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	11/22/2024

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 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. 41072 Based on observation and interview and record review, it was determined that the facility failed to ensure that the residents' dining experience was provided in a manner to promote dignity and respect of the residents. This deficient practice was identified in 1 of 6 dining areas observed, (the Activities room) and was evidenced by the following: On 11/19/24 at 11:59 AM, the surveyor observed dining on the first-floor activities room. The surveyor observed two (2) residents (Resident #22 and Resident #94) sitting at the same table. Resident #94 had their lunch tray and was eating. Resident #22 had not received their lunch tray. At that time, the surveyor interviewed a Licensed Practical Nurse (LPN # 2) who stated that residents who were seated at the same table should have been served their lunch at the same time. At 12:02 PM, LPN #2 stated that she had called the kitchen to obtain Resident #22's lunch tray. At that time, the surveyor observed Resident #22 take a piece of brownie from Resident # 94's plate and ate it. Then, Resident #94 tried to feed a forkful of broccoli to Resident #22 and LPN #1 intervened. LPN #1 stated I Know Resident #22 is on a regular diet. At 12:11 PM, the surveyor observed Resident # 22's lunch was delivered, and the resident began eating. A review of Resident #22's Order Summary Report revealed a Physician's order, dated 9/10/24, for a Regular diet. On 11/20/24 at 8:29 AM, the surveyor interview with the Registered Dietician (RD) who stated that all residents who were seated at the same table should have been served their meals at the same time. The RD stated that it was important to serve all residents at the same table their meals at the same time for dignity. The RD further stated that a resident should not be sitting at a table for a long period of time without food. On 11/21/24 at 12:44 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, who stated when serving residents in the dining areas, one table should be served their meals at the same time. The DON further stated that the importance of serving meals to all residents at the same table at the same time was so that a resident would not be waiting to eat while other residents were eating. The DON stated that Resident#22 and Resident #97 should have been served their lunch at the same time. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/24 at 9:42 AM, the LNHA, in the presence of the DON and survey team, stated that Resident #22 usually ate lunch in the main dining room but due to the main dining room being unavailable that day, Resident #22 was rerouted to the activities room for lunch and their lunch tray should have gone to the activities room. A review of the facility's Dining Room Services policy, revised/updated May 2024, included Dignity and Respect: All residents should be treated with dignity and respect during mealtimes. A review of the facility's Resident Rights policy, reviewed/revised 12/20/2023, included that all employees shall treat all residents with kindness, respect, and dignity. NJAC 8:39-4.1(a)12

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 40041 Based on interview, medical record review, and review of other facility documentation, it was determined that the facility failed to document a resident's life-sustaining treatment preference on the physician's orders. This deficient practice was identified for one (1) of one (1) resident (Resident #52) reviewed for advanced directives and was evidenced by the following: On 11/18/24 at 11:18 AM, the surveyor reviewed the medical record for Resident #52. There was no documented evidence of the resident's code status. A review of the Admission Record, (an admission summary) revealed the resident was admitted to the facility with diagnoses which included: heart failure, depression, obstructive sleep apnea, atrial fibrillation, hyperlipidemia, and hypertensive chronic kidney disease. A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated 11/3/24, included the resident had a Brief Interview Mental Status (BIMS) score of 13 out of 15, which indicated the resident's cognition was intact. On 11/20/24 at 11:25 AM, the surveyor interviewed the Registered Nurse (RN) #1 who stated, if the resident was admitted without a code status, they informed the Social Worker (SW) and the physician. She stated that if the resident did not have a code status, we put full code until we clarify. At that time, RN #1 reviewed Resident #52's electronic medical record (EMR) and confirmed the code status was not documented. She then stated, I don't know how that was missed. On 11/20/24 at 2:23 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident's code status should be determined upon admission to the facility as it was a part of the admission process. She further stated if the resident did not have a Provider Orders for Life-Sustaining Treatment (POLST - a specific type of advance directive that communicates your wishes for emergency medical treatment when you are unable to speak for yourself.) form on admission, then during the care conference with the Interdisciplinary Team (IDT) the advance directive would be confirmed. She explained the physician then created a POLST form, and a physician order (PO) for the code status was written. On 11/22/24 at 10:08 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and the survey team. The LNHA stated that every resident should have a code status and it should be determined on admission. A review of the facility's Advanced Directives policy, reviewed/revised December 2023, included, Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. NJAC 8:39 - 9.6 (a)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37547 Complaint #NJ169388 Based on interview, record review, and review of facility documents, it was determined that the facility failed to report an allegation of staff to resident abuse to the New Jersey Department of Health and the Office of the Ombudsman in a timely manner in accordance with state and federal requirements and the facility policy. This deficient practice was identified for 1 of 1 resident (Resident #199) reviewed for abuse and was evidenced by the following: Refer to F610 A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, recurrent, moderate, generalized anxiety disorder, mild cognitive impairment of uncertain or unknown etiology, unspecified urinary incontinence, and morbid (severe) obesity due to excess calories. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 12/10/23, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had a functional limitation in range of motion impairment on both sides of the upper and lower extremities and was always incontinent of both bowel and bladder. Further review of the MDS indicated that the resident had no documented behaviors. A review of the residents individual comprehensive care plan (ICCP) included a focus area, that indicated the resident had activities of daily living (ADL) self care deficit physical limitations. Interventions included: Assist with ADL's x 1 (one) staff, Ambulation: total dependence, Toileting: total dependence, Bed Mobility: Total assist x 2 (two) staff and Transfers: Total dependence. On 11/19/24 at 10:46 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #5) who stated that the resident had behaviors which included giving a hard time to a care giver who was not consistent. LPN #5 stated that the resident would would yell at them and did not talk to them in a nice way. LPN #5 stated that if a resident were denied care, the aide would be removed from the assignment and both the supervisor and the Director of Nursing (DON) would handle that. LPN #5 stated that one time, an agency aide asked the resident's family members to step out of the resident's room and that was when I called the supervisor. LPN #5 stated that the resident was specific with their words and the aide said the same thing. LPN #5 stated that the resident meant no harm, as that was just how they talked. LPN #5 stated that everything was then handled by the supervisors. When the surveyor asked if it was abuse if the CNA refused to provide care and LPN #5 responded, abuse is a strong word, I would say negligence. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 11:03 AM, the surveyor requested all investigations that pertained to the resident and the Director of Nursing (DON) provided the surveyor with a Reportable Event Record/Report (RER/R) dated 11/29/23, for a report of staff-to-resident abuse that occurred at an unspecified time in the AM on 11/26/23. The portion of the form designated to determine, Was this a Significant event? and Was Significant Event called in (to the New Jersey Department of Health (NJDOH)) with the date and time was not completed. Further review of the RER/R revealed that on 11/29/23, the resident's family member alleged emotional abuse towards the resident during an interaction with a care taker on 11/26/23, and the identified caretaker was removed from the schedule pending the investigation. When the surveyor asked if the allegation was phoned into the NJDOH she replied yes, and that it was human error that area designated for the date and time the allegation was phoned in was left blank. Further review of the RER/R included an Individual Statement Form that was written by Registered Nurse/Supervisor (RN/S) #2 on 11/27/23. RN/S #2 documented that on the afternoon (time not specified) of 11/26/23, RN/S #2 received a text message that was intended for the DON from the resident's family member, which conveyed that a CNA (Certified Nursing Assistant) from the prior evening was rude to the resident. The family member also had a complaint about today's CNA, CNA #7, who asked the resident's two family members to please leave the room while she changed the resident. The family members asked why they were asked to leave the room and the CNA stated that it would be easier for her to get around the bed. When the family members refused to leave CNA #7 walked out and that was when RN/S #2 documented that she got involved and changed the resident. RN/S #2 documented that she had CNA #7 write a statement and removed her from the resident's assignment. RN/S #2 documented, refer to CNA #7's statement. Further review of the RER/R failed to contain documented evidence of CNA #7's statement as referenced by RN/S#2. On 11/19/24 at 1:19 PM, the surveyor interviewed the DON who stated that the RN/S #2 wrote a statement on 11/27/23 about the concerns raised by the resident's family on 11/25/23 and 11/26/23. The DON stated the interaction that occurred was between the employee and the resident's family member. The Supervisor provided care and reassigned the CNA. The DON stated that was CNA #7's first and only day that she worked at the facility. The surveyor asked if RN/S #2 was responsible to phone in an allegation of abuse to the NJDOH? The DON stated that was not the facility practice. The DON stated that the supervisor's role was to just to write a statement form, collect statements, and follow through. At that time, the surveyor asked the DON if she had spoken to anyone at the NJDOH after the RER/R was submitted? The DON responded, that she believed that someone had reached out to her to request additional information. The DON further stated that she also believed that someone from the NJDOH came in and spoke with the resident directly regarding the incident. The DON maintained that it was human error that the date and time she phoned the complaint in to NJDOH was omitted from the form. On 11/20/24 at 1:49 PM, the surveyor reviewed the Transmission Verification Report (TVR) (confirmation of facsimile (fax) submission) that was dated 11/29/23 at 6:54 PM. Further review of the TVR revealed that three pages, the length of the RER/R was faxed to an incorrect fax number that was unrelated to the NJDOH. The surveyor confirmed with the NJDOH Long-Term Care Complaints Department that there was no receipt of a Facility Reported Event (FRE) or a RER/R being phoned in or faxed from the facility that pertained to the resident's allegation of emotional abuse. There was also no record of a summary and conclusion of the abuse investigation on file at the NJDOH. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 2:00 PM, in the presence of the survey team the DON stated that she was unsure if she was required to call in an allegation of abuse within two hours or within twenty-four hours and stated that she would have to refer to the policy. The DON further stated, You do not have to call and send it in. You just send it in. On 11/21/24 at 11:40 AM, the DON provided the surveyor with a copy of the Summary and Conclusion for the investigation that was completed on 12/1/23 and was sent to the NJDOH yesterday (11/20/24). When the surveyor requested a TVR to confirm when the Summary and Conclusion was originally sent to the NJDOH the DON stated that she did not have one. On 11/22/24 at 9:54 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and asked if the Office of the Ombudsman were notified of the abuse allegation timely? The LNHA stated that the notification would have been faxed or emailed to the Office of the Ombudsman. The DON who was present stated that she would have to check and see if there were a second fax confirmation. The facility failed to provide documented evidence that the Office of the Ombudsman was notified of the resident's allegation of emotional abuse. A review of the facility's Abuse Investigation And Reporting policy, updated 7/10/23, included: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations shall also be reported. Witness reports shall be obtained in writing. Either the witness shall write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. The investigator shall notify the ombudsman that an abuse investigation is being conducted. The investigator shall consult daily with the Administrator concerning the progress/findings of the investigation. Upon conclusion of the investigation, the investigator shall record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property shall be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The State licensing/certification agency responsible for surveying/licensing the facility; The local/State Ombudsman; The Resident's Representative (Sponsor) of Record; Law enforcement officials; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Attending Physician An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) shall be reported immediately, but not later than: Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone. Notices shall include, as appropriate: The name of the resident; The number of the room in which the resident resides; The type of abuse that was allegedly committed (i.e., Verbal, Physical, Sexual, Neglect, etc.); The date and time the alleged incident occurred; The name (s) of all persons involved in the incident; and What immediate action was taken by the facility. The Administrator/designee, shall provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident . NJAC 8:39-9.4 (f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Complaint #NJ169388 Based on interview, record review, and review of facility documents, it was determined that the facility failed to conduct a timely and thorough investigation in accordance with the facility policy for an allegation of staff to resident abuse. This deficient practice was identified for 1 of 1 resident (Resident #199) reviewed for abuse and was evidenced by the following: Refer to F609 On 11/18/24 at 10:27 AM, the surveyor reviewed the closed medical record for Resident #199. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, recurrent, moderate, generalized anxiety disorder, mild cognitive impairment of uncertain or unknown etiology, unspecified urinary incontinence, and morbid (severe) obesity due to excess calories. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 12/10/23, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident had a functional limitation in range of motion impairment on both sides of the upper and lower extremities and was always incontinent of both bowel and bladder. Further review of the MDS indicated that the resident had no documented behaviors. A review of the residents individual comprehensive care plan (ICCP) included a focus area, that indicated the resident had activities of daily living (ADL) self care deficit physical limitations. Interventions included: Assist with ADL's x 1 (one) staff, Ambulation: total dependence, Toileting: total dependence, Bed Mobility: Total assist x 2 (two) staff and Transfers: Total dependence. On 11/19/24 at 10:46 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #5 who stated that the resident had behaviors which included giving a hard time to a care giver who was not consistent. LPN #5 stated that the resident would would yell at them and did not talk to them in a nice way. LPN #5 stated that if a resident were denied care, the aide would be removed from the assignment and both the supervisor and the Director of Nursing (DON) would handle that. LPN #5 stated that one time, an agency aide asked the resident's family members to step out of the resident's room and that was when I called the supervisor. LPN #5 stated that the resident was specific with his/her words and the aide said the same thing. LPN #5 stated that the resident meant no harm, as that was just how he/she talked. LPN #5 stated that everything was then handled by the supervisors. When the surveyor asked if were abuse if the CNA refused to provide care LPN #5 responded, abuse is a strong word, I would say negligence. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's Progress Notes (PN) revealed there was no documented evidence of the incident that was described by LPN #5. On 11/19/24 at 11:03 AM, the surveyor requested all investigations for the resident and the Director of Nursing (DON) provided the surveyor with a Reportable Event Record/Report (RER/R) dated 11/29/23, for a report of staff-to-resident abuse that occurred at an unspecified time in the AM on 11/26/23. Further review of the RER/R revealed that on 11/29/23, the resident's family member alleged emotional abuse towards the resident during an interaction with a care taker on 11/26/23, and the identified caretaker was removed from the schedule pending the investigation. Further review of the RER/R included an Individual Statement Form that was written by Registered Nurse/Supervisor (RN/S) #2 on 11/27/23. RN/S #2 documented that on the afternoon (time not specified) of 11/26/23, RN/S #2 received a text message that was intended for the DON from the resident's family member, which conveyed that a CNA (Certified Nursing Assistant) from the prior evening was rude to the resident. The family member also had a complaint about today's CNA, CNA #7, who asked the resident's two family members to please leave the room while she changed the resident. The family members asked why they were asked to leave the room and the CNA stated that it would be easier for her to get around the bed. When the family members refused to leave CNA #7 walked out and that was when RN/S #2 documented that she got involved and changed the resident. RN/S #2 documented that she had CNA #7 write a statement and removed her from the resident's assignment. RN/S #2 documented, refer to CNA #7's statement. Further review of the RER/R failed to contain documented evidence of CNA #7's statement as referenced by RN/S#2. Further review of the RER/R included a statement that was written by the Licensed Nursing Home Administrator (LNHA) on 11/29/23, which indicated that he had spoken with the resident's family member with the DON present. The LNHA documented that he asked the resident's family member to explain the written statement in his/her email correspondence provided to the facility that mentioned there was staff-to-resident abuse. The family member reportedly told the LNHA that the resident experienced emotional abuse and not physical abuse on Sunday (11/26/23) with a CNA, after they found the resident tearful and the CNA was rude. The family member reportedly stated that the resident had difficulty recalling or remembering things and also informed the LNHA that the resident's room mate was present at the time. Further review of the RER/R failed to contain documented evidence that the facility interviewed or obtained a statement from the resident's room mate, an unsampled resident whose BIMS was 15 out of 15, according to the resident's MDS dated [DATE]. Further review of the RER/R included four resident interviews that were dated 11/30/23. There were no further Statement Forms attached to the investigation to indicate that the resident, resident's roommate, the resident's assigned nurse, or facility staff were interviewed as potential witnesses to the abuse allegation as required of the facility policy. On 11/19/23 at 11:33 AM, the surveyor unsuccessfully attempted to contact both RN/S #2 and CNA #7 via telephone for an interview. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 1:19 PM, the surveyor interviewed the DON and asked why the facility failed to provide the surveyor with a statement from CNA #7 that was referenced by RN/S #2? At that time, the DON provided the surveyor with a copy of an email sent to the facility by the resident's family dated 11/27/24 at 12:03 PM, and referenced an undated or timed interview that the DON reportedly wrote on the back of the email. The DON stated that when she realized that CNA #7's statement was missing, she called her a few days later after the event. The DON stated that when interviewed, CNA #7 stated that when she entered the resident's room, they immediately asked who she was and were constantly on the call bell. The DON stated that CNA #7 did not even have a chance to introduce herself. The DON stated that CNA #7 stated that the residents wanted a nurse and she got them some ice. CNA #7 stated that the resident's room mate was reportedly demeaning to her. The DON stated that she had given the family her number and the supervisors number to call her directly if needed. The DON further stated that we made a follow-up call on Sunday, 11/26/23, and there was no allegation of abuse. The DON stated that when the LNHA phoned the family, that was when they alleged abuse. The DON stated that if abuse was alleged during the shift, clear alleged abuse, then we send the aide home rather than just remove them from the resident's assignment. The DON further stated that RN/S #2 was interviewed and stated that the CNA #7 asked the resident's family to step out because they were hindering the aide. RN/S #2 stated that the two family members stood at the end of the bed in a small space and were very confrontational and CNA #7 felt hindered from getting supplies and could not perform the care. RN/S #2 stated that CNA #7 felt the family was demeaning and got the supervisor. The DON stated from the reports she received, the resident did not voice aggression or inappropriateness. The conversation was with the family, not the resident. The DON stated that it was the family's perception that CNA #7 was nasty to them. The DON stated that was when CNA #7 was removed from the resident's assignment and was permitted to work the rest of the shift. The DON stated that the family just did not want CNA #7 assigned to the resident as she had a rude attitude. The DON stated that according to RN/S #2, The resident was not affected. The DON stated that when the family went to get the supervisor, she came and completed the resident's care and assigned the resident to another CNA. The DON stated that was CNA #7's first and only day that she ever worked at the facility and was then placed on the do not return list. The DON further stated that the RN/S #2 initiated a concern, not a risk management, as it was not their practice. The RN/S #2 spoke with the family and obtained statements and the DON initiated an investigation. (continued on next page)

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	315231	A. Building B. Wing	11/22/2024

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor then reviewed the email the DON provided dated 11/27/23 at 12:03 PM, from the resident's family that was sent to both the DON and LNHA. The family advised the facility that on 11/25/23, the resident and his/her room mate had an aide that was extremely nasty to them when she came on duty at 7:00 PM and they did not want her back on Sunday. The family documented that the concern was presented to RN/S #2 when she came to the room to talk with us on Sunday. Further review of the email indicated that the family presented to the facility around 12:45 PM, on 11/26/23 and neither the resident or his/her room mate had baths or were dressed. The family was reportedly told that no one would be getting out of bed because there was short staffing. When asked about changing the resident, CNA #7 stated, I just changed you which was not the case because the family was there for almost two hours at that point. The email further indicated that CNA #7 stated she would be back and did not return for 1.5 hours and that was when they texted RN/S #2. Then when CNA #7 finally came back, she requested that we leave the room when the resident wanted us to stay. When the family asked why CNA #7 stated, I want them to leave and proceeded to leave and left the resident lying flat in the bed. The family described CNA #7 as beyond rude and ignorant. The family then informed LPN #5 after twenty minutes passed who stated, the aide is agency and it was the resident's option to have his/her family there or not. The family indicated that when CNA #7 walked by the family asked if she would go back and change the resident and CNA #7 allegedly stated if he/she needs help he/she can ring the bell for that. On 11/20/24 at 9:10 AM, the surveyor interviewed the DON in the presence of the survey team and asked why the resident's roommate was not interviewed when the resident's family indicated his/her presence during the allegation? The DON stated, The roommate did not complain about it. I do not know. A review of the facility's Abuse Investigation And Reporting policy, updated 7/10/23, included: All reports of resident abuse, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations shall also be reported. .Role of the Investigator: The individual conducting the investigation shall, as a minimum: Review the completed forms; Review the resident's medical record to determine events leading up to the incident; Interview the person (s) reporting the incident; Interview any witnesses to the incident; Interview the resident (as medically appropriate); Interview the resident's nurse/Attending Physician as needed to determine the resident's current level of function and medical condition; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate; Interview other residents to whom the accused employee provides care or services; and Review all events leading up to the alleged incident. A review of the facility's Abuse Prevention Program updated 7/10/23, included: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. .Identify and assess all possible incidents of abuse; Investigate and report any allegations of abuse within the timeframes as required by federal requirements; Protect residents during abuse investigations; . Abuse is defined as .the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, and mental abuse including abuse facilitated or enabled by the use of technology. Neglect, as defined .means the failure of the facility, and its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .the nurse shall assess the individual and document related findings. Assessment data shall include: injury assessment (bleeding, bruising, deformity, swelling etc.); Pain assessment; Current behavior; Patient's age and sex; All current medications, especially anticoagulants (thins the blood), NSAIDS (non-steroidal anti-inflammatory medications),salicylate (aspirin); . Vital signs; Behavior over last 24 hours . .All active diagnoses; and Any recent labs. .The staff, with the physician's input as needed, shall investigate alleged abuse and neglect to clarify what happened and identify possible causes. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician shall provide adequate documentation regarding negative outcomes that have resulted from a resident's underlying medical illnesses or conditions, despite appropriate care. .The staff and physician shall monitor individuals who have been abused to address any issues regarding their medical condition, mood and function. The medical director shall advise facility management and staff about ways to ensure that basic medical, functional, and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately. The physician shall advise the facility and help review and address abuse and neglect issues as part of the quality assurance process. NJAC 8:39-4.1(a) 5

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41260 Complaint #: NJ173651 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to revise a resident's individual comprehensive care plan after a resident developed contractures for 1 of 2 residents (Resident #2) reviewed for limited range of motion. This deficient practice was evidenced by the following: On 11/17/24 at 10:16 AM, the surveyor observed Resident #2 lying in bed. The resident's left hand appeared contracted. On 11/18/24 at 10:24 AM, the surveyor reviewed the medical record for Resident #2. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: unspecified dementia, major depressive disorder, generalized anxiety disorder, insomnia, and muscle weakness. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 10/23/24, included the resident had a Brief Interview for Mental Status score of 3 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident had impaired range of motion (ROM) to upper and lower extremities on both sides. A review of the Individualized Comprehensive Care Plan (ICCP) did not include the resident's impaired range of motion to upper and lower extremities on both sides. Further review of the ICCP did not include interventions to treat or prevent reduction in ROM. A review of the Order Summary Report, dated as of 11/21/24, did not include any physician orders (PO) to treat or prevent reduction in ROM. A review of the Certified Nursing Assistant (CNA) Kardex, dated as of 11/21/24, did not include any instructions for the CNA to provide or assist the resident with ROM exercises to prevent a reduction in ROM. A review of the Record of Patient and Family Concerns form, dated 8/16/23, included on the second page titled, Areas of Concerns, that the resident was contracted. On 11/20/24 at 10:20 AM, the surveyor interviewed CNA #2 who stated she had been Resident #2's CNA for about a year and that both the resident's hands were contracted. When asked how long the resident's hands were contracted, the CNA stated she was unsure the exact timeframe, but that the resident's hands were not contracted when the CNA was first assigned to the resident about a year ago. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 10:41 AM, the surveyor interviewed the Director of Rehab (DOR) who stated that the resident was seen by Occupational Therapy (OT) from 2/21/24 to 3/20/24, and that the resident's hands were not contracted at that time. The DOR reviewed the OT treatment notes and stated the resident preferred hands fisted and that OT provided education to the nurse and CNA to provide ROM exercises to the resident's upper extremities. At that time, the DOR provided the surveyor with copies of the OT and Physical Therapy (PT) evaluations, treatment notes, and discharge summaries, as well as the Training and Education Log that OT created to train the nurse and CNA on ROM exercises. A review of the PT Evaluation and Plan of Treatment, dated 2/20/24, included the resident had diagnoses of right knee contracture and left knee contracture. A review of the OT Evaluation and Plan of Treatment, dated 2/21/24, included the resident had diagnoses of unspecified dementia and muscle weakness. Further review included OT educated the CNAs on the benefit of ROM to resident's left upper extremity. A review of the Training and Education Log, dated 3/19/24, included the resident would benefit from daily ROM to both upper extremities, and that ROM could be incorporated into daily resident morning care. Further review included the resident refused any devices to prevent reduction in ROM. A review of the OT Discharge Summary, dated 3/20/24, included discharge recommendations for nursing staff to continue ROM to the resident's upper extremities. On 11/20/24 at 11:22 AM, the surveyor conducted a follow-up interview with CNA #2 who stated she performed ROM exercises for Resident #2's hand contractures. The CNA explained that she would open and close the resident's hands during care, but that the resident's left hand was stuck, and caused the resident pain when opened. On 11/20/24 at 12:04 PM, the surveyor interviewed the Hospice Aide (HA) who stated she tried to perform ROM exercises on the resident's left hand, but the resident refused to let the HA open the resident's hand. On 11/21/24 at 10:57 AM, the surveyor conducted a follow-up interview with CNA #2 who stated for residents with contractures, the CNAs repositioned the resident every two hours and performed ROM exercises with care. The CNA further stated it was important to provide ROM exercises to contracted residents in order to make the resident flexible and prevent them from getting stuck. On 11/21/24 at 11:05 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #4 who stated for residents with contractures, the nursing staff performed ROM exercises and repositioned the resident every two hour to prevent worsening. LPN #4 further stated that contractures should be included on the resident's ICCP so that staff know what is going on with the resident to provide proper care. On 11/21/24 at 11:15 AM, the surveyor interviewed Licensed Practical Nurse/Resource Nurse (LPN/RSN) #1 who stated for residents with contractures, the nursing staff monitored the resident's skin integrity and performed ROM exercises for the resident to prevent worsening. LPN/RSN #1 further stated contractures should be included on the resident's ICCP so that everyone can follow the resident's plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 12:45 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated that for contracted residents, staff should be following the recommendations made by the therapy department to prevent worsening of contractures. The DON further stated the therapy recommendations should be included on the resident's ICCP which was revised by the interdisciplinary team as soon as there were changes in the resident's condition because the ICCP details the care that the resident needs. At that time, the surveyor informed the DON that Resident #2's ICCP did not include the resident's contractures and the DON confirmed that the resident's ICCP should have been revised to include the contractures. A review of the facility's Range of Motion Exercises policy, revised December 2023, included, Review the resident's care plan to assess for any special needs of the resident. A review of the facility's Care Plans, Comprehensive, Person-Centered policy, revised January 2024, included, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change, and, The Interdisciplinary Team must review and update the care plan: . At least quarterly, in conjunction with the required quarterly MDS assessment. NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41260 Complaint #: NJ173651 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide nail care to a resident who was unable to carry out activities of daily living (ADL) for 1 of 4 residents (Resident #2) reviewed for ADL care. This deficient practice was evidenced by the following: On 11/18/24 at 10:54 AM, the surveyor observed Resident #2 lying in bed. The resident's left hand appeared contracted and the fingernail on the resident's left middle finger was long in length and jagged. On 11/18/24 at 10:24 AM, the surveyor reviewed the medical record for Resident #2. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: unspecified dementia, major depressive disorder, generalized anxiety disorder, insomnia, and muscle weakness. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 10/23/24, included the resident had a Brief Interview for Mental Status score of 3 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident was dependent on staff for all activities of daily living (ADL). A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area, dated 8/1/23, that the resident had an ADL self-care performance deficit related to dementia. Interventions included: Check nail length and trim and clean on bath day and as necessary. A review of the Order Summary Report (OSR), dated as of 11/21/24, included the following physician orders (PO): A PO, dated 7/16/24, for showers biweekly every Tuesday and Saturday night shift. A review of the Progress Notes (PN) in the last six (6) months revealed there was no documentation that the resident refused to have his/her fingernails trimmed. On 11/20/24 at 10:20 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #2 who stated the activities staff were responsible for resident fingernail care. When asked about Resident #2, CNA #2 stated she had been the resident's CNA for about a year and that the resident's left hand was contracted. On 11/20/24 at 12:04 PM, the surveyor interviewed the Hospice Aide (HA) who stated she normally would file Resident #2's fingernails, but the resident refused the left hand. At that time, the surveyor observed both of Resident #2's hands in the presence of the HA who confirmed that the resident's right-hand fingernails were trimmed, but the left-hand fingernails were long. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 2:11 PM, the surveyor interviewed the Activities Director (AD) who stated the activities staff paint resident fingernails, but were not allowed to trim resident fingernails. On 11/21/24 at 10:57 AM, the surveyor conducted a follow-up interview with CNA #2 who stated the CNAs were responsible for residents' fingernail care and if the resident refused, the CNA would notify the nurse. CNA #2 further stated that it was important to provide nail care to prevent long nails for infection control and if the resident's hand was contracted, the fingernails could dig into the hands. On 11/21/24 at 11:05 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #4 who stated it was important to ensure residents with contracted hands did not have long fingernails to prevent skin breakdown. LPN #4 further stated he was unsure who was responsible for trimming resident fingernails, but that if a resident refused nail care, the nurse would document the refusal in the progress notes. On 11/21/24 at 11:15 AM, the surveyor interviewed Licensed Practical Nurse/Resource Nurse (LPN/RSN) #1 who stated it was important to ensure residents with contracted hands did not have long fingernails because it could create skin impairments. LPN/RSN#1 further stated it was the CNA's responsibility to check the residents' hands every day to see if the fingernails needed to be cleaned or trimmed. LPN/RSN#1 added that if the resident refused nail care, the staff should reapproach to improve compliance. On 11/21/24 at 12:45 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated the CNAs file the residents' nails as part of the residents' daily care. The DON further stated that if the resident refused nail care, the nurse should document the refusal. At that time, the surveyor informed the DON of Resident #2's long fingernails and the DON confirmed the CNA should notify the nurse of the resident's refusal for nail care. On 11/22/24 at 9:43 AM, in the presence of the LNHA and the survey team, the DON confirmed that she observed Resident #2's fingernails on the left hand to be jagged. A review of the facility's Care of Fingernails/Toenails policy, revised December 2023, included, Nail care includes daily cleaning and regular trimming, and, Trimmed and smooth nails prevent the resident from accidently scratching and injuring his or her skin. Further review of the policy included, Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if the nails are too hard or too thick to cut with ease, and, Notify the supervisor if the resident refuses the care. NJAC 8:39-27.2 (g)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 41260 Complaint #: NJ173651 and NJ174353 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to provide a resident with meaningful activities that reflected the resident's preferences for 1 of 1 resident (Resident #2) reviewed for activities. This deficient practice was evidenced by the following: On 10/18/24 at 10:24 AM, the surveyor reviewed the medical record for Resident #2. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: unspecified dementia, major depressive disorder, generalized anxiety disorder, insomnia, and muscle weakness. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 4/25/24, included the resident had a Brief Interview for Mental Status score of 3 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed it was important for the resident to do things with groups of people and that the resident was dependent on staff for all activities of daily living (ADLs). A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area, dated 11/1/23, that the resident was dependent on staff for meeting his/her leisure needs related to physical limitations and disease process. Interventions included: Patient preference of activities includes: socials and/or special events . day room activities . recreational room activities . and, Invite and assist to all daily activities as appropriate. [Resident #2] comes to the Recreation Room after lunch for the 2:00 activity. Further review of the ICCP revealed there was no documentation of refusal to go to activities. A review of the Progress Notes (PN) in the last six (6) months revealed the last Activity Participation Note was dated 5/23/24 at 2:32 PM which included, [Resident #2] received an individual visit from this writer for socialization and sensory stimulation. A further review of the PN in the last 6 months revealed there was no documentation that the resident refused to go to activities. On 11/20/24 at 1:00 PM, the surveyor reviewed the November 2024 Activities Calendar which revealed there was an activity called Family Feud scheduled for 2:00 PM in the Recreation Room. On 11/20/24 at 1:56 PM, the surveyor observed Resident #2 was lying in bed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 1:57 PM, the surveyor observed the Recreation Room. There were approximately five (5) residents sitting around a table talking to one (1) Certified Nursing Assistant (CNA #5). CNA #5 stated she was in the Recreation Room because she was on light-duty. When asked if an activity was going to start at 2:00 PM, the CNA was unsure about any activity or if an activity staff member was coming to the Recreational Room. The surveyor waited outside the Recreation Room until 2:10 PM, but no activity staff showed up to start the 2:00 PM activity. On 11/20/24 at 2:11 PM, the surveyor interviewed the Activities Director (AD) who was in her office at the time. The AD stated most of the activities were ran by the AD because there were currently no other activities staff. The AD explained the Family Feud activities game included residents being split into two teams that take turn answering questions related to a topic chosen by the AD. When asked if the activity was currently being held in the Recreational Room, the AD stated, I haven't gotten down there yet. The surveyor then asked about Resident #2, and the AD stated the resident stayed in his/her room primarily, but that the resident would benefit from attending activities in the Recreational Room because he/she could get stimulation from being around other residents. On 11/20/24 at 2:28 PM, the surveyor interviewed CNA #2 who stated Resident #2 did not have a get up schedule because the resident does not get out of bed, but that the resident had a geri-chair if he/she wanted to get up. CNA #2 further stated that the last time she asked the resident if he/she wanted to get up for an activity was about a week ago and the resident refused due to pain. At that time, the surveyor and the CNA entered Resident #2's room to ask if the resident wanted to attend an activity, and the resident stated he/she would like to go to the activity. CNA #2 then stated she would get the mechanical lift to get the resident out of bed. On 11/20/24 at 2:35 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #5 who stated Resident #2 had not gotten out of bed in a while, because the resident was contracted. LPN #5 explained that the resident did not go to the Recreational Room for activities because he/she hasn't been getting up. When asked about refusals, the LPN stated that if a resident refused to get up, the CNA would notify the nurse who would document the refusal in the resident's progress notes. LPN #5 verified that she was not made aware of any refusals by the CNA for Resident #2 for the current shift. On 11/20/24 at 2:40 PM, the surveyor observed CNA #2 with the mechanical lift in Resident #2's room with CNA #3 and CNA #4 who were assisting. During the transfer into the geri-chair, the resident did not refuse getting out of bed. CNA #3 stated the resident did not have his/her own assigned geri-chair, but that the resident should because the resident was on hospice. Once the resident was transferred into the geri-chair, CNA #2 stated she would take the resident to the Recreational Room. Further review of the November 2024 Activities Calendar revealed there was a 3:00 PM activity scheduled for the Recreational Room. On 11/21/24 at 10:57 AM, the surveyor conducted a follow-up interview with CNA #2 who stated the CNAs were responsible for getting residents ready to attend activities and either the CNA or the activity aide could take the resident to the Recreational Room. CNA #2 further stated activities were important to help residents relieve stress, calm residents, and make residents feel at home. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 11:05 AM, the surveyor interviewed LPN #4 who stated the CNAs, nurses, or activity aides were responsible for taking residents to the Recreational Room for activities. LPN #4 further stated that activities were important to keep residents social. When asked about refusals, the LPN stated that staff would encourage residents to go to activities and document in the progress notes whether the resident attended or refused the activity. On 11/21/24 at 11:15 AM, the surveyor interviewed Licensed Practical Nurse/Resource Nurse (LPN/RSN) #1 who stated CNAs were responsible for taking residents to the Recreational Room for activities. LPN/RSN #1 further stated that activities were important so that residents can be stimulated, socialized, and for their well-being. When asked about refusals, the LPN/RSN stated the resident has the right to refuse activities, and that the nurse would document the refusal in the progress notes. On 11/21/24 at 12:45 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated that if a resident was care planned to attend the 2:00 PM activity, staff should get the resident out of bed and ready for the activity, and if the resident refused, the staff should document in the resident's progress notes. The DON explained that activities were important for social interaction and resident engagement. At that time, the surveyor informed the DON of the observation made during the 2:00 PM activity and the DON confirmed that the staff should have offered to get Resident #2 out of bed for the activity. A review of the facility's Activities policy, revised March 2024, included the following: Activities should be planned with resident input and tailored to meet the individual interests, abilities, and needs of residents. The activities program should include a mix of group activities, one-on-one interactions, and self-directed activities. Activities should be inclusive, allowing residents of all physical and cognitive abilities to participate. Residents have the right to choose which activities they participate in and to decline participation without consequence. Their choice should be respected, and alternative options should be offered when possible. A record of all activities, including participation and outcomes, should be maintained. NJAC 8:39-4.1(a)22 NJAC 8:39-7.3(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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37547 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to: a.) notify the physician of an injury sustained by a resident, b.) obtain a physician's order for a wound treatment, and c.) document a skin assessment in accordance with the facility policy and professional standards of nursing practice. This deficient practice was identified for 1 of 1 resident (Resident #78) reviewed for skin conditions and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 11/17/24 at 10:54 AM, the surveyor observed Resident #78 lying in bed with a bandage that was not dated on his/her right lower forearm. There was a dried red substance on the right side of the resident's pillow. When interviewed, the resident stated that the bandage was applied by an unknown staff member the other day after the resident scratched themselves. On 11/18/24 at 12:19 PM, the surveyor observed Resident #78 lying asleep in bed. The resident had a bandage on his/her right lower forearm. On 11/19/24 at 9:35 AM, the surveyor reviewed the medical record for Resident #78. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: repeated falls, multiple fractures of ribs, right side, subsequent encounter for fracture with routine healing, malignant neoplasm (cancer) of unspecified site of right and left female breasts, chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe), pressure ulcer of left heel, unstageable (occurs when prolonged pressure prevents blood flow and oxygen from reaching the tissue) and a need for assistance with personal care. A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated 10/23/24, included the resident had a Brief Interview for Mental Status Score of 14 out of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed the resident was at risk for developing pressure ulcers/injuries but did not have any documented unhealed pressure ulcers/injuries present upon admission to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 10/17/24, that identified that the the resident was at risk for alteration in skin integrity related to impaired mobility. Interventions included: Weekly body audit by licensed staff. Report changes in skin integrity to MD (medical doctor), and Treatment as ordered by physician. A review of the Order Summary Report (OSR), included a Physician's Order (PO) dated 10/17/24, to conduct a full body assessment weekly on Thursday and document findings in assessments (weekly skin observation tool) every night shift every Thursday for skin check. With new wound identified. A PO dated 10/17/24, for Consults: Wound consult and treat as needed. A review of the Progress Notes (PN) revealed there was no documented evidence that the resident scratched themselves and required a bandage to be applied to the right lower forearm area as described by the resident. A review of the resident's Skin/Observation/checks dated 10/17/24, 11/7/24, and 11/8/24, reflected no documented evidence for the resident's right lower forearm skin alteration. On 11/19/24 at 10:04 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #6 who stated that she did not know why the resident had a bandage on his/her right lower forearm. CNA #6 further stated that the nurse removed it before he/she left yesterday. On 11/20/24 at 11:11 AM, the surveyor interviewed Registered Nurse (RN) #1 who stated that she was not aware that the resident had a bandage on his/her right lower forearm. RN #1 stated that if the resident had a skin tear you had to write a note in the progress notes, notify the family, call the doctor to initiate a treatment, and complete an incident report if it was a big skin tear. RN #1 stated that the resident's bandage should have been dated. RN #1 stated, as a nurse you have to write an order before you do a treatment. On 11/21/24 at 11:32 AM, the surveyor interviewed the Director of Nursing (DON) who stated that if a skin tear were identified, there should have been a wound investigation completed and a treatment order should have been obtained. The DON stated that if a scratch was observed on the resident's skin it should have been documented in the progress notes. The DON stated that she would have dated the dressing as it was part of an investigation and wound management. The DON further stated that she would also have expected to have seen it documented on the skin assessment if it were new. At that time, the DON confirmed that a wound investigation was not completed as required. A review of the facility's Accidents and Incidents-Investigating and Reporting policy reviewed/revised January 2024, included: The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following data, as applicable, shall be included on the Report of Incident/Accident form: The date and time the accident or incident took place; The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); The circumstances surrounding the accident or incident; Where the accident or incident took place; The name (s) of witnesses and their accounts of the accidents or incident; The injured person's account of the accident or incident; The time the injured person's Attending Physician was notified, as well as the time the physician responded and his other instructions; The date/time the injured person's family was notified and by whom; . Any corrective action taken; follow-up information; Other pertinent data as necessary or required; and The signature and title of the person completing the report . The Nurse/Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing services within 24 hours of the incident or accident. The Director of Nursing shall ensure that the administrator receives a copy of the Report of Incident/Accident form for each occurrence. A review of the facility's Charting and Documentation policy, reviewed/revised 1/21, included: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident' medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. .The following information is to be documented in the resident medical record: Objective observations; Treatments or services performed; Changes in the resident's condition; Events, incidents or accidents involving the resident; . .Documentation of procedures and treatments will include care-specific details including: The date and time the procedure/treatment was provided; The name and title of the individual (s) providing the care; The assessment data and/or unusual findings obtained during the procedure/treatment; How the resident tolerated the procedure/treatment; .Notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting. NJAC 8:39-11.2(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41260 Complaint #: NJ173651 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure floor mats were in place for 1 of 2 residents (Resident #2) reviewed for falls. This deficient practice was evidenced by: On 10/17/24 at 10:16 AM and 10/18/24 at 10:54 AM, the surveyor observed Resident #2 lying in bed. On both observations, there were no floor mats on either side of the resident's bed. On 10/18/24 at 10:24 AM, the surveyor reviewed the medical record for Resident #2. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: unspecified dementia, major depressive disorder, generalized anxiety disorder, insomnia, and muscle weakness. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 10/23/24, included the resident had a Brief Interview for Mental Status score of 3 out of 15 which indicated the resident's cognition was severely impaired. Further review of the MDS revealed the resident was dependent on staff for all activities of daily living (ADLs). A review of the individualized comprehensive care plan (ICCP) included a focus area, dated 8/1/23, that the resident was at risk for falls related to confusion, deconditioning, and incontinence. Interventions included: fall mat in place to left side of bed while resident is in bed, dated 8/2/23, and floor mat placed on right side of bed, dated 8/29/23. A review of the Order Summary Report (OSR), dated as of 11/21/24, included the following physician orders (PO): A PO, dated 8/2/23, for a floor mat in place to the left side of bed. A review of the Treatment Administration Record (TAR) for November 2024 did not include the PO for the floor mat. A review of the Progress Notes (PN) included a Nurses Note (NN), dated 8/29/23 at 11:52 PM, which revealed the resident rolled out of bed to the floor and sustained a bump to the right side of the head. A review of the Incident Report (IR), dated 8/29/24, revealed the resident was conscious laying on the right side next to his/her bed and had a small bump to the right side of his/her head. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 10:10 AM, the surveyor observed Resident #2 lying in bed and there was a floor mat to the resident's left side of the bed. On 11/20/24 at 12:04 PM, the surveyor interviewed the Hospice Aide (HA) who stated she has been the resident's HA for about three months. When asked how long the resident had a floor mat, the HA stated it must have been placed the night before because there was no floor mat when she cared for the resident the day before (11/19/24). On 11/21/24 at 10:57 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #2 who stated residents who had floor mats were supposed to have the floor mats down when the resident was in bed to prevent injury from falls. On 11/21/24 at 11:05 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #4 who stated residents who had floor mats were supposed to have the floor mats down when the resident was in bed to prevent serious injury from falls. On 11/21/24 at 11:15 AM, the surveyor interviewed Licensed Practical Nurse/Resource Nurse (LPN/RSN) #1 who stated fall interventions could include floor mats while the resident was in bed to prevent injury from falls. LPN/RSN #1 further stated that if a resident had a PO or was care planned for floor mats, the resident should have floor mats in place while in bed. On 11/21/24 at 12:45 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team. The DON stated if a resident had a PO for floor mats and the ICCP included interventions for floor mats, the resident should have floor mats in place while in bed for injury prevention. At that time, the surveyor informed the DON of observations of Resident #2's room without floor mats while the resident was in bed, and the DON confirmed that staff should have ensured the PO was carried out and that the floor mats were in place. The facility was unable to provide a policy related to floor mats. 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. 40041 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed a.) to provide a continuous positive airway pressure (CPAP- a machine used to keep breathing airways open during sleep) to accommodate the respiratory needs of a resident upon admission to the facility, b.) ensure the CPAP was stored in accordance with professional standards when not in use, and c.) ensure the individualized comprehensive care plan included CPAP therapy. This deficient practice was identified for 1 of 3 residents reviewed for respiratory care (Resident #52), and the evidence was as follows: On 11/17/24 at 11:10 AM, during the initial tour, Resident #52 was observed sitting upright in the wheelchair with their eyes closed. At that time, the surveyor observed a CPAP machine and face mask on top of the nightstand and the face mask was not properly stored inside a plastic bag. A review of the Admission Record (an admission summary), revealed the resident was admitted to the facility with diagnoses which included: heart failure, depression, obstructive sleep apnea, atrial fibrillation, hyperlipidemia, diabetes mellitus, and hypertensive chronic kidney disease. A review of the admission Minimum Data Set (MDS), an assessment tool, dated 10/31/24, revealed that the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) score of 13 out of 15, which indicated the resident's cognition was intact. Further review of the MDS did not reflect that the resident used a CPAP. A review of the Admission Notification form (a form completed prior to the arrival of the resident) indicated Resident #52 needed a CPAP machine. A review of the Physician's Progress Notes revealed the following: 10/31/24 at 9:15 AM, Late Entry .* obstructive sleep apnea (OSA) -continue cpap . 11/4/24 at 10:00 AM, *OSA -continue cpap. 11/7/24 at 9:43 AM, .*OSA needs mask, continue cpap. A review of the Order Summary Report (OSR) reflected a physician order (PO) dated 11/8/24, to apply cpap at eight (8) pressure setting indication (psi) at bedtime for sleep apnea. A review of the November 2024 Medication Administration Record (MAR) reflected that the resident did not begin CPAP therapy until 11/8/24. On 11/20/24 at 1:02 PM, the surveyor interviewed Registered Nurse (RN) #1, who stated that when there was an admission, she would review the discharge documentation from the hospital to find all the equipment and medication the resident needs. She also stated, they received an email as well, so they knew all of the things that the patient needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 9:46 AM, the surveyor interviewed the Case Manager (CM), Liaison who stated she would get the referrals from the sending facility and review their chart for clinical information. The CM further stated she completed the Admission Notification form, which included documentation of any special equipment the resident needed, and sent it to the unit secretaries. On 11/21/24 at 9:56 AM, the surveyor interviewed the Admission Coordinator (AC), who stated that when she received the Admission Notification form, notified the phyisican, the nurses, the Director of Nursing (DON), and Licensed Nursing Home Administrator (LNHA). She further stated she sent an email which included any special equipment such as oxygen, bipap/cpap machine that the resident needed. At that time, the AC pulled up an email pertaining to Resident #52's admission that was sent on 10/28/24 at 9:16 AM. She stated the email was sent to the Assistant Director of Nursing (ADON), the admissions department, the physicians, and nursing. On 11/21/24 at 10:13 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #3, who stated that before the resident arrived on the unit, she would get the completed Admission Notification form. LPN #3 further stated, most residents bring their own CPAP, but if the resident did not have their own CPAP, she would notify the resource nurse to follow-up, and usually the respiratory department would provide it. She continued by stating, she would get orders for the resident. The supervisor would then check the physician's orders, and if there was anything missing, they would obtain orders. On 11/21/24 at 10:58 AM, the surveyor interviewed the Medical Doctor (MD), who stated that if the resident has been on a BiPAP/CPAP, the facility can find a machine for him. The resident would just continue with the CPAP, and he was not sure why there was a delay. On 11/21/24 at 12:15 PM, the surveyor conducted a follow-up interview with the resident, who stated that while at home, he/she used the CPAP every night and was not sure of the delay in receiving it. Resident #52 also stated he/she had a nice CPAP at home but did not have anyone to bring it to the facility. They further stated did not think anyone knew at the time that they were on a CPAP or anything so they asked for one. On 11/21/24 at 12:28 PM, the surveyor conducted a follow-up interview with RN #1, who confirmed that she would get the Admission Notification form and the discharge summary upon admission. She further stated, if I were the one who caught this, I would call the doctor and say, the CPAP is not on the discharge summary. RN #1 stated she would ask the physican if they wanted to continue with it. RN #1 also stated that the resident complained that he/she used a CPAP and they did not have one. On 11/21/24 at 2:10 PM, in the presence of the survey team, and LNHA, the DON stated, the Admission Notification Form did not go to the nurse who admitted Resident #52. She further stated the Admission Notification form went to the physician and when a resident was admiited, the discharge summary was followed. 2.) On 11/17/24 at 11:10 AM, the surveyor observed Resident #52 sitting in a wheelchair with their eyes closed. The CPAP mask was on the resident's nightstand, uncovered and not in use. On 11/19/24 at 11:50 AM, the surveyor observed the resident sitting in a chair with his their eyes closed. The CPAP mask was on the resident's nightstand, uncovered and not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 11:51 AM, the surveyor returned to the resident's room for a follow-up. The resident was not present in their room at that time. The CPAP mask was observed hanging over the resident's nightstand and touching the floor. The surveyor left the resident's room and then returned with RN #1 to confirm the findings. At that time, RN #1 started to disconnect the mask from the CPAP and stated that she was going to replace it. On 11/19/24 at 11:53 AM, the surveyor interviewed LPN #5, who stated, the mask was supposed to be cleaned off with soap and water, after it dried it should be placed in the bag near the CPAP machine. On 11/20/24 at 11:29 AM, the surveyor interviewed RN #1, who stated, if the mask was not in use, it had to be in a bag. 3.) A review of the individualized comprehensive care plan (ICCP) did not include the CPAP. On 11/20/24 at 11:29 AM, the surveyor interviewed RN #1, who stated, when a resident was on a CPAP, it should be included on the care plan so everyone knew how to care for the resident. At that time, RN #1 pulled up the resident's electronic medical record (EMR) and confirmed that the care plan did not include the CPAP. On 11/20/24 at 02:30 PM, the surveyor interviewed the DON who stated, if a resident did not have their own CPAP/BiPAP machine, the facility had them in stock, we just program it and apply it to the patient. She further stated that the CPAP mask should be bagged and stored away, when not in use. The DON also stated the CPAP should be included in the care plan. A review of the facility's Durable Medical Equipment (DME) policy, reviewed/revised December 2023, included, Policy: The facility will ensure that residents or patients are provided Durable Medical Equipment, as prescribed by their provider. Durable Medical Equipment refers to items that are prescribed by a healthcare provider to aid in the treatment of a resident's medical condition. DME is intended for long-term use and includes items like: Wheelchairs, Hospital beds, Oxygen equipment, Walkers, Commode chairs, CPAP machines, Shower chairs, Prosthetics and orthotics .Storage: DME must be stored safely and properly to avoid damage or misuse. Facility will have designated areas for storing equipment when not in use. A review of the facility's Care Plan, Comprehensive Person-Centered policy, reviewed/revised January 2024, included Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and time tables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. NJAC 8:39 - 27.1(a) NJAC 8:39 - 19.4(a)(1-6) NJAC 8:39 - 11.2(f)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41072 Complaint NJ #'s: 168276, 169388, 173735 and 174353 Based on observation, interview, record review, and document review, it was determined that the facility failed to provide sufficient nursing staff to ensure all residents reached their highest practical wellbeing by failing to: a) provide timely incontinence care to 1 out of 4 residents (Resident #47) reviewed for Activities of Daily Living, and (b) sufficient nursing staff for 5 of 5 weeks of staffing prior to the recertification survey date of 11/22/24. The deficient practice was evidenced by the following: Refer to S0560 1.) On 11/19/24 at 11:04 AM, the surveyor observed the resident #47 lying in bed with his/her eyes closed. observed resident in bed. The surveyor observed the resident's family member at the bedside. The family member repositioned Resident #47 and showed the surveyor Resietn #47 incontinence brief which was saturated with urine and urine had leaked onto the cloth underpad. The resident's family meember stated that the resident was usually washed, dressed, and up in their wheelchair by this time. At 11:08AM, the assigned Licensed Practical Nurse (LPN #1) entered the room and confirmed that the incontinence brief was saturated with urine and had leaked urine onto the cloth underpad. At that time, the assigned Certified Nursing Assistant (CNA #1), along with another CNA, entered the room and confirmed the incontinence brief was saturated with urine and urine had leaked onto the cloth underpad. At that time, the surveyor along with the family member exited the room so the CNAs could provide incontinence care to Resident #47. On 11/19/24 at 11:24 AM, the surveyor observed Resident #47 dressed and sitting in his/her wheelchair. At that time, the surveyor interviewed CNA #1 who stated that she usually does ADLS with Resident #47 first thing in the morning but today she had to get rehabilitation residents up first, so they were ready for therapy. CNA #1 stated that she had a total of 13 residents that day which included 7 long term care residents who were dependent for ADL's and 3 rehabilitation residents (residents who were admitted for therapy) who also dependent in their ADL's. CNA #1 further stated that 4 of her 13 assigned residents also needed total assist with feeding. A review of the CNA Assignment Sheet, dated 11/19/24, indicated that CNA #1 was assigned 12 residents. On 11/18/24 at 11:24 AM, the surveyor reviewed the medical record for Resident #47. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), muscle weakness, mild cognitive impairment of unknown etiology, unspecified psychosis, and major depressive disorder. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated 10/8/24, 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 dependent in all activities of daily living, non-ambulatory, and always incontinent of bladder. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 9/11/23, that the resident was incontinent of bowel and bladder. Interventions included: clean peri-area with each incontinence episode. On 11/20/24 at 12:28 PM, the surveyor conducted d a follow up interview with CNA #1 who stated that on this day she was assigned a total of 10 long term care residents which included 8 residents who were dependent for all care. On 11/21/24 at 12:44 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, who stated that the nurse's on the unit will make the assignment for the CNA's. The DON stated that the CNA's should perform incontinence rounds on their residents every 2 hours and as needed. The DON stated that she was aware of the New Jersey (NJ) Mandated staffing ratios of one (1) CNA for every eight (8) residents on day shift. The DON confirmed that CNA #1 should not have been assigned 13 residents per the NJ Mandated staffing ratio. The DON further stated that the facility determined staffing levels needed per day by the census and the total care of the residents. A review of the facility's Supporting Activities of Daily Living policy, reviewed/revised January 2024, included that appropriate care and services will be provided for residents who are unable to carry out ADLs independently including .c) elimination (toileting). 43308 2.) A review of the Nurse Staffing Report for the following weeks provided by the facility revealed the following: 1. For the week of Complaint staffing from 10/08/2023 to 10/14/2023, the facility was deficient in Certified Nurse Aide (CNA) staffing for residents on 7 of 7 day shifts as follows: -10/08/23 had 9 CNAs for 131 residents on the day shift, required at least 16 CNAs. -10/09/23 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -10/10/23 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -10/11/23 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -10/12/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. -10/13/23 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. -10/14/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. For the week of Complaint staffing from 11/26/2023 to 12/02/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -11/26/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -11/27/23 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -11/28/23 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -12/02/23 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -12/02/23 had 6.9 CNAs to 15.4 total staff on the evening shift, required at least 8 CNAs. 3. For the week of Complaint staffing from 06/02/2024 to 06/08/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -06/03/24 had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. -06/07/24 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs. -06/08/24 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs. 4. For the 2 weeks of staffing prior to survey from 11/03/2024 to 11/16/2024, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -11/05/24 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -11/07/24 had 18 CNAs for 151 residents on the day shift, required at least 19 CNAs. -11/09/24 had 14.5 total staff for 151 residents on the evening shift, required at least 15 total staff. -11/10/24 had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. -11/12/24 had 17 CNAs for 148 residents on the day shift, required at least 18 CNAs. -11/16/24 had 19 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 11/21/24 at 2:22 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated the Director of Nursing (DON) and the Assistant DON (ADON) informed her of the staffing ratio requirements. She stated she scheduled according to the facility's census to ensure she met the requirements. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/22/24 at 9:58 AM, the surveyor interviewed the DON who stated the facility had an on-call rotation for staffing and they educated the staff on the expectations on arriving on time and calling out. The DON stated the facility did everything they could to handle call outs in real time. She stated that the staffing ratios had been okay and tried to ensure they were staffed according to the required staffing ratios. A review of the facility's Staffing policy revised December 2023, included, 1. Staffing levels: the facility will meet federal state, and local staffing requirements. 3. Staff to Resident Ratios: the facility will maintain a minimum staff-to-resident ratio of 1:8 during the day shifts, 1:10 during the evening shifts, and 1:14 during the night shifts. 4. Adjustments to staffing will be made based on: resident acuity levels; special care units; and fluctuations in resident census. 5. Staffing Assignments and Schedules: A staffing plan will be developed and reviewed regularly by the Director of Nursing, Scheduler, or designee to ensure appropriate allocation of resources. NJAC 8:39-5.1(a); 25.2(a,b); 27.1(a)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 37547 Based on observation, interview, and review of facility documents, it was determined that the facility failed to ensure that the daily Nursing Home Resident Care Staffing Report was posted and displayed in a place that was readily accessible to be viewed by both residents and the general public as indicated on the report. This deficient practice was identified on 5 of 5 nursing units and was evidenced by the following: On 11/18/24 at 9:37 AM, the surveyor observed the facility's Nursing Home Resident Care Staffing Report posted on the receptionist's desk in the front main lobby. A pass code was required to be entered into a keypad on the wall to gain access to the locked double doors that led to the nursing units. The surveyor toured the facility and did not observe the daily Nursing Home Resident Care Staffing Report posted on any of the five nursing units. On 11/21/24 at 2:10 PM, when the surveyor asked the Director of Nursing (DON) where the staffing report was posted she stated that it was posted at both entrances to the facility. When asked if the staffing report was available for residents and the general public to view without having to ask to see it, the Licensed Nursing Home Administrator (LNHA) was present and stated, Is that something that we need to have? On 11/21/24 at 2:22 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she just posted the staffing in the front and rehab lobbies and it was not accessible on the nursing units. A review of the facility's Staffing policy, reviewed/revised December 2023, failed to include any details that pertained to the required daily posting of the Nursing Home Resident Care Staffing Report. NJAC 8:39-41.2 (a)(d)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41072 Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was identified in the facility's kitchen and 5 of 5 pantries designated for resident food, and was evidenced by the following: On 11/88/24 from 9:16 AM to 10:26 AM, the surveyor, accompanied by the Food Service Director (FSD) toured the kitchen and observed the following: In the Walk-in Freezer: 1. one box containing French toast inside a plastic bag that was not closed and the French toast was open to the air. 2.One 10-pound box of veggie burgers inside a plastic bag that was not closed, and the burgers were open to the air. At that time, the FSD stated that the French toast and the veggie burgers should be closed and wrapped. On 11/19/24 at 9:32 AM, the surveyor accompanied by the Licensed Practical Nurse (LPN #1) observed the following in the 200-unit pantry: a) the freezer did not contain a thermometer b) the freezer had dark dust like debris on the white plastic bottom shelf. LPN #1 stated the freezer should be clean. On 11/19/24 at 9:20 AM, the surveyor, accompanied by the Director of Nursing (DON), observed the following in the 100 Unit pantry: a) the freezer had dark dust like debris on the white plastic bottom shelf. b) the Microwave had dried food particles inside oven and on the inside of the door. The DON stated that housekeeping cleans the refrigerators and freezers. On 11/19/24 at 9:32 AM, the surveyor, accompanied by the Registered Nurse/Resource Nurse (RN/RSN #1), observed the following in the 300 Unit pantry: a) the freezer did not contain a thermometer (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b) the freezer had ice build up c) the freezer contained a pint of chocolate brownie ice cream, not dated, or labeled, with ice buildup on the container. RN/RSN #1 stated that the ice cream belonged to a resident and should have had a name and date on it. The surveyor observed a sign on the refrigerator that all temperature logs maintained in the kitchen. On 11/19/24 at 9:49 AM, the surveyor, accompanied by the Minimum Data Set (MDS) Coordinator, observed the following in the 400-unit locked pantry: a) a stainless-steel sink had dried food particles and dust like debris in the sink area. b) The water machine outside the locked pantry had white debris on the grate. The MDS Coordinator stated that she thought housekeeping was responsible to clean the pantry. On 11/19/24 at 9:58 AM, the surveyor, accompanied by the Registered Nurse/Resource Nurse (RN/RNS#2), observed the following in the 500-unit locked pantry: a) food particles outside the microwave. b) red and clear liquid on the bottom tray of the refrigerator. RN/RNS #2 stated that FSD comes into the pantry and cleans it, or housekeeping cleans the pantry. On 11/19/ 24 at 10:05 AM, the surveyor interviewed the housekeeper on the 500 unit (HSK #1) who stated that the floor technician was responsible and I think they are cleaned daily. On 11/19/24 at 9:36 AM, the surveyor interviewed HSK #2 who stated that the floor technician was responsible for cleaning the pantry. On 11/20/24 at 10:07 AM, the surveyor interviewed the Housekeeping Supervisor (HS) who stated that the floor technician was responsible to clean the floors, tables, sink and counter in the pantries and the dietary department was responsible for the refrigerator, freezer, and ice machine. The HS stated that the housekeeper should have cleaned the stainless sink and microwaves in the pantries. The HS further stated that there was a miscommunication of who cleans the stainless sinks in the locked pantries on the 400 and 500 units. On 11/21/24 at 10:38 AM, the surveyor interviewed the FSD who stated that dietary department was responsible for cleaning the refrigerator and freezers daily. The FSD stated the freezers would be de-iced once a week, on Fridays, when the refrigerators were scheduled for a deep clean. The deep clean would be completed by both the dietary and housekeeping departments.The FSD further stated that ice machines were cleaned monthly. The FSD stated that he removed the thermometers from the 200- and 300-unit freezers because they weren't working. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/21/24 at 12:44 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), in the presence of the DON and survey team, stated that his expectation would be that the pantries would be kept clean, thermometers would be in the freezers, and the refrigerators and freezers would be clean. Review of the facility's Food receiving and Storage policy, reviewed/revised December 2023, included, All foods stored in the refrigerator or freezer will be covered, labeled, and dated. All food belonging to residents must be labeled with the resident's name, the item, and the date. Refrigerators must have working thermometers and be monitored for temperature according to state specific guidelines. The facility did not provide a policy on the cleaning the pantry area. NJAC 8:39-17.2(g)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 41072 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris. This deficient practice was evidenced by the following: On 11/18/14 at 10:06 AM, during initial kitchen tour with the Food Service Director (FSD), the surveyor observed the trash company at the dumpster area. The surveyor observed the debris, trash, leaves around the enclosed dumpster area. The dumpster area included four (4) blue dumpsters and one (1) black dumpster container for used oil. The surveyor observed five (5) black trash bags lying directly on the ground next to the first dumpster and one (1) black trash bag lying directly on ground next to third dumpster. At that time, the surveyor, in the presence of the FSD, interviewed the driver of the trash company who stated that he had just moved the (5) black trash bags that were lying in front of the dumpster directly on the ground to the side of the dumpster so he could get access the dumpster. The FSD stated that there should be no debris, trash, or trash bags outside or around the dumpster area. The FSD further stated that it was maintenance, housekeeping and dietary who was responsible for cleaning the dumpster area. The FSD stated it was important to keep the dumpster area clean to avoid pests or rodents to get in the area. On 11/20/24 at 9:45 AM, the surveyor interviewed the Facility Manager (FM) who stated that both maintenance and dietary were responsible to clean the dumpster area. The FM further stated that no debris, trash, or trash bags should be on the ground around the dumpsters to keep out rodents. On 11/21/24 at 12:44 PM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON) and the survey team, stated that it was unacceptable to leave bags of trash on the ground around the dumpsters. A review of facility's Disposal of garbage: policy, reviewed/revised March 2024, included: - containers and dumpsters shall be kept covered when not being loaded and the surrounding shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized. -garbage should not accumulate or be left outside the dumpster. N.J.A.C. 8:39-19.3(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37547 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to follow appropriate infection control practices during the provision of a wound treatment. This deficient practice was observed for 1 of 1 nurse (400 Unit) observed during the provision of wound care to 1 of 1 resident (Resident #62) and was evidenced by the following: On 11/17/24 at 11:24 AM, the surveyor observed Resident #62 lying in bed on an air mattress. On 11/18/24 at 12:27 PM, the surveyor reviewed the medical record for Resident #62. A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included: osteomyelitis (a bone infection), unspecified, type 2 (two) diabetes mellitus with diabetic chronic kidney disease, muscle weakness (generalized), need for assistance with personal care and pressure ulcer of sacral region, Stage 4 (four) (Full thickness tissue loss with exposed bone, tendon or muscle). A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool, dated 10/31/24, 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 had one Stage 2 (two) pressure ulcer (partial thickness loss of dermis (skin)), and one Stage 4 (four) pressure ulcer that were present upon admission/entry or reentry to the facility. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 10/26/24, that the resident had actual skin breakdown related to a sacral and right buttock wound. Interventions included: Administer treatment per physician orders, Encourage and assist as needed to turn and reposition; use assistive devices as needed, Pressure reducing specialty mattress on bed, and Wound clinic referral and follow-up as ordered. A review of the Order Summary Report (OSR) included the following physician's orders (PO): A PO, dated 11/3/24, for Cleanse wound to right buttock with normal saline, pat dry and apply Medihoney then dressing every shift. A PO, dated 11/3/24, for Santyl (to remove damaged skin from chronic wounds) External Ointment 250 Unit/GM (grams) (Collagenase) Apply to sacrum topically every shift for sacral wound. Cleanse sacral wound with normal saline, apply Santyl and pack with gauze soaked with Dakin's solution. Then apply dry dressing. A PO, dated 11/4/24, for Dakin's (1/4 strength) External Solution 0.125 % Apply to sacral (triangular bone at the base of the spine) wound topically every day shift for pack sacral wound with Dakin's soaked gauze. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 10:19 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #7 who stated that she worked at the facility for one month and had seen improvement in the resident's wound. LPN #7 stated that she was assigned to Resident #62 and was prepared to perform the resident's wound treatment at that time. LPN #7 was at the medication cart and cleaned her hands with Alcohol Based Hand Rub (ABHR) before she accessed the computer to review resident's wound treatment orders aloud prior to the treatment observation. LPN #7 then proceeded to clean the treatment cart with a disinfectant wipe. LPN #7 then accessed the treatment cart without first performing hand hygiene and removed a bottle of Dakin's 1/4 strength solution from the treatment cart. She then proceeded to donn (put on) gloves and prepared sterile gauze with normal saline solution. LPN #7 then proceeded to doff (remove) her gloves. LPN #7 then donned gloves without first performing hand hygiene before she prepared sterile gauze with Dakin's 1/4 strength solution, prepared the Medihoney and Santyl and obtained a border gauze dressing. LPN #7 then doffed her gloves and failed to perform hand hygiene, before she proceeded to look through the treatment cart and removed different styles of dressings before she made a selection. LPN #7 then donned a pair of gloves and opened a package of gauze pads, and the applied Medihoney onto the gauze pad with a tongue depressor. LPN #7 then doffed her gloves and cleaned her hands with ABHR. LPN #7 brought the treatment supplies into the resident's room and placed them on the resident's table which was already sanitized and had a drape that covered the top. LPN #7 then proceeded to doff her gloves and washed her hands in the resident's room for eight seconds before she donned a mask, gown, and gloves. LPN #7 then proceeded to remove the resident's outer dressing and packing from his/her sacral wound. LPN #7 then doffed her gloves and cleaned her hands with ABHR. LPN #7 then donned gloves and cleaned the resident's sacral wound with normal saline solution. LPN #7 then doffed her gloves and washed her hands for eight seconds. LPN #7 then donned gloves and applied Santyl to slough (dead tissue) with a sterile cotton tipped stick. LPN #7 then doffed her gloves and donned another pair of gloves without first performing hand hygiene. LPN #7 then proceeded to pack the resident's sacral wound with a tongue depressor. LPN #7 then applied a border gauze dressing that was dated to the outer sacral wound. LPN #7 then cleaned her hands with ABHR before she donned gloves and applied Medihoney to the right buttock and covered it with a dated border dressing. LPN #7 then doffed her gloves and began to remove the trash from the room. LPN #7 then donned gloves without first performing hand hygiene and proceeded to clean the treatment scissors with a disinfectant wipe. LPN #7 then doffed her mask, gown, and gloves, discarded the trash and washed her hands after the treatment was completed. On 11/20/24 at 10:53 AM, the surveyor interviewed LPN #7 who stated that she was required to wash her hands for at least 30 seconds and sang happy birthday twice to ensure the appropriate length of time for hand washing. LPN #7 stated that when you doffed your gloves, you were supposed to use ABHR or wash your hands. (continued on next page)

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	11/22/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 11:17 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that staff were required to wash their hands for 20 seconds. The IP further stated that if hand washing were performed for less than twenty seconds it was an infection control concern. The IP further stated that when doing a wound treatment, when the soiled dressing was removed hand washing was required to be performed for twenty seconds. The IP stated that if hand washing was performed for less than twenty seconds then they were not taking the germs off of their hands. The IP further stated that staff were required to wash their hands when they doffed their gloves or cross-contamination could occur. The IP stated that stuff could get inside your gloves and you have to use soap and water to get the bacteria off of your hands, not the hand sanitizer. On 11/21/24 at 11:36 AM, the surveyor interviewed the Director of Nursing (DON) who stated that every time staff removed (doffed) their gloves they were required to perform hand hygiene. The DON stated that hands should be scrubbed for thirty seconds, or twenty seconds minimally. The DON stated that if staff washed their hands for less than twenty seconds they were not cleaned. On 11/22/24 at 10:20 AM, the DON provided the surveyor with a Licensed Nurse Clinical Skills Checklist and Competency evaluation and an Infection Control Competency Checklist which included, Skill #1: Hand Hygiene (Hand Washing) that was completed by LPN #7 on 10/22/24 with demonstrated competency and a Treatment Administration competency that was completed by LPN #7 on 10/22/24 with demonstrated competency. A review of the facility's HandWashing/Hand Hygiene policy, reviewed/revised May 2023, included: The facility considers hand hygiene the primary means to prevent the spread of infections. .All personnel shall follow the hand washing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. .Wash hands with soap .and water for the following situations: When hands are visibly soiled; . .Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap . Before and after coming on duty; Before and after direct contact with residents; Before preparing and handling medications; Before performing any non-surgical invasive procedures; . .Before donning sterile gloves; Before handling clean or soiled dressings, gauze pads, etc.; (continued on next page)

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	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Before moving from a contaminated body site to a clean body site during resident care; After contact with a resident's intact skin; After contact with blood or bodily fluids; After handling used dressings, contaminated equipment, etc.; After contact with objects in the immediate vicinity of the resident; After removing gloves; Before and after entering isolation precaution settings; . .the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. .Washing Hands: Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) . NJAC 8:39-19.4