STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315231	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center for Rehab & Nursing Washington Township	535 Egg Harbor Road Sewell, NJ 08080

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50919 Complaint#: NJ182815 Based on observations, interviews, and review of other facility documentation on 3/5/2025 and 3/6/2025, it was determined that the facility failed to maintain a homelike environment for residents that included access to clean linens. The deficient practice was identified for 1 of 1 nursing units observed. This deficient practice was evidenced by the following: During a tour of the 500 Unit on 3/5/2025 at 10:55 AM, the surveyor asked what the resident census was on the unit, and the Resource Nurse/Registered Nurse (Resource/RN) stated 30 residents. At 11:36 AM, the surveyor toured the 500 High Hallway Linen Room and observed four wash cloths on the shelf. At 11:38 AM, the surveyor toured the linen room for the 500 Low Hallway Linen Room and observed three wash cloths on the shelf. The surveyor reviewed the Resident Council Meeting Minutes dated 12/19/2024, 1/3/2025, and 1/30/2025 which revealed resident complaints on the lack of linens available for resident care. On 3/5/2025 at 1:07 PM, the surveyor interviewed the Housekeeper (HK) who was working in the laundry room. The HK stated that the linen was delivered to the units twice a day. The HK indicated that PAR levels (the amount of inventory established by the facility) were used to determine the number of linens that go on each linen cart. The HK stated that there were always resident complaints about linens and that there were not enough towels and washcloths in the facility. On 3/5/2025 at 2:41 PM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that there were three washcloths in the linen room this morning. CNA #1 indicated the linens were delivered to the unit late every day, usually after 10:30 AM. CNA #1 indicated there were times, when she had to wait for linen to come to the unit, which resulted in her cutting a bath blanket to be able to provide care to the residents. On 3/5/2025 at 3:17 PM, the surveyor interviewed the Housekeeping Director (HD) who stated that the PAR levels for the linen were low and identified there needed to be changes made. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315231	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER: The Center for Rehab & Nursing Washington Township		STREET ADDRESS, CITY, STATE, ZIP CODE: 535 Egg Harbor Road Sewell, NJ 08080	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/5/2025 at 4:10 PM, the surveyor interviewed the Director of Nursing (DON) who stated she was aware of not having enough linens in the facility. The DON indicated that the facility investigated and found that the staff were throwing away linens due to improperly labeled bins in the soiled linen room. On 3/6/2025 at 10:20 AM, the surveyor toured the 500 Low Hallway Linen Room and observed no washcloths and three towels. At 12:07 PM, the surveyor conducted a tour of the 500 Unit High hallway Linen Room and observed no washcloths and three towels. At 12:10 PM, the surveyor did a follow-up tour of the 500 Low Hallway Linen Room and observed no washcloths and towels. On 3/6/2024 at 12:11 PM, the surveyor interviewed the Resource/RN who confirmed there were no washcloths and three towels in the 500 Unit High Hallway Linen Room and no washcloths and towels in the 500 Unit Low Hallway Linen Room. The Resource/RN indicated that the lack of linens had been an ongoing issue and staff would have to call the laundry to bring more linens to the unit. The Resource/RN stated there were times when the staff had to cut bath blankets to provide resident care. On 3/6/2025 at 1:58 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and the survey team who stated that he was aware of the issue with the lack of linen, and it was brought up in the last Resident Council meeting. The LNHA stated that he had ordered more linens to help resolve the issue. The LNHA indicated that linens should always be readily accessible to residents. The LNHA stated that he thought the staff calling laundry for linens was considered readily accessible. On 3/6/2025 at 2:05 PM, the DON in the presence of the LNHA and the surveyor team stated that it was not acceptable for staff to use bath blankets to provide care to the residents in place of towels and washcloths. NJAC 8:39-21.3 (a)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45622 Complaint #: NJ184057 Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation on 03/05/2025 and 03/05/2025, it was determined that the facility failed to update and revise a resident's care plan, specifically for a newly identified wound, for 1 of 1 resident reviewed for comprehensive person-centered care plans, (Resident #4). This deficient practice was evidenced by the following: A review of the Admission Record (an admission summary) reflected that Resident #4 was admitted to the facility with diagnoses that included but were not limited to: Anemia (low healthy red blood cells and hemoglobin), Depression (feeling of sadness), and Muscle Weakness. A review of the admission Minimum Data Set, an assessment tool used to facilitate the management of care dated 01/12/2025, reflected that the resident had a Brief Interview for Mental Status score of 14 out of 15, indicating that the resident was cognitively intact. Section M0100 revealed no pressure ulcer. A review of Resident #4's Care Plan (CP) initiated on 01/06/2025 included under Focus At risk for alteration in skin integrity related to fragile skin and immobility. A review of Resident #4's Progress Notes (PNs) dated 01/23/2025 revealed the following written by LPN #1: Aide [certified nursing assistant] informed me today that patient [Resident #4] has a skin tare in the sacral area. Cleaned with NSS [normal saline solution], and applied Medi honey and dry border gauze. Risk management note done and wound consult in chart. A review of Resident #4's wound care notes with an effective date of 01/28/2025 revealed the following wound care recommendations: Wound Location: Sacrum Etiology: old pilonidal cyst reopened Signs of infection: none Size: 2 cm x 2 cm x 0.5 cm Tissue type: necrotic Drainage: mod serous Peri wound: intact (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315231	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER: The Center for Rehab & Nursing Washington Township		STREET ADDRESS, CITY, STATE, ZIP CODE: 535 Egg Harbor Road Sewell, NJ 08080	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Edema: none Description: none Dressing: Dakin's dressing A review of Resident #4's CP showed no updates with interventions of the aforementioned. On 03/05/2025 at 4:03 P.M., during an interview with the Resource Nurse/Registered Nurse, the surveyor asked what was the importance of the CP and who was reposnsible to update the CP? In the presence of another surveyor, the Resource Nurse/ Registered Nurse said she was unable to answer the question. On 03/05/2025 at 4:05 P.M., during an interview with the Director of Nursing (DON), she stated the importance of the CP is how the team stays updated on the resident's needs, and what care needs to be provided for the resident. The DON stated the CP should be updated or revised with any new change in a resident's condition. When presented Resident #4's CP, the DON confirmed the CP was not revised or updated to reflect an actual skin breakdown on 01/23/2025. She said the CP should have been updated and revised once the resident (Resident #4) developed a wound. The observation of the wound and interventions should have been on the CP. She further stated the Interdisciplinary Team (nurses, social worker, therapist,) is responsible to initiate and/or revise the CP A review of the facility's policy with a revised date of 01/2025 titled Care Plans, Comprehensive, Person-Centered under Policy Statement reveals 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. Under Policy Interpretation and Implementation #13. Assessments of residents are ongoing, and care plans are revised as information about the residents and residents' NJAC 8:39-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. 45622 Complaint #: NJ184057 Based on observation, interview, and review of pertinent facility documents on 03/05/2025 and 03/05/2025, it was determined that the facility failed to: a.) ensure the treatment cart was secured during wound care observation, b.) initial, date, and time a dressing prior to applying on a resident (R#4) in accordance with professional standards of clinical practice. The facility also failed to follow its policies titled Storage of Medications and Wound Care This deficient practice was identified for 1 of 1 resident observed for wound 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 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. On 03/05/25 at 12:00 P.M., the surveyor observed the Registered Nurse (RN#1) parked the treatment cart outside the door of Resident #4's room. RN#1 performed hand hygiene, don clean gloves, and gathered all supplies needed and proceeded to the resident's room to perform wound care. RN#1 left the treatment cart unlocked and walked to Resident #4's room who was in bed and pulled the resident's privacy curtain. The treatment cart was out of the line of sight of RN#1 and no residents were observed present in the hallway and by the treatment cart. RN#1 was observed performed wound care after which she applied a clean dressing to the resident's wound without initials, date or time. On 03/05/2025 at 12:45 P.M., during an interview with RN#1, she stated the treatment cart should always be locked. She said its important to keep the treatment and medication carts always locked to avoid residents from getting into the carts. RN#1 acknowledged the treatment cart was unlocked and left unattended while performing wound care for Resident #4. RN#1stated if a treatment cart is left unlocked, a resident could get an ointment to ingest or rub causing harm or injury to the resident. During the same interview, RN#1 confirmed the dressing for Resident #4 was not initial, dated or time prior to application on the resident's wound. She stated the importance of dating, timing and writing the initial on a dressing is so that other staff caring for the resident knows the last time the wound care was performed for the resident. She stated, I should have initial, timed and dated the dressing prior to applying the dressing on the resident's wound. On 03/05/2025 at 1:00 P.M., during an interview with the Resource Nurse/RN, she stated all wound dressings should have an initial, date and time written on it prior to applying on a resident's wound. She stated it was important so that staff are aware of the last time the dressing change was completed. The Resource Nurse/RN also stated the medication and treatment carts should be locked unless I am standing there, it is important for safety. If a resident got into a medication cart or treatment cart, there could be a potential for harm or injury to the resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 03/05/2025 at 4:10 P.M. during an interview with the Director of Nursing (DON), she stated my expectation is for all dressings to be dated with the nurse's initials and time prior to applying the dressing. The DON also said the medication and treatment carts should be locked by the nurse when not in use. Its is important because of the safety of the residents. A review of the facility's policy titled Storage of Medications with a revised date of 6/2024, under Policy Interpretation and Implementation 7. Compartments (including drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport items shall not be left unattended if open or otherwise potentially available to others. A review of the facility's policy titled Wound Care with a revised date of 04/2024 under Steps in the Procedure 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time and date and apply dressing. NJAC 8:39-29.4(h)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45622 Complaint #: NJ184057 Based on interview, record review, and review of other pertinent facility documents on 03/05/2025 and 03/06/2025, it was determined that the facility failed to: a.) obtain a Physician's Order for a wound care recommendation which resulted in worsening of the wound; b.) implement recommendations from the wound care consultant to prevent worsening of facility acquired pressure injury. This deficient practice occurred for 1 of 1 resident reviewed for pressure ulcer (Resident #4). This deficient practice was evidenced by the following: Resident #4 was identified as having a skin alteration within the sacral region on 01/23/2025. The Licensed Practical Nurse (LPN) failed to transcribe the verbal order obtained for wound care. On 01/28/2025 during a wound consult, Resident #4's sacral wound measured 2 centimeters (cm) x 2 cm x 0.5 cm and progressed to 3 cm x 3 cm x 1 cm on 02/04/2025. Review of Resident #4's Order Summary Report (OSR) from 01/23/2025 through 02/04/2025 showed no evidence for wound care order in place for the resident's sacral wound. On 02/13/2025, Resident #4 was seen by the Physician and transferred out to the emergency room for sacral wound debridement. According to the hospital records, Resident #4 was admitted to the hospital on 02/13/2025 with a diagnosis of Sacral Wound. This deficient practice was evidenced by the following: A review of the Admission Record (an admission summary) reflected that Resident #4 was admitted to the facility with diagnoses that included but were not limited to; Anemia (low healthy red blood cells and hemoglobin), Depression (feeling of sadness), and Muscle Weakness. A review of the admission Minimum Data Set, an assessment tool used to facilitate the management of care dated 01/12/2025, reflected that the resident had a Brief Interview for Mental Status score of 14 out of 15, indicating that the resident was cognitively intact. Section M0100 revealed no pressure ulcer. A review of Resident #4's Progress Notes (PNs) dated 01/23/2025 revealed the following written by LPN #1: Aide [certified nursing assistant] informed me today that patient [Resident #4] has a skin tare in the sacral area. Cleaned with NSS [normal saline solution], and applied Medi honey and dry border gauze. Risk management note done and wound consult in chart. A review of Resident #4's wound care notes with an effective date of 01/28/2025 revealed the following: Wound Location: Sacrum Etiology: old pilonidal cyst reopened Signs of infection: none (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Size: 2 cm x 2 cm x 0.5 cm Tissue type: necrotic Drainage: mod serous Peri wound: intact Edema: none Description: none Dressing: Dakin's dressing Review a wound care notes with an effective date of 02/04/2025 revealed the following: Wound Location: Sacrum Etiology: old pilonidal cyst reopened Signs of infection: none Size: 3 cm x 3 cm x 1 cm Tissue type: necrotic/ purple edges Drainage: mod serous Peri wound: intact Edema: none Description: none Dressing: Santyl/Dakin's dressing A review of Resident #4's OSR and TAR revealed no evidence the wound care recommendations were implemented for the resident's sacral wound care from 01/23/2025 through 02/04/2025. A review of Resident #4's PNs dated 02/02/2025 revealed: pt [Resident #4] AAO x3 [alert, awake, oriented to person, place and time], all medications tolerated whole with water. C/O [complained of] pain in their sacral area. Dressing cleaned and changed. Further review of Resident #4's PNs dated 01/23/2025 through 02/04/2025, showed no further evidence wound care was provided. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #4's OSR with an order date of 02/05/2025, revealed the following order: Wound care: Dress sacrum with Santyl to base then cover with Dakin moist gauze then ABD [abdominal dressing] pad post NSS [normal saline solution] cleanse. One time a day for sacrum break down. A review of Resident #4's TAR dated 02/05/2025 revealed the aforementioned order for wound care. On 03/05/2025 at 3:49 P.M., during an interview with LPN#1, she confirmed to the surveyor that she received a verbal order from the physician for Medi honey with border gauze for Resident #4's sacral wound and did not put the order in Point Click Care (PCC) as per facility's policy. LPN #1 stated once a wound is observed, the process is to evaluate the wound, notify the resident's Physician of the wound and obtain an order for wound care. She said the expectation is for the nurse to put the order in PCC where it's transcribed to the TAR for implementation. She further stated, all new wounds and existing wounds should have a treatment order in place. When asked by the surveyor if the order she received on 01/23/205 for Resident #4 should have been put in PCC and transcribed to the TAR, she said, yes. LPN#1 said the nurse is responsible to notify the physician of recommendations for wound care and obtain a Physician's Order for the recommendations. LPN#1 said she was unsure why the physician was not notified for Resident #2's wound recommendations. LPN#1 said, if wound care is not provided as ordered, the wound could get worse On 03/05/2025 at 4:10 P.M., during an interview with the Director of Nursing (DON), she said, if there is a skin alteration, the nurse will evaluate and notify the Physician, get a new treatment order, start the risk management and request a wound consult. The DON said, the expectation is if a nurse obtains a new wound care order from the Physician, the order should be placed in PCC and carried out on the TAR as per physician specifics. The DON said there should be a treatment order in place for all skin alteration and the resident's wound could get worse if there is no treatment in place. The DON also said wound care recommendations should be carried out on the TAR, and wounds care provided as ordered. The DON confirmed there was no treatment order on the TAR from 01/23/2025 through 02/04/2025. On 03/13/2025 at 10:00 A.M., during an offsite interview with Resident #4's Physician, he said the expectation is, wound care orders should be followed as ordered. He said once the nurse receives a verbal order for wound care, the order should be implemented immediately. He said it is unacceptable if wound care is not done or followed. The Physician said, if wound care is not started immediately, the wound could get worse. During the same interview, the Physician said there should be an order in place for all wounds. A review of the facility's policy title Wound Care with a revised date of 04/2024 under Policy revealed the following: The purpose of this procedure is to provide guidelines for the care of wounds to promote wound healing. A review if the facility's policy with a revised date of 12/2024 titled Medication and Treatment Order under Policy Interpretation and Implementation revealed: 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, date and time of the order. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility's policy titled Charting and Documentation under policy Statement revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's' medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. NJAC 8:39-27.1

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50919 Complaint#: NJ182815 Based on observations, interviews, and review of other facility documentation on 3/5/2025, it was determined that the facility failed to: a.) ensure that food items were dated, b.) ensure outdated food items were discarded, and c.) ensure refrigerator temperatures in the kitchen were completed to prevent foodborne illnesses. This deficient practice was evidenced by the following: On 3/5/2025 from 10:08 AM to 10:40 AM, the surveyor, accompanied by the Dietary Director (DD), observed the following during a tour of the kitchen: 1. On the bread rack, the surveyor observed: - an unopened loaf of sliced rye sandwich bread with a use by date of 2/22/25. - an opened gluten free white wide slice bread with a use by date of 2/11/25. -an opened bag of 8 English muffins with no label and no expiration date. 2. The surveyor observed a temperature log sheet outside the walk-in refrigerator that had a blank space for 3/4/2025, for PM temperatures. 3. The surveyor and DD entered the walk-in refrigerator that contained milk and juice. The surveyor observed a cart in the walk-in refrigerator that contained the following: - a pitcher of orange juice that had no date on it. -an opened 64 oz. cranberry apple juice bottle with no date on it. -an opened 64 oz. cranberry raspberry juice bottle with no date on it. On 3/5/2025 at 10:30 AM, the surveyor interviewed the DD who stated that all food and juice items should have been dated once opened. The DD indicated that gluten free items have a longer shelf date, and the gluten free bread had the incorrect use by sticker on it. The DD agreed that any food items past the use by date should have been discarded. The DD confirmed the blank space on the walk-in refrigerator temperature log sheet and indicated the PM temperature for 3/4/2025 should have been recorded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility food service policy titled, Dating/Labeling of Food Items with a reviewed/revised date of 01/2025 revealed under Policy Explanation and Compliance Guidelines for Staffing, 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a label, the day/date of opening, and the day/date the item must be consumed or discarded. Review of the facility job description titled, Dietary Director dated April 2020 revealed under Essential Duties and Responsibilities, Monitor food preparation and food storage areas to be sure that health and sanitation regulations are being met. NJAC 8:39-17.2 (g)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center for Rehab & Nursing Washington Township	535 Egg Harbor Road Sewell, NJ 08080

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. 45622 Complaint #: NJ184057 Based on observation, interview, and review of pertinent facility documents on 3/5/2025 and 3/6/2025, it was determined that the facility staff failed to maintain appropriate infection control practices specifically by not properly discarding an opened pack of unused 4x4 gauze after a wound care observation to prevent the potential spread of infection in accordance with the Center for Disease and Control prevention guidelines and Standards of Clinical Practice. The facility staff failed to follow their policy titled Infection Prevention and Control Program. This defiant practice was identified during 1 of 1 wound care observation. On 3/5/2025 at 12:00 P.M., the surveyor observed the Registered Nurse (RN#1) complete a wound care treatment. Upon completion of the wound care, RN#1 was observed gathering and returned an opened pack of unused 4x4 gauze and placed it in the treatment cart. On 03/05/2025 at 12:45 P.M., during an interview with RN#1, she stated the opened pack of unused 4x4 gauze from the resident's room should have been discarded and not placed in the treatment cart. She further started it was important not to put the opened pack of unused 4x4 gauze back on the treatment cart to avoid cross contamination. On 03/05/2025 at 1:31 P.M., during an interview with the Infection Preventionist (IP), she stated all unused treatment supplies should be discarded once not used during a wound care. The IP stated the expectation is to take only items needed during a treatment with the treatment cart outside the door to obtain extra supplies if needed. Opened unused gauze should not be placed back on the treatment cart once it was previously taken in the resident's room, it is important because of infection prevention. On 03/05/2025 at 4:10 P.M., during an interview with the Director of Nursing (DON), she stated unused wound supplies should be discarded after a wound dressing. When asked by the surveyor if an opened pack of unused 4x4 gauze should be returned to the treatment cart, the DON stated, no, the nurse should not put unused wound supplies back on the treatment cart. It's important to prevent cross contamination. A review of the facility policy with a revised date of 01/2025, title Infection Prevention and Control Program under Purpose revealed: To ensure the facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and state requirements. NJAC 8:39-19.1

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F 0919

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Make sure that a working call system is available in each resident's bathroom and bathing area.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50919

Complaint #: NJ182815

Based on observations and interviews on 3/5/2025 and 3/6/2025, it was determined that the facility failed to ensure their wireless call bell system communicated calls directly to the staff.

This deficient practice was evidenced by the following:

1. According to the Admission Record (AR), Resident #1 was admitted to the facility with diagnoses that included but were not limited to: fracture of unspecified part of neck of left femur, sarcoidosis (an inflammatory disease of the lungs and lymph nodes), and hypertension.

A review of resident #1's Minimum Data Set (MDS), an assessment tool dated 2/28/2025, revealed a Brief Interview of mental Status (BIMS) score of 13 out of 15, which indicated the resident's cognition was intact. The MDS further revealed the resident was dependent for toileting hygiene.

On 3/5/2025 at 11:21 AM, the surveyor interviewed Resident # 1 in the presence of the resident's family member. The resident stated he /she was admitted to the facility several weeks ago. Resident #1 indicated that the day before it took staff 50 minutes to answer his/her call light. Resident #1 further stated that this was not the first time this occurred and that he/she had reported it to the nurse. The surveyor had Resident #1 ring his/her call bell. The surveyor returned to the resident's room at 11:35 AM and observed the call bell light still on with no audible sound present. The resident stated no staff had answered his/her call bell yet. Resident #1 further indicated that the staff had come to his/her room about ten minutes prior to the surveyor coming to the room the first time. Resident #1 stated the staff probably were not going to come back since she called for them earlier and they had already responded.

2. According to the AR, Resident #3 was admitted to the facility with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a lung condition caused by damage to the airways, due to smoking or other irritants), anemia, and hyperlipidemia.

A review of Resident #3's MDS, an assessment tool dated 2/13/2025, revealed a BIMS score of 12 out of 15, which indicated the resident's cognition was moderately impaired. The MDS further revealed the resident needed substantial assistance for toileting hygiene.

3. According to the AR, Resident #7 was admitted to the facility with diagnoses that included but were not limited to: diabetes, morbid obesity, and unspecified falls.

A review of Resident #7's MDS, an assessment tool dated 1/10/2025, revealed a BIMS score of 14 out of 15, which indicated the resident's cognition was intact. The MDS further revealed the resident was dependent for toileting hygiene.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/6/2025 at 10:01 AM, the surveyor interviewed Resident #7 who stated that sometimes it took the staff more than ten minutes to answer his/her call bell. The resident further indicated that there were times his/her call bell was not answered by the staff. The resident further stated this mostly had occurred on the evening shift. On 3/5/2025 at 11:23 AM, the surveyor interviewed Resident # 3 who stated he/she had been a resident of the facility previously and recently came back. Resident #3 indicated that it took a long time for staff to answer his/her call light and sometimes the staff never came to the room to answer the light. Resident #3 further stated that he/she had made the charge nurse aware. On 3/5/2025 at 2:52 PM, the surveyor interviewed the Certified Nursing Assistant (CNA #2) who stated the call bells on the 500 Unit did not ring to the staff work areas. CNA #2 proceeded inside a resident room and rang the call bell. The surveyor observed a green light illuminate with no audible sound present on the ceiling in front of the resident room. CNA #2 indicated that the green light meant the resident would be calling from their room and if the light was red, it was calling from the resident bathroom. CNA #2 stated the only way she was aware that the call bell was ringing was if she looked up at the ceiling while standing in the hallway when she was not busy providing care to other residents. On 3/5/2025 at 3:00 PM, the surveyor did not observe any staff at the designated staff work areas on the 500 Unit Low and High Hallways. On 3/6/2025 at 9:55 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #2) who stated she was unable to see two rooms (room [ROOM NUMBER] and 514) call lights from the staff work area in the 500 High Hallway. The LPN indicated a staff member would have to sit in the middle of the hallway to see if the call lights would illuminate from those two rooms. The LPN confirmed that there was no call bell system at the workstation to alert the staff that the residents were ringing their call bells. On 3/6/2025 at 10:12 AM, the surveyor interviewed the Registered Nurse (RN#1) who stated she was unable to see the call lights for two rooms (room [ROOM NUMBER] and 504) from the staff work area in the 500 Low Hallway. RN #1 indicated that the staff should be in the hallways to monitor the call bells since they were not audible and do not ring to any main location. On 3/6/2025 at 10:16 AM, the surveyor interviewed the Resource Nurse/Registered Nurse (Resource/ RN) who indicated that she was aware that the residents had complained about their call bells not being answered for more than ten minutes especially on the 7pm-7am shift. The Resource/ RN stated that the staff were supposed to be monitoring the call lights hourly as the call bells were not audible on the unit and were to respond in a timely manner. On 3/6/2025 at 1:58 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA). The DON stated she was not aware of any resident complaints regarding the call bells not being answered. The DON further indicated that the staff were expected to respond to the call bells in a timely manner. The DON stated it was everyone's responsibility to answer the call bells and that staff had received training on responding to the resident call bells. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Center for Rehab & Nursing Washington Township		STREET ADDRESS, CITY, STATE, ZIP CODE 535 Egg Harbor Road Sewell, NJ 08080	

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/6/2025 at 1:58 PM, the surveyor interviewed the LNHA that confirmed the call bells in the new building which consisted of the 400 and 500 unit, did not ring to a centralized location and that staff had to visually see if the call bell was ringing. Review of the facility's policy titled, Communication-Call System with a reviewed/revised date of 01/2025 revealed under Purpose, To provide a mechanism for residents to promptly communicate with nursing staff. Under Procedures, 7. Nursing staff will answer call bells promptly . NJAC 8:39-27.1 (a)