavern Road Brick, NJ 08724

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and policy review, the facility failed to ensure the kitchen was clean, staff washed hands and wore gloves appropriately between task changes, and dishes were stacked dry. These failures had the potential to affect 153 residents who consumed food prepared by the kitchen.Findings include:Observations of the kitchen on 01/05/26 at 10:16 AM, revealed dust and debris were visible on the top of the dishwasher that included a rusted spring and dirty knife. The tile wall next to the grill had dust and stains scattered throughout the surface. The floor behind the oven and stove had a layer of black substance against the floorboard and under the three-compartment sink. The oven and stove top had built up grease and black debris. Also, the plate warmers had debris and dust on top of them and there were plates in the warmer that had water on them stacked on top of each other. During an interview on 01/05/26 at 10:45 AM, the Regional Dietary Director (RDD) confirmed the areas during the initial tour of the kitchen, stating they were not clean. The RDD also confirmed the water on the plates should not be there because they could carry bacteria and cause an infection.During an observation on 01/07/26 at 10:50 AM, the RDD was observed to bring in four boxes of pasta and put them on the prep table. The RDD collected five plates of food from breakfast and took them to the dirty area of the dishwasher. The RDD then went to the refrigerator and pulled on the handle without washing his/her hands from the time of entrance.On 01/07/26 at 10:55 AM, the Regional Director of Dietary Services (RDDS) was asked if staff should wash their hands when entering the kitchen. The RDDS stated yes. Observations on 01/07/26 at 11:09 AM, revealed the plate warmer had debris on top and the plates were visibly wet and were placed on the trays that were going out to residents. On 01/07/26 at 11:33 AM, the Food Service Director (FDS) was observed washing hands and walking away with the paper towels and then using the same paper towels to wipe his/her face and threw the towels away. The FDS then pulled out gloves from the box and put them on. The FDS went to the stove and continued cooking. During an interview on 01/07/26 at 12:10 PM, the RDDS was asked about the plates that were stacked on each other and placed on trays. The RDDS looked at it and started pulling the wet plates and stated the plates should be dry because it was called wet nesting and it could cause bacteria to grow. The RDDS pulled out 16 more wet plates. Continued observations on 01/07/26 at 12:24 PM, revealed Dietary Aide (DA)2 walked away from the serving line and went to the door where an unidentified staff member gave him/her a dietary ticket. After taking the ticket in the gloved hand, DA2 went back to the serving line and began to set up trays. During an interview on 01/07/26 at 12:28 PM, the RDDS was asked about staff walking away from the serving line doing a different task then returning to the line wearing the same gloves. The RDDS stated the gloves should have been disposed of and the hands washed before coming back to the line. The RDDS was also asked about the FDS wiping his/her face with the paper towel and then putting gloves on afterward. The RDDS stated the hands should have been washed again. During an observation on 01/07/26 at 1:01 PM, DA3 was observed to his/her wash hands at the sink and finished by drying his/her hands with the disposable paper towels. DA3 lifted the lid of the trash can which contaminated the hands. The trash can had a working foot peddle. During an interview on 01/07/26 at 1:10 PM, the RDDS was asked about using hands to lift the lid of the trash can after (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	washing hands. The RDDS stated the trash can had a foot pedal, so the lid did not have to be touched. During an interview on 01/07/26 at 1:13 PM, DA3 was asked about using his/her hands to lift the lid when the trash can had a foot pedal. DA3 stated, I did not think about it.Review of the undated facility policy titled, General Sanitation of Kitchen, revealed, Policy: Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Review of the undated assignment sheet titled, Daily Cleaning Assignments revealed, on Sunday the AM [NAME] should clean the plate warmer and the PM [NAME] should clean the stove. On Sundays and Thursdays clean outside dishwasher, Saturdays PM#3 clean three sink area.Review of the undated facility policy titled, Bare Hand Contact with Food and Use of Plastic Gloves, revealed, Policy: Single-use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from food handlers' hands to the food product being served. 4. Hands are to be washed when entering the kitchen and before putting on the single use gloves and after removing single use gloves. 6. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed. b. After handling garbage or garbage cans. Wash hands after removing gloves. NJAC 8:39-17.2(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff donned personal protective equipment (PPE) when entering a room with a resident on transmission-based precautions, droplet precautions, and while providing direct care to a resident on enhanced barrier precautions (EBP) for two of five residents (Resident (R)40 and R89) reviewed for infection prevention and control out of a total sample of 49 residents. This failure placed staff and residents at risk of infection from cross-contamination.Findings include:.1. Review of R89's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R89 was admitted to the facility on [DATE], with diagnoses that included stroke, non-Alzheimer's dementia, aphasia (difficulty speaking), and a feeding tube.Review of R89's undated Physician Orders, located under the Orders tab of the EMR, reflected the following orders: Enteral Feed Order four times a day. Give Jevity 1.5 Bolus Feeding of one container (237 mLs) [milliliters], four times daily as listed and crush medications per manufacturer recommendations (do not crush enteric coated or extended-release medications, or those not approved by manufacturer) and mix in 5mL warm water each. Confirm placement, flush with 30 mL of warm water, administer medications individually flushing with 15 mLs of warm water in between, and with 30 mLs of warm water after all meds are given.During an observation on 01/07/26 at 11:30 AM, Licensed Practical Nurse (LPN)1 was observed administering a bolus feeding to R89 who was on EBP. LPN1 did not wear a gown. A sign was posted outside R89's room that indicated EBP were in place and that providers and staff must wear gloves and a gown for the following high-contact resident care activities, device care, or use, which included a feeding tube.During an interview on 01/07/26 at 11:53 AM, LPN1 indicated that he/she forgot to put on a gown before accessing the resident's feeding tube. LPN1 said staff were required to wear a gown and gloves whenever direct care was provided to a resident on enhanced barrier precautions.During an interview on 01/08/26 at 2:18 PM, the infection preventionist (IP) stated that the facility followed the Centers for Disease Control and Prevention (CDC) guidelines for EBP. The IP said that he/she provided education to staff and ensured appropriate signs were posted at resident rooms within line of sight and placed PPE bins at the doorway for PPE access before entering room. The IP said that staff must ensure they properly put on the appropriate PPE before entering the room.During an interview and record review on 01/08/26 at 4:30 PM, the Assistant Director of Nursing (ADON) said that he/she completed competency assessments during new hire on-boarding, skills fairs, and annual reviews. The ADON presented a PPE Donning/Doffing Checklist Competency form for LPN1 dated 11/04/25, that reflected LPN1 met donning and doffing of PPE requirements. The ADON signed and dated the form on 11/04/25.Review of the facility's policy titled, Personal Protective Equipment dated October 2018, revealed, 1. Personnel who perform tasks that may involve exposure to blood/body fluids are provided appropriate personal protective equipment (PPE) at no charge.3. Not all tasks involve the same risk of exposure, or the same kind or extent of protection. The type of PPE required for a task is based on: (a) the type of transmission-based precaution;(b.) the fluid or tissue to which there is a potential exposure; (c.) the likelihood of exposure; (d.) the potential volume of material; (e.) the probable route of exposure; and (f.) the overall working conditions and job requirements.5. Training on the proper donning, use and disposal of PPE is provided upon orientation and at regular intervals.2. Review of R40's electronic medical record (EMR) revealed an undated admission Record, located under the Profile tab with an admission date of 12/23/25, with diagnoses of wedge compression fracture, atherosclerotic heart disease, and muscle wasting.Review of the R40's Physician Orders, located in the EMR under the Orders tab revealed on 12/31/25, flu place resident in droplet isolation.During an observation on 01/06/26 at 10:37 AM, a sign was posted on R40's door stating droplet precautions and it had pictures of a gown, gloves, mask, and eye wear.During an observation on 01/06/26 at 11:19 AM, Certified Nursing Assistant (CNA)2 put on a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown, gloves and mask and went into the room.During an interview on 01/06/26 at 11:22 AM, CNA2 was asked to look at the sign to see if everything that should have been worn was worn. CNA2 stated that the eye wear was not worn. CNA2 also stated that no personal care was provided.During an interview on 01/08/26 at 9:44 AM, the Director of Nursing (DON) was asked what the expectations were when droplet isolation was put into place. The DON stated the expectation was for the staff to follow the sign and guidance. During an interview on 01/08/26 at 3:19 PM, the IP was asked about expectations for following the precautions. The IP stated all PPE indicated on the sign should be worn for droplet precautions. Review of the facility policy titled, Personal Protective Equipment revised October 2018, revealed, Policy Statement: Personal protective equipment appropriate to specific task requirements is available at all times. NJAC 8:39-19.4

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to promote a dignified dining experience by standing to feed two of 15 residents (Resident (R)42 and R101) reviewed for dignity while dining on the Memory Care Unit. This failure had the potential to negatively impact the quality of life for the affected residents.Findings include:1.Review of the admission Record, located in the electronic medical record (EMR) under the Profile tab revealed R42 was admitted on [DATE], with diagnoses including dementia with anxiety, aphasia, and dysphagia.Review of the modified Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/25, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated R42 was severely cognitively impaired.2.Review of the admission Record, located in the EMR under the Profile tab revealed R101 was admitted on [DATE], with diagnoses that included Alzheimer's disease and aphasia. Review of the quarterly MDS with an ARD of 09/18/25, revealed a BIMS score of three out of 15 which indicated R101 was severely cognitively impaired.An observation of the assisted dining room on 01/07/26 at 12:20 PM, revealed 15 residents waiting for lunch. Residents were observed talking, asking to eat, yelling out, and were encouraged to sit down when standing. Six staff members were in the dining room at the time of the observation. At 12:20 PM, the first meal cart arrived to be delivered to the residents who chose to eat in their rooms. At 12:47 PM, the tray cart for the assisted dining room arrived. R42's lunch tray was not on the cart. R101 was served his/her meal and was eating with verbal encouragement from staff as they were passing trays. R42 was observed to reach for R101's food as he/she had none. A certified nursing assistant (CNA3) observed R42 attempting to eat R101's food, obtained a container of yogurt for R42, and encouraged him/her to eat the yogurt as his/her tray had not arrived. At 12:56 PM, CNA3 was observed standing next to R42, assisting him/her to eat the yogurt. CNA3 was asked if he/she should stand to assist a resident to eat or sit next to them. CNA3 stated, We're waiting for the next cart. I know I'm supposed to sit. R42's tray arrived at 1:08 PM. At 1:05 PM, Registered Nurse (RN3) was observed standing next to R101 and assisting him/her to drink his/her juice. When asked if he/she should stand to assist a resident to eat or sit next to them, RN3 stated, Oh yes, I should have gotten a chair. During an interview on 01/08/26 at 9:31 AM, the Unit Nurse Manager, Licensed Practical Nurse (LPN3) said, Staff are expected to sit to assist residents to eat. I should have gotten chairs for them.During an interview on 01/08/26 at 12:15 PM, with the Administrator, Director of Operations, and the Director of Nurses (DON), the Administrator stated, they should sit next to residents, when assisting a resident with their meals.Review of the facility's policy titled, Assistance with Meals dated 03/22, revealed, Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity for example, not standing over residents while assisting them with meals. NJAC 8:39-4.1(a)12

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on observations, record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure a Significant Change Minimum Data Set (MDS) assessment was completed within 14 calendar days after one of one resident (Resident (R) 36 elected hospice benefits out of a sample of 33 residents. This failure could potentially place the resident(s) at risk for unmet care needs being addressed, coordination of hospice care, and care planning of the resident.Findings include:Review of the RAI Manual, dated 10/01/2019, indicated under Section A0310A=04 Significant Change in Status Assessment (SCSA) The SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change in guidelines for either major improvement or decline.An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program.and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice election.An SCSA must be performed regardless of whether as assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place.During an observation and interview on 01/05/26 at 10:00 AM, R36 was observed in his/her room and confirmed he/she was receiving hospice services.Review of R36's facility Physician orders, dated 08/25/25, and located under the Orders tab in the electronic medical record (EMR) indicated, Admit to [name of hospice agency].Review of R36's [name of hospice agency] documentation located in a white hospice binder at the nurse's station indicated R36 was admitted to hospice services on 08/22/25, for a terminal diagnosis of malignant neoplasm of overlap sited of bronchus and lung.Review of R36's significant change MDS with an ARD of 09/21/25 and located in the residents EMR under the MDS tab revealed R36 was currently receiving hospice services. Further review of the significant change MDS revealed it was not completed within 14 days from when R36 elected hospice benefits. The significant change MDS section regarding hospice services revealed it was not signed as being completed by the MDS Coordinator until 09/24/25. This was 33 days after receiving the hospice physician order to be placed on hospice services.During a phone interview on 01/07/26 at 10:26 AM, the Hospice Clinical Director with the [name of hospice company] stated R36 has been receiving hospice services since 08/22/25, and has not come off hospice services.During an interview on 01/07/26 at 11:56 AM, when reviewing R36's EMR with the MDS Coordinator (MDSC)1, he/she confirmed R36 went onto hospice services on 08/22/25. The MDS Coordinator then stated, Whenever there is a significant change, the sig [sic] change MDS has to be put in within 14 days of that change. The MDS Coordinator confirmed that he/she completed the hospice section of the significant change MDS and signed it as being completed on 09/24/25. When asked why it was not completed within the required 14 days, she stated, I don't know why. I just missed it.During an interview on 01/07/26 at 12:16 PM, when reviewing R36's EMR with the Director of Nursing (DON) regarding the timeliness of significant change MDS, the DON confirmed R36 went onto hospice services on 08/22/24. The DON stated, I'm also seeing the sig [sic] change portion for hospice services was signed and completed by the [name of the MDS Coordinator] on 09/24/25. The DON confirmed it was not completed within the required 14-day requirement and stated, It would be my expectation that we are completing the documentation within the required timeframe.During an interview on 01/07/26 at 4:24 PM, when reviewing R36's EMR with the Regional MDS Coordinator regarding the completion of the significant change MDS for R36, he/she confirmed the sig [sic] change MDS was not completed within 14 days of coming on hospice services and stated, It was not done when it should have been within the 14 day requirement. NJAC 8:39-11.2(i)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observations, record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for two of 33 sampled residents (Residents (R) 9 and R36) receiving hospice services. Failure to ensure the accuracy of the MDS for residents receiving hospice services could lead to inaccurate assessment, place the residents at risk for unmet care needs being addressed, and care planning of the residents.Findings include: Review of the RAI Manual, dated 10/01/2019, indicated under Section J1400 Prognosis: indicated Definition: Condition or chronic disease that may result in a life expectancy of less than 6 months; In the physician's judgement, the resident has a diagnoses or combination of clinical conditions that have advanced or will continue to advance to a point that the average resident with that level of illness would not be expected to survive more than 6 months. This judgement should be sustained by a physician note.Steps for Assessment: 1. Review the medical record for documentation by the physician that the resident's condition of chronic disease may results in a life expectancy of less than 6 months, or that they have a terminal illness. 2. If the physician states that the resident's life expectancy may be less than 6 months, request that he or she document this in the medical record.3. Review the medical record to determine whether the resident is receiving hospice services. Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. Code 1, yes: if the medical record includes physician documentation: 1) that the patient is terminally ill; or 2) the resident is receiving hospice services.'Terminally ill' means that the individual has a medical prognoses that his or her life expectancy is 6 months or less if the illness runs its normal care; Code residents identified as being in a hospice program for terminally ill persons.1.During an observation on 01/06/26 at 9:30 AM, R9 was observed in his/her room lying in bed. R9 was also observed to be non-interviewable at this time.Review of R9's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an admission date to hospice services on 02/17/23, with medical diagnoses that included dementia with behavioral disturbances.Review of R9's Physician order, dated 02/17/23, and located under the Orders tab in the EMR revealed hospice eval [evaluation] and tx [treatment]. Review of R9's Care Plan, located in the EMR under the Care Plan tab and initiated on 02/21/23, indicated, I have a terminal prognosis r/t [related to] Alzheimer's. Interventions indicated, I 'am receiving hospice services through [name of hospice agency].Review of R9's [name of hospice agency] most recent hospice physician face-to-face encounter note located in a [name of hospice company] white binder located at the nurses station and dated 11/10/25 indicated, I certify the patient is terminally ill with a life expectancy of six (6) months or less if the disease process runs its normal course.Review of R9's [name of hospice agency] physician orders located in a [name of hospice company] white binder located at the nurses station dated 11/25/25, indicated Patients medical prognosis is that their life expectancy is 6 months or less and the terminal illness is running its normal course as evidenced by following clinical findings: Alzheimer's disease and senile degeneration of the brain.Review of R9's quarterly MDS, with an Assessment Reference Date (ARD) of 12/02/25, and located in the resident's EMR under the MDS tab revealed Section J1400 Prognosis was completed by the MDS Coordinator on 12/08/25. It further indicated the MDS was coded as No to the question of does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months. The MDS further indicated that R9 was receiving hospice services when the MDS was completed.During a phone interview on 01/07/26 at 11:04 AM, the Hospice Registered Nurse (RN)4 with the [name of hospice company] confirmed the terminal diagnoses of R9 and stated R9 has been on hospice services since 02/21/23. RN4 further stated that R9 has never come off hospice services.During an interview on 01/07/26 at 11:56 AM, when reviewing R9's EMR with the MDS Coordinator (MDSC)1, he/she confirmed that he/she completed R9's quarterly MDS sections for terminal illness and hospice services on 12/08/25. The MDS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinator confirmed that he/she coded the terminal prognosis of R9 as no and further coded R9 as receiving hospice services as a yes. The MDS Coordinator stated, I just missed it, I guess. It should have been coded as yes for the terminal prognoses.During an interview on 01/07/26 at 12:16 PM, when reviewing R9's EMR with the Director of Nursing (DON), the DON confirmed R9 began receiving hospice services on 02/21/23. When reviewing the quarterly MDS for R9 and the inaccuracies between the section of terminal prognosis of less than 6 months and hospice services, the DON was asked what her expectation would be for accurate coding of the MDS, she stated, I would assume they review the records when completing their sections of the MDS and make sure we are reviewing all documentation. I'm seeing the coding was not accurate. It would be my expectation that when completing the MDS, they are being coded accurately. During an interview on 01/07/26 at 4:24 PM, when reviewing R9's EMR with the Regional MDS Coordinator, he/she stated, According to the RAI manual, which is what we would follow, it would be the expectation that both sections (referring to the terminal prognosis and hospice services of the MDS) match. I can see that the section for terminal illness is marked as no, and I see he/she has been receiving hospice services since 2023. It would be an error on our part as they should match.2. During an observation and interview on 01/05/26 at 10:00 AM, R36 was observed in his/her room and, he/she confirmed that she was receiving hospice services.Review of R36's facility Physician orders, dated 08/25/25, and located under the Orders tab in the EMR indicated, Admit to [name of hospice agency].Review of R36's [name of hospice agency] documentation located in a white hospice binder at the nurse's station indicated R36 was admitted to hospice services on 08/22/25. The hospice documentation indicated on 08/27/25, the physician certified that the patient's prognosis is six months or less if the disease runs its normal course. The terminal diagnosis was Malignant neoplasm of overlap sites of bronchus and lungs.Review of R36's [name of hospice agency] Hospice Physician Narrative, for certification benefit period of 08/22/25 to 11/19/25 [located in the white hospice binder at the nurse's station] indicated an admission to hospice services on 08/22/25. It further indicated, Prognosis given the ongoing cognitive and functional decline and recent infections life expectancy is estimated to be less than 6 months.Review of R36's [name of hospice agency] Hospice Certification and Plan of Care, with a certification benefit period of 08/22/25 to 11/19/25 [located in the white hospice binder at the nurses station] indicated the terminal diagnoses, and also signed by the physician on 09/02/25 indicating I certify/recertify the patient is terminally ill with a life expectancy of six (6) months or less if the disease process runs its normal course.Review of R36's Hospice Physician Orders, located in the [name of hospice agency] white hospice binder at the nurse's station and dated 11/05/25 indicated, Terminal Diagnosis of malignant neoplasm of overlap sites of bronchus and lung. Patient continues to meet eligibility for hospice services.Review of R36's [name of hospice agency] Hospice Physician narrative, for certification benefit period of 11/20/25 to 02/17/26, located in the white hospice binder at the nurses' station indicated, Prognosis given the ongoing and functional decline, poor nutrition status and recent infections, life expectancy is estimated to be less than 6 months.Review of R36's significant change MDS, with an ARD of 09/21/25, and located in the residents EMR under the MDS tab revealed Section J1400 Prognosis was completed by the MDS Coordinator on 09/24/25. It further indicated the MDS was coded as No to the question of does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months. The MDS further indicated that R36 was receiving hospice services when the MDS was completed.Review of R36's quarterly MDS, with an ARD of 12/22/25, and located in the residents EMR under the MDS tab revealed Section J1400 Prognosis was completed by the MDS Coordinator on 12/31/25. It further indicated the MDS was coded as No to the question of does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months. The MDS further indicated that R36 was also receiving hospice services when the MDS was completed.During a phone interview on 01/07/26 at 10:26 AM, the Hospice Clinical Director with the [name of hospice company] stated that R36 has been receiving hospice services since 08/22/25, and had not come off hospice services.During an (continued on next page)

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Willow Springs Rehabilitation and Healthcare Ctr	1049 Burnt Tavern Road Brick, NJ 08724

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 01/07/26 at 11:56 AM, when reviewing R36's EMR with theMDSC1 he/she confirmed that he/she completed R36's significant change MDS sections for terminal illness and hospice services on 09/22/25. He/she also confirmed he/she completed R36's quarterly MDS on 12/31/25. The MDS Coordinator confirmed he/she coded the terminal prognosis of R36 as no and further coded R36 as receiving hospice services as a yes on both the significant change MDS and quarterly MDS. He/she then stated, I just missed it. During an interview on 01/07/26 at 12:16 PM, when reviewing R36's EMR with the DON, the DON confirmed R36 began receiving hospice services on 08/22/25. When reviewing the significant change MDS and the quarterly MDS for R36 and the inaccuracies between the section of terminal prognosis of less than 6 months and hospice services, the DON stated, It would be my expectation they are completed accurately. NJAC 8:39-33.2(d)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure two of 33 sampled residents (Resident(R)7 and R174) received a baseline care plan within 48 hours of admission into the facility. This deficient practice had the potential to allow residents not to receive the instructions for a person-centered care plan after admission. Findings include:1.Review of R7's admission Record, located in the electronic medical record (EMR) under the Profile tab revealed R7 was admitted to the facility on [DATE], with diagnoses of muscle wasting, heart failure, and falls.Review of the Progress Notes, located in the EMR under Progress Notes revealed an Initial Navigation Guide Meeting note dated 10/15/25, revealed the review of the baseline care plan was completed13 days after R7's admission.2.Review of R174's admission Record, located in the EMR under the Profile tab revealed R174 was admitted to the facility on [DATE], with diagnoses of trauma ischemic muscle, type two diabetes, and hypertension.Review of the Progress Notes, located in the EMR under Progress Notes revealed an Initial Navigation Guide Meeting note dated 12/31/25, revealed the review of the baseline care plan was completed five days after R174's admission. During an interview on 01/08/26 at 9:54 AM, the Director of Nursing (DON) stated the baseline care plan should be discussed with the resident and family and should be completed within 48 hours after admission. [NAME] an interview on 01/08/26 at 10:15 AM, the Social Service Director (SSD) was asked about the baseline care plan being discussed within 48 hours of admission. The SSD stated the team of social services and nursing meet with the family and/or residents within 48 hours to discuss the baseline care plan. When asked about the date of 10/15/25, for R7's meeting the SSD stated there should have been a meeting within 48 hours and that was not met. The SSD was asked to review R174's meeting date. The SSD stated the resident came in late on a Friday evening, so it was probably done on the following Monday after the weekend. When the SSD reviewed the day, the SSD stated it was on a Wednesday, and the care plan should have been done before then. Review of the revised facility policy titled, Care Plan-Baseline, dated March 2022, revealed Policy Statement: A baseline plan of care to meet resident's immediate health and safety needs developed for each resident within forty-eight (48) hours of admission. NJAC 8:39-11.1;11.2

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record reviews, interviews, and facility policy review, the facility failed to ensure a person-centered comprehensive care plan was developed for one of one resident (R36) receiving hospice services out of a total of 33 sampled residents. This deficient practice placed the resident at risk for unmet resident care needs.Findings include:During an observation and interview on 01/05/26 at 10:00 AM, R36 was observed in his/her room and confirmed that he/she was receiving hospice services.Review of R36's facility Physician orders, dated 08/25/25, and located under the Orders tab in the electronic medical record (EMR) indicated, Admit to [name of hospice agency].Review of R36's [name of hospice agency] documentation located in a white hospice binder at the nurse's station indicated R36 was admitted to hospice services on 08/22/25 with a terminal diagnosis to include malignant neoplasm of overlap sites of bronchus and lungs.Review of R36's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/21/25, and located in the residents EMR under the MDS tab revealed R36 was receiving hospice services.Review of R36's Care Plan, and located in the EMR under the Care Plan tab initiated on 11/12/25, indicated, I have a terminal prognosis r/t [related to] cancer of the lung. Further review of R36's EMR revealed there was no additional care plan implemented prior to 11/12/25, regarding hospice services and/or a terminal diagnosis with measurable goals and interventions related to hospice services.During a phone interview on 01/07/26 at 10:26 AM, the Hospice Clinical Director with the [name of hospice company] stated that R36 had been receiving hospice services since 08/22/25, and had not come off hospice services.During an interview on 01/07/26 at 11:56 AM, when reviewing R36's EMR with the MDS Coordinator (MDSC)1, he/she confirmed R36 went on hospice services on 08/22/25. MDSC1 further confirmed that the comprehensive care plan was not developed or initiated until 11/12/25, by stating, I'm seeing it was not done.During an interview on 01/07/26 at 12:16 PM, when reviewing R36's EMR with the Director of Nursing (DON) regarding the comprehensive care plan for hospice services, the DON stated, I would assume and it would be my expectation that the staff complete the comprehensive care plan around the time he/she [referring to R36] went on hospice services. The DON confirmed the comprehensive care plan was not implemented for R36 regarding hospice services until 11/12/25.During an interview on 01/07/26 at 12:30 PM, when reviewing R36's EMR with the Registered Nurse (RN)2 regarding the comprehensive care plan, he/she confirmed that he/she initiated R36's comprehensive care plan for terminal illness on 11/12/25. He/she stated, I was fairly new to the facility and when I started working here in October, and I started going through the care plans to see which ones were not done or updated. This was one of them.During an interview on 01/07/26 at 4:24 PM, when reviewing R36's EMR with the Regional MDS Coordinator he/she stated, The Care plans are opened the day after the ARD of the MDS is done and when I reviewed the chart. I also saw the comprehensive care plan was not completed for hospice services until 11/12/25.Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual, or Significant Change in Status), and no more than 21 days after admission. NJAC 8:39-11.2(e) thru(i)NJAC 8:39-27.1(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure feeding tube placement was verified prior to administering a nutrition supplement for one of two residents (Resident (R) 89) reviewed with feeding tubes out of a total sample of 33. This failure had the potential to place residents at risk of aspiration and hospitalization.Findings include:Review of R89's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R89 was admitted to the facility on [DATE], with diagnoses that included stroke, non-Alzheimer's dementia, aphasia (difficulty speaking), and a feeding tube.Review of R89's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/13/25, and located under the MDS tab of the EMR, revealed R89 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R89 was cognitively intact.Review of R89's undated Physician Orders, located under the Orders tab of the EMR, reflected the following orders: Enteral Feed Order four times a day. Give Jevity 1.5 Bolus Feeding of one container (237 mLs), four times daily as listed and crush medications per manufacturer recommendations (do not crush enteric coated or extended-release medications, or those not approved by manufacturer) and mix in 5mL warm water each. Confirm placement, flush with 30 mL of warm water, administer medications individually flushing with 15 mLs of warm water in between, and with 30 mLs of warm water after all meds are given.During an observation of medication pass on 01/07/26 at 11:25 AM, Licensed Practical Nurse (LPN)1 administered Jevity 1.5 bolus feeding. LPN1 did not verify placement before administering the nutrition supplement.During an interview on 01/07/26 at 11:53 AM, LPN1 indicated that he/she forgot to verify the gastric tube placement before administering the bolus feeding. LPN1 said that tube placement was verified by pulling back gastric residual in a syringe. LPN1 stated that the risk of not verifying gastric tube placement was aspiration.During an interview and record review on 01/08/26 at 4:30 PM, the Assistant Director of Nursing (ADON) said that he/she completed competency assessments during new hire on-boarding, skills fairs, and annual reviews. The ADON presented an Enteral Tube Feeding Continuous Pump Competency Assessment for LPN1 dated 11/05/25, that reflected LPN1 demonstrated competency in enteral feedings following general guidelines. The ADON entered his/her initials as the observer next to each task, checked yes that competency was demonstrated, signed, and dated 11/05/25.Review of the facility's policy titled, Maintaining Patency of a Feeding Tube (Flushing), revealed . 5. Confirm placement of tube.6. For intermittent feeding, flush with warm purified water before and after the feeding. 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 facility policy review, the facility failed to ensure oxygen (O2) concentrators had filters or were free of dust for one of one sampled resident (Resident (R)66) out of a sample size of 33. This failure had the potential for residents to have an increased chance of unnecessary respiratory treatments and/or infection.Findings include:During an observation on 01/05/26 at 2:19 PM, R66 was wearing an oxygen canula connected to an O2 concentrator. The cabinet filter had a layer of dust and lint.During an observation on 01/07/26 at 9:12 AM, R66 was wearing an oxygen canula connected to an O2 concentrator. The cabinet filter had a layer of dust and lint.During an observation and interview on 01/08/26 at 9:41 AM, The Director of Nursing (DON) was shown the filter, and the DON confirmed the filter had lint that should not be there. The DON stated they were just out here servicing the concentrators. Review of R66's electronic medical record (EMR) located under the Profile tab was an undated admission Record, with an admission date of 11/26/25, with diagnoses of chronic obstructive pulmonary disease (COPD) and atelectasis. Review of R66's Physician Orders, located in the EMR under the Orders tab revealed on 11/28/25, intermittent oxygen as needed at 2 liters per minute to keep saturation greater than 90%. Additional orders dated 11/28/25, revealed change oxygen tubing, humidifier and clean filter weekly on Tuesday 11/7 shift and as needed for soiling or damage.Review of the revised November 2011 facility policy titled, Departmental (Respiratory Therapy)- Prevention of Infection revealed Purpose: the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment.9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. NJAC 8:39-27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interviews, the facility failed to pharmacy implement processes for receiving controlled substances (CS) for two (Cedar Unit - High Side and Cedar Unit - Low Side Medication Carts) of three medication carts observed for medication storage and labeling. This failure had the potential to create a risk of drug diversion, theft, improper handling of returns, all impacting patient safety and compliance.Findings include:Observation of the medication cart on Cedar - High Side on 01/07/26 at 10:09 AM, with Licensed Practical Nurse (LPN)4 revealed the following controlled substance inventory log sheets of the logbook for controlled medications located on the medication cart, were missing all required components such as the Rx number (a unique identifier assigned to your specific prescription by the pharmacy), Rx date (date controlled substances were issued by pharmacy), and/or the controlled substance label directions:Page (pg) 147 - no Rx numberPg 148 - no Rx number, no Rx datePg 154 - no Rx number, no Rx datePg 155 - no label directionsPg 156 - no Rx number, no Rx date, no label directionsPg 169 - no Rx number, no Rx datePg 172 - no Rx number, no Rx dateDuring an interview on 01/07/26 at 10:45 AM, LPN4 said that the nurses, who received the narcotics and controlled substances, from the pharmacy were responsible for transcribing the resident's name, prescribing doctor, directions for medication administration as printed on the label, the Rx number, and the Rx issue date on the inventory sheet. LPN4 said that the pharmacist consultant also checked the inventory logbooks when on-site to audit the medication carts. LPN4 said that he/she did not ensure the inventory sheets were complete before logging controlled medications that he/she removed for administration.Observation of the medication cart on Cedar - Low Side on 01/07/26 at 10:55 AM, with LPN5 revealed the following controlled substance inventory log sheets of the logbook for controlled medications located on the medication cart, were missing all required components such as the Rx number, Rx date, and/or the controlled substance label directions:Pg 45 - no label directionsPg 58 - no label directionsPg 65 - no label directionsPg 67 - no Rx numberPg 70 - no Rx numberPg 72 - no Rx numberPg 72 - no Rx number, no Rx date, no label directionsPg 79 - no label directionsDuring an interview on 01/07/26 at 10:59 AM, LPN5 said he/she did not notice the inventory sheets were incomplete when he/she documented medications were removed from the narcotic drawer. LPN5 said incomplete sheets without the label directions could place residents at risk for harm if not administered correctly. He/she also stated the poor record-keeping could cause the narcotic count to be incorrect. During an interview on 01/07/26 at 11:15 AM, the Director of Nursing (DON) said that the nurses and Unit Manager were responsible for overseeing procedures that prevented drug diversion such as monitoring the inventory log sheets and actual narcotic count. The DON said that the pharmacy consultant also audited the medication carts every two to three months to ensure that the facility complied with policies and procedures. The DON said that he/she would ensure that the logbook for controlled medications was completed following the facility process.Review of Consultant Pharmacist Services Med Room and Med Cart Audit forms provided by the DON, dated 12/10/25, revealed an audit of the Cedar Unit was conducted by the Consultant Pharmacist. The results in the Controlled Drugs section, reflected Receipt of Controlled Substances: Is Rx Number, Date, Drug, Dose, Amount Received and Directions complete in the logbook (spot check sample of 10 pages per book) was answered no. A comment followed, Rx number, Rx date and directions must be included in logbook for each drug.A request for a specific facility policy about Controlled Substances was made on 01/07/26 at 11:30 AM and 01/08/26 at 4:00 PM. This was not received before the survey exit. NJAC 8:39-29.7(c)

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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, policy review, and interviews, the facility failed to remove expired medications stored in two of three medication carts (Cedar Unit - High Side and Cedar Unit - Low Side Medication Carts) observed for medication storage and labeling. This failure had the potential for reduced effectiveness or ineffective treatment of medical issues and was at risk for bacterial growth.Findings include:Observation of the Cedar - High Side medication cart on 01/07/26 at 10:09 AM, with Licensed Practical Nurse (LPN)4 revealed the following expired (over the counter (OTC) medications:Zinc 50 mg (milligrams) tablets - expiration date 08/2025; opened 10/06/24Dairy Aid tablets - expiration date 08/2025; opened 11/20/24Folic Acid 800 mcg (micrograms) tablets - expiration date 09/2025; No open dateFish Oil 1000 mg softgels - expiration date 12/2025; No open dateFish Oil 1200 mg softgels - expiration date 11/2025; No open dateDuring a continued observation of the medication cart on Cedar - High Side on 01/07/26 at 10:14 AM, with LPN4 four Potassium chloride extended release (ER) 10 milliequivalent (mEq) (750 mg) tablets in daily dose packs were not labeled for an individual resident and one bottle of OTC Advil liquid gels with a resident's name written on the bottle who had been discharged from the facility were observed. During an interview on 01/07/26 at 10:45 AM, LPN4 said that the nurses, who worked on the medication carts, were responsible for checking the cart for expired medications. LPN4 said that the pharmacist consultant also checked the carts when on-site for expired medications and compliance with pharmacy services. LPN4 said that she checked the OTC medications expiration date before medications were administered to a resident. LPN4 said the appropriate procedure was to remove the medication from the cart and place it in the medication room for disposal.Observation of the medication cart on Cedar - Low Side on 01/07/26 at 10:55 AM, with LPN5 revealed a vial of Tuberculin Purified Protein Derivative (Mantoux) Test dose that must remain refrigerated, was stored in the top drawer. The box the vial was placed in had a label that read, discard opened product after 30 days. There was no open date.During an interview on 01/07/26 at 10:59 AM, LPN5 said that the Tuberculin Purified Protein Derivative (Mantoux) Test was administered to residents and the multi-dose vial should be dated and refrigerated. LPN5 could not state when the vial was opened or how long the vial had been in the medication cart.During an interview on 01/07/26 at 11:15 AM, the Director of Nursing (DON) said that the nurses and Unit Manager were responsible for checking the medication carts for expired medications and removing the expired medications. OTC and prescription medications should be checked for expiration dates before they are administered to residents. The DON said that the pharmacy consultant also audited the medications carts every two to three months to ensure that the facility was complying with policies and procedures. The DON said that all expired medications must be removed from the active supply and destroyed in accordance with facility policy, regardless of the amount remaining.Review of the facility's policy titled, Medication Labeling and Storage, dated 2001, revealed .3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 6. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secure location. Medications are stored separately from food and are labeled accordingly. NJAC 8:39-29.4