STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315245	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cherry Hill	1399 Chapel Ave West Cherry Hill, NJ 08002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, it was determined that the facility failed to: a) maintain kitchen equipment in a clean, safe and sanitary manner, and b) maintain the garbage dumpster area in a clean, safe manner, and free from pests as evidenced by the following:On 8/21/25 at 10:36 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following:1. The can-opener blade had a metal chip on the right side and brown sticky food debris on the blade and screw connection. The FSD acknowledged it had not been changed since she started working at the facility. The FSD acknowledged that the can-opener was not cleaned according to facility policy. The FSD was unable to produce a maintenance log to indicate when the blade should be replaced.2. The can-opener holder attached to the counter had a blue insert which was covered with brown sticky debris. A cleaning log for the can-opener could not be provided. The FSD acknowledged that it was not cleaned according to facility policy.3. The garbage dumpster and surrounding area had loose debris on the ground, and the dumpster lids were left open. The FSD acknowledged it and stated that it should be cleaned and closed according to facility policy.On 8/25/25 at 1:57PM The surveyor interviewed the FSD, who stated, the can-opener should have been cleaned, and the blades should be checked and changed when needed. She further stated, the dumpster lids should have been closed, fallen debris should have been picked up, and the surrounding area should have been cleaned to prevent the attraction of flies, rodents or other vermin. The FSD acknowledged the surveyors concerns and agreed that it was not done according to the facility policy.On 8/27/2025 at 10:12 AM, the surveyor met with Licensed Nursing Home Administrator (LNHA) and Chief Operating Officer (COO). The LNHA acknowledged the surveyors concerns after reviewing the pictures of the kitchen equipment and dumpster area. The LNHA stated that the equipment should be cleaned and maintained to prevent food borne illness, contamination, or injury. The LNHA stated this ensures the safety of our resident and staff.A review of the facility's undated, Food Preparation Area policy, .[Facility name redacted] will maintain a clean, sanitary, and safe food preparation area.all machines and equipment that require cleaning shall be cleaned after use.A review of the facility's undated, Sanitation policy, .the food service area shall be maintained in a clean and sanitary manner.keep food service areas, equipment, and utensils clean, sanitary, and well maintained.repair or discard damaged items that affect cleanliness or safety.Food Service Manager to schedule cleaning and oversee staff maintenance of cleanliness and equipment.A review of the facility's undated, Food-Related Garbage and Rubbish Disposal policy,.food-related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters.garbage and rubbish containing such wastes will be stored in a manner that is inaccessible to vermin.outside dumpsters provided by garbage pickup services may be kept closed and free of surrounding litter.NJAC 8:39-17.2(g)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Many	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to: a) follow appropriate infection control protocol for hand hygiene during the medication pass observation b) ensure that essential personal protective equipment (PPE, equipment worn to prevent the spread of infection) was readily available for all staff and visitors: This deficient practice was identified for 1 of 2 nurses on 1 of 2 nursing units (Second Floor) during the medication pass observation and for 3 of 3 nursing units observed for adherence to infection control practices. This deficient practice was evidenced by the following:1) On 8/22/25 at 8:21 AM, the surveyor met with Licensed Practical Nurse (LPN) #4 at the medication cart to observe the medication pass. LPN #4 stated that she needed to clean the electronic blood pressure machine prior to use. LPN #4 then proceeded to donn (put on) gloves before she used a disinfectant wipe to clean the attached blood pressure cuff and pulse oximeter probe (a device placed on the finger to obtain the amount of oxygen in the blood). LPN #4 then doffed (removed) her gloves and discarded them and then failed to perform hand hygiene before she proceeded to donn a disposable face mask. LPN #4 then proceeded to push the rolling automated blood pressure machine into Resident # 49's room. LPN #4 then placed the blood pressure cuff on the resident's right arm and then placed the pulse oximetry probe (a device placed on the finger to measure the blood oxygen level) on the resident's left index finger and obtained the resident's vital signs (blood pressure, heart rate, and pulse oximetry reading). On 8/22/25 at 8:27 AM, the surveyor observed LPN #4 as she returned to the medication cart and donned a pair of gloves before she cleaned the blood pressure machine, blood pressure cuff, and pulse oximetry probe with a disinfectant wipe. LPN #4 then proceeded to doff her gloves and failed to perform hand hygiene before she accessed the computer and picked up the water pitcher and poured water into a disposable cup intended for the resident. LPN #4 then prepared Resident #49's medications for administration. Immediately after, LPN #4 entered Resident #49's room and handed the resident their oral medications that were stored in a plastic medication cup and then handed the resident a cup of water to take their medications with. On 8/22/25 at 8:34 AM, LPN #4 returned to the medication cart and used alcohol-based hand rub (ABHR) to clean her hands after she medicated Resident #49. On 8/22/25 at 8:48 AM, LPN #4 entered the room of Resident #116 and placed a blood pressure cuff on the resident's right arm and a pulse oximetry probe on the resident's left index finger. At that time, LPN #4 donned gloves and requested assistance of another staff member to pull the resident up in the bed in preparation for medication administration. On 8/22/25 at 8:55 AM, LPN #4 doffed her gloves and failed to perform hand hygiene after before she began to prepare medications for Resident #116. LPN #4 stated that that she ordered Keppra (anti-seizure medication) 500 MG (milligrams) half tablets (250 MG) yesterday, but the order was not yet received. LPN #4 then stated, I can just break it in half and then proceeded to use her bare hands to split the Keppra 500 MG scored (marked) tablet in half. LPN #4 then proceeded to crush the resident's medications with a pull crusher before she placed the crushed medication in apple sauce and administered the medication to the resident with a plastic spoon. On 8/22/25 at 9:01 AM, LPN #4 entered the pantry and proceeded to wash her hands for twenty seconds. When finished, she dried her hands on a paper towel, and she then used the same paper towel that she dried her hands off with to turn off the faucet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/22/25 at 9:03 AM, LPN #4 donned gloves and proceeded to clean the blood pressure machine, cuff, and pulse oximetry probe with a disinfectant wipe. At that time, Resident #19 approached the medication cart in a wheelchair and asked LPN #4 for their medications. Without first doffing her gloves and performing hand hygiene, LPN #4 then proceeded to place a blood pressure cuff on Resident #19's left lower arm with her gloved hands that she had previously worn to clean the blood pressure machine. On 8/22/25 at 9:07 AM, LPN #4 then cleaned the blood pressure cuff and machine after use with a disinfectant wipe. On 8/22/25 at 9:08 AM, LPN #4 doffed her gloves and accessed the computer without first performing hand hygiene. LPN #4 then opened the top drawer of the medication cart and removed a multidose bottle of aspirin without first performing hand hygiene. On 8/22/25 at 12:54 PM, in a later interview with LPN #4, LPN #4 stated that hand hygiene should have occurred before she donned her gloves and after she doffed her gloves. LPN #4 stated that she should have sanitized her hands prior to medication administration for infection control purposes. LPN #4 stated that she should have cleaned her hands after she obtained Resident #116's vital signs and pulled the resident up in bed. LPN #4 further stated that she should have then washed her hands before she touched a medication with her bare hands for infection control purposes. LPN #4 stated that it was an infection control issue if soiled gloves were worn to clean the blood pressure machine and then proceeded to obtain Resident #19's vital signs. LPN #4 further stated that she should have performed hand hygiene before she then proceeded to prepare medications for Resident #19 for infection control purposes. On 8/22/25 at 1:12 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that it was an infection control issue if gloves were worn to clean the blood pressure machine, hand hygiene was not performed after the gloves were doffed. The LPN/UM #1 stated that hand hygiene should have been performed prior to medication administration. The LPN/UM #1 stated that you had to remove your gloves after the blood pressure machine was cleaned and then cleaned your hands before you obtained the resident's vital signs for infection control purposes. The LPN/UM #4 stated that the nurse should not have broken the scored medication with her bare hands because that was an infection control issue. On 8/22/25 at 2:05 PM, the surveyor interviewed the Director of Nursing (DON) #1 who stated that it was not appropriate to break a scored medication with your bare hands for infection control purposes. The DON #1 stated that LPN #4 should have used hand sanitizer or washed her hands after she cleaned the blood pressure machine and before she medicated the resident for infection control and to prevent the spread of germs. The DON #1 stated that LPN #4 should have doffed her gloves and washed her hands before she obtained the resident's vital signs. At that time, DON #1 stated that after you washed and dried your hands and disposed of the paper towel, you should get a dry paper towel to turn off the faucet. The DON #1 further stated that the same paper towel that was used to dry your hands should not have been used to turn off the faucet for infection control purposes. On 8/26/25 at 1:23 PM, in the presence of the survey team the Licensed Nursing Home Administrator (LNHA) was made aware of all infection control concerns that were observed during the medication pass observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) On 08/21/2025 at 11:18 AM, a surveyor observed a resident room with a blue bird sign on the name plate. The surveyor asked Licensed Practical Nurse (LPN) #1 what the sign meant, she replied they indicated Enhanced Barrier Precautions (EBP) residents required the use of gloves and gowns to be worn for when a resident had a wound, or indwelling urinary catheter, etc. When asked where Personal protective equipment (PPE) was kept, LPN #1 stated that gloves were in the room, and gowns and masks were kept in a yellow cart at the end of the hallway. The surveyor observed the cart and noted that there were no gowns inside. On 8/22/25 at 12:34 PM, the surveyor observed the first-floor PPE (personal protective equipment, clothing or equipment worn to protect one from infection or harm) cart in the hallway and it was out of protective gowns. On 08/25/2025 at 10:08 AM, the surveyor observed the second floor yellow PPE cart in the hallway. It was stocked with gloves and masks, but no protective gowns were observed. The surveyor interviewed LPN #2 who stated all the PPE was kept in the yellow PPE carts, and there was one per unit. When asked about the lack of gowns in the PPE cart, LPN #2 stated that the cart must be out of stock, and that more gowns were stored downstairs. LPN #2 further stated that she would let someone know. On 8/26/25 at 10:36 AM, the surveyor observed the first floor yellow PPE cart in the hallway. It was stocked with gloves and masks, but no gowns were present. On 8/26/25 at 11:43 AM, the surveyor observed the second floor yellow PPE cart in the hallway. It was stocked with gloves, masks, and three isolation gowns were present. At that time the surveyor asked LPN/Unit Manager (LPN/UM) #1 how staff was made aware that caring for a resident would require PPE; she stated the rooms were marked with a blue bird sign, and the isolation status was listed in the resident's chart. When asked if all PPE was stored in the yellow carts, LPN/UM #1 stated that all PPE for the unit was kept in the cart; and if the cart ran out of a particular PPE item, she would call down to request more from central supply. On 8/26/25 at 12:28 PM, the surveyor, in the presence of another surveyor and the Chief Operation Officer (COO) observed the first-floor isolation cart with no isolation gowns available. The COO confirmed that gowns were not present in the cart and he walked the surveyors to the central supply room where they confirmed that the facility was out of gowns and had placed an order the day before on 8/25/25 and was expecting a delivery by 8/27/25. When asked about the importance of having isolation gowns and other PPE readily available for staff and visitors; the COO stated the use of PPE was important to prevent the spread of infection, house wide, and that the Infection Preventionist usually kept Periodic Automatic Replacement (PAR) levels, but they were on vacation. On 8/26/25 at 1:19 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) was made aware of all infection control concerns related to Personal Protective Equipment. A review of the facility's undated Handwashing/Hand Hygiene policy, Included: It is the policy of this facility that handwashing/hand hygiene be regarded as the single most important means of preventing the spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Appropriate handwashing/hand hygiene must be performed at the follow [sic.] times:.Before preparing medication pass,.before and after all resident care activities. A review of the facility's Enhanced Barrier Precautions policy undated, included, Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/Showering, Transferring, Providing hygiene, changing linens, device care or use, wound care, changing briefs or assisting with toileting.make PPE, including gowns and gloves, available immediately outside of the resident room. NJAC 8:39-19.4;19.8

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview and document review, it was determined that the facility failed to ensure that all residents that maintained a Personal Needs Account (PNA): a.) received a written notification when approaching the limit that could jeopardize a resident's eligibility for Medicaid or Supplemental Security Income (SSI) and b.) funds and final accounting of those funds were conveyed within 30 days of the resident's discharge to the proper jurisdiction.This deficient practice was identified for 3 of 3 residents (Resident #50, #55 and #143) reviewed for PNA and was evidenced by: A review of the facility's Trial Balance revealed 3 (three) residents had balances that ranged from $1,901.47 to $6,917.52.On 8/25/2025 at 1:59 PM, the surveyor interviewed the Business Office Manager (BOM) who stated a written notification should be sent out when the resident's balance reached $1800.00 for the monies to be spent down. She stated the residents could not have more than $2,000 in their account. The BOM stated if the resident was over the limit they would not be eligible for recertification for Medicaid eligibility because they were over resourced. At that time, the BOM stated that Resident #50 Trial Balance was $2,112, and the resident's representative payee should have been notified. The BOM then stated she did not know if the representative was notified because she did not manage the accounts.The BOM stated Resident #55 was at $1,901.47 and there was no way to know if the notices were sent out. The BOM stated Resident #143's Trial Balance reflected a balance of $6,917.52, and the monies for room and board were not applied. The BOM stated that the resident was discharged on 7/9/24, and the balance that remained in the account should have been sent to the resident directly if he/she requested it or sent back to social security. The BOM stated the monies should have been returned in 30 days, but that preceded her employment. The BOM acknowledged and confirmed that the residents should have been notified of the need to spend down their monies at the $1,800 balance mark. The BOM further stated that the monies should have been returned within 30 days of the resident being discharged . On 8/26/25 at 2:35 PM, the Licensed Nursing Home Administrator (LNHA) provided the PNA balances as of 8/21/25. On 8/27/25 at 10:03 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) #2 confirmed the notifications were not sent. He acknowledged the written notification letter should have been set out to the resident reaching the maximum amount and the monies should have been sent back within 30 days of the resident being discharged . A review of the facility's Resident Funds policy undated, included, to provide clear accountability for each resident's funds held by the facility.upon DC [discharge] the facility will convey in 30 days the resident's funds and a final accounting of those funds to the resident NJAC 8:39-9.5

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the resident's environment, equipment, and living areas in a safe, sanitary, and homelike manner for 3 of 3 nursing units (100 unit, 200 unit, and 300 unit) observed for environment.This deficient practice was evidenced by the following: 1) On 8/21/25 at 11:18 AM, during the initial tour of the first-floor unit, the surveyor observed an unsampled resident in room130-D lying in bed with his/her eyes closed. The surveyor observed brown liquid on the floor at the base of the tube feeding pole next to the head of the bed. There was a black fly observed on the linens on bed 130-D. At that time, the surveyor observed the linens on the unoccupied bed in room [ROOM NUMBER]-C had a brown stain in the middle of the bed and had three (3) three black flies on the linens and one (1) black fly on the air mattress pump. The surveyor also observed a white plastic laundry basket next to bed 130-C that had a brown substance smeared inside of the basket. On 8/25/25 at 9:04 AM, the surveyor observed two (2) black flies on the resident's linens in room [ROOM NUMBER]-D and two (2) black flies on the linens of bed 130-C. On 08/25/25 at 9:31 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #2 who also acknowledged the presence of black flies on bed 130-C. CNA #2 stated that there had been flies on resident's beds before, but they are mostly residents who were incontinent. On 8/25/25 at 9:07 AM, the surveyor observed a floor mat next to the bed in room [ROOM NUMBER]-A with white crumbs noted on the mat. On 8/26/25 at 9:16 AM, the surveyor interviewed the housekeeper (HK) #1 who stated that she was the housekeeper for H1, which included the rooms, the unit kitchen and the bathroom. HK #1 stated that each room was cleaned daily, and the rooms were only deep cleaned when a resident was discharged . HK #1 further stated that she had not seen any flies in the residents' rooms. On 8/2625 at 9:27 AM, the surveyor interviewed the housekeeping director (HD) who stated that that the housekeepers clean each room daily. He stated that there was a schedule for daily cleaning. The HD further stated that the previous director of housekeeping did not have a schedule for rooms to be deep cleaned and the rooms were only deep cleaned after a resident was discharged . The surveyor showed the HD the pictures from room [ROOM NUMBER] which included the flies, linens and brown liquid on the floor. The HD stated that he had room [ROOM NUMBER] on the list to be deep cleaned. The HD stated that it was important that residents' rooms were kept in a clean and sanitary condition because they lived at the facility, and it was their right. On 8/26/25 at 10:23 AM, the surveyor interviewed the Director of Maintenance (DOM) who stated that no one had alerted him about the black flies in room [ROOM NUMBER]. The DOM stated If I was notified of the black flies, I would have called an exterminator. On 8/26/25 at 12:05 PM, the surveyor interviewed with Licensed Nursing Home administrator (LNHA) who stated the resident's rooms were cleaned every day. The housekeepers have a schedule they used when cleaning the nursing units. The LNHA stated there was a schedule for rooms to be deep (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaned and he would provide the schedule. The LNHA stated that it was important that residents' rooms were kept clean and sanitary because the residents should have a homelike environment. The LNHA stated that If the staff saw flies in a resident's room, the staff should put it in the electronic maintenance log or verbally inform the maintenance department. The LNHA stated We were aware that room [ROOM NUMBER] had been a problem, so we put that room on a every two-weeks deep cleaning schedule. On 08/27/2025 at 9:36 AM, the LNHA stated that the previous housekeeping director had a deep clean schedule that each room was deep cleaned every 60-90 days. The LNHA provided a calendar schedule for August 2025 that included room [ROOM NUMBER] was to be deep cleaned on 8/27/25, but he was unable to provide any documentation when room [ROOM NUMBER] was last deep cleaned. The LNHA also proved a copy of the pest log which revealed there were no reports of black flies in resident's rooms until 8/26/25, after surveyor inquiry. The surveyor showed the LNHA pictures of the black flies, laundry basket, linens, brown liquid on the floor in room [ROOM NUMBER] and the picture of the floor mat in room [ROOM NUMBER]. On 8/26/25 at1:21 PM, the surveyor notified the LNHA and the DON of the concern with the environment in room [ROOM NUMBER] and room [ROOM NUMBER]. On 8/27/25 at 10:02 AM, in the presence of the survey team and DON, the LNHA stated that room [ROOM NUMBER] should have been on a more frequent deep cleaning schedule and will now be on every two-week deep cleaning schedule. 2) On 8/21/2025 at 10:47AM, in the presence of the Director of Maintenance (DOM) and the Assistant Maintenance Technician (AMT), the Life Safety Code surveyor (LSC) observed rotted, crumbling sheetrock (dry wall) behind the loose cove base (a trip piece used to transition between a wall and the floor) in room [ROOM NUMBER]. At 10:50 AM, the LSC surveyor observed a shared hall bathroom, across from the nursing station on 200 hall, with the door wide open, feces smeared across the toilet seat, and what appeared to be a used adult brief was opened and laid on the upright toilet seat, and an overflowing trash can. At 11:00 AM, the LSC surveyor observed bags and boxes piled on the tile floor of the resident shower room. When interviewed, the DOM and AMT confirmed the observations. On 8/21/2025 at 1:37 PM, in the presence of the AMT, the LSC observed environmental concerns in room [ROOM NUMBER] while conducting a Life Safety tour of the room. The LSC surveyor noted five flies on the toilet seat in the bathroom and flies were seen flying within the bathroom as well. When the LSC surveyor approached bed B, a resident pointed out what appeared to be drain flies hovering over the bed. Across from this bed was a laundry basket that was smeared with what appeared to be feces with flies on it. The room was generally dirty with an unpleasant odor. In an interview with an unsampled resident of the room, it was stated that the bed assigned had not been slept in since arriving at the facility because of the flies surrounding it. The AMT confirmed the observations. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 8/22/25 at 1:27 PM, Surveyor #2 entered room [ROOM NUMBER] with Resident #9's permission and noted that all of the vents from the PTAC Unit (Packaged Terminal Air Conditioner, a heating and air conditioner unit) had been removed from the top of the unit which left the internal components exposed and there was a moderate amount of dried food that had fallen inside of the unit. The resident also had a portable air conditioning unit at the bedside that was reportedly in use. When interviewed at that time, the resident stated, They will get around to it eventually. On 8/25/2025 at 2:44 PM, the surveyor entered room [ROOM NUMBER] accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who viewed the PTAC unit and stated, Who took this apart? LPN/UM #1 stated that the PTAC Unit was nonfunctional. She stated the unit would have to cleaned out and she assumed that maintenance was trying to fix it. On 8/25/2025 2:46 PM The surveyor accompanied by LPN/UM #1 entered the bathroom in room [ROOM NUMBER] and noted a strong, foul odor in the bathroom and the flooring had marked stickiness and the baseboards and miter joints (the way the baseboards are joined in the corner) had a thick buildup of a gray dried matter. The LPN/UM #1 stated that she thought that the base boards needed to be cleaned with bleach, but the floors were mopped by housekeeping. On 8/25/2025 at 2:47 PM, The Director of Maintenance (DOM) entered the room and stated that somebody removed all these vent covers, and he proceeded to place the vent covers back into the PTAC Unit. The MD stated that the facility did monthly cleaning and vacuumed the dust out. The MD stated that we probably did not see the food in there. On 8/26/2025 at 10:36 AM, the surveyor interviewed Housekeeper (HK) #1 who stated that she mopped the bathroom floors daily and used a chemical cleaner and a brush for the corners. HK #1 stated that she was not assigned to room [ROOM NUMBER]. On 8/26/2025 at 10:59 AM, the surveyor interviewed the Housekeeping Director (HD) in room [ROOM NUMBER]. The HD stated that since there was a blue cleaning solution that remained inside the toilet bowl, there should be no smell. The HD stated the moldings should be cleaned with a brush. The MD stated, The floor was dirty if it was sticky. The HD stated this floor needed to be restriped because wax was laid over dirt. Blue cleaning agent was in toilet and was left to sit. The HD stated, The smell of urine was overpowering the cleaner and that should not be. The HD stated that he did rounds daily and saw this during his first week on the job. The HD stated that he had not spoken to his lead cleaner who was assigned to the room about it, and he was disappointed that she did not bring it to his attention. The HD stated that carbolization (a terminal room cleaning) was done upon resident discharge. He stated the facility did not have a carbolization schedule in place prior. On 8/26/2025 at 11:10 AM, the surveyor interviewed HK #2 in the presence of the HD, and she stated that she already cleaned room [ROOM NUMBER] today. HK #2 stated that she cleaned the bathroom and wiped down the toilet. HK #2 stated it was hard to get behind the toilet which was heavily soiled with a black substance. HK #2 stated the floor techs cleaned the moldings and jams. At that time, the HD stated that wax was placed over dirt and the floor was not cleaned or rinsed first before wax was applied. The HD stated the condition of the bathroom could be better because this was their home. On 8/26/2025 at 11:18 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated the bathroom should be cleaned every day. The LNHA stated that he would not expect for the floor to be sticky after it were cleaned. The LNHA further stated it was not a proper home like environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 8/26/2025 at 11:00 AM, the surveyor toured the resident lounge area with the Licensed Practical Nurse/Unit Manager (LPN/UM) #2. The surveyor observed debris lodged in the refrigerator door seal gasket, no freezer thermometer, non-working refrigerator thermometer, no temperature log for refrigerator, and no temperature log for freezer. The freezer door contained opened package of sausages which was labeled with a name and room number, but was not dated or sealed. The top shelf of the refrigerator had one clear plastic contained filled with food and the lid was labeled but was not dated. On 8/26/2025 at 11:15 AM, the surveyor interviewed LPN/UM #2, who acknowledged that the resident refrigerator was not clean and the food contents were not labeled or dated. There was no temperature log for the freezer or refrigerator. The LPN/UM #2 was unable to provide the temperatures to the surveyor because neither the freezer nor the refrigerator had a portable thermometer. On 8/26/2025 at 11:30 AM, the surveyor interviewed the Resident Housekeeper (RH) who was newly assigned to this area and was unaware of the need to clean the refrigerator in the Chapel Unit area. On 8/26/2025 at 11:45 AM, the surveyor toured the First Floor Unit Pantry with the Housekeeping Director (HD) and observed debris in the freezer door seal gasket, debris in the lower cabinet under the sink, debris on lower cabinet door, a missing drawer from the lower cabinets, and cabinet space under the sink had a warped, broken, cracked floor and wall. The HD acknowledged that the pantry was not cleaned. On 8/26/2025 at 11:50 AM, the surveyor interviewed Resident Housekeeper #2 (RH) #2 who stated the First Floor Unit pantry was cleaned every Monday. On 8/26/2025 at 11:55 AM, the surveyor interviewed the HD who acknowledged the findings on both units and agreed that it was not cleaned or maintained according to the facility policy. On 8/26/2025 at 12:05 PM, the surveyor interviewed the Maintenance Director (MD) who was made aware of the missing lower base cabinet drawer located in the First Floor Unit Pantry. He stated, he had not received an electronic work order but would go and assess and fix the pantry. On 8/27/2025 at 10:12 AM, the surveyor met with Licensed Nursing Home Administrator (LNHA) and Chief Operating Officer (COO), who reviewed pictures presented by the surveyor and acknowledged the surveyor findings. The LNHA stated that it was his expectation that all personnel including housekeeping and maintenance, should enter any issues into the electronic maintenance system for repairs timely. A review of the facility's undated Homelike Environment Policy, included: Residents are provided with a safe, clean, comfortable and homelike environment . The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary and orderly environment; . .Clean bed and bath linens that are in good condition; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pleasant, neutral scents . A review of the facility's undated Foods Brought by Family/Visitors, policy, included.Liberalized diets will be permitted as much as possible. Staff must be aware of, and approve, food(s) brought to a resident by family/visitors .Perishable foods must be discarded after an appropriate time (specific to food and temperature). Food kept in the refrigerator for a resident must be labeled with the resident's name and the date. A review of the facility's undated Refrigerators and Freezers policy, included.the facility will ensure safe refrigerator and freezer maintenance, temperatures, sanitation, and will observe food expiration guidelines.Acceptable temperatures shall be 35 degrees F to 40 degrees F for refrigerators and less than 0 degrees F for freezers.Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures.designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. NJAC 8:39-27.1(a);31.4(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to: a) administer medications in a timely manner in accordance with the facility policy and professional standards of nursing practice b) ensure accountability of the narcotic shift count logs, c) accurately account for the administration of controlled medications d) follow a physicians order (PO) for both the application and the removal of a Lidocaine Pain Patch (transdermal pain reliever). This deficient practice was identified on one (1) of three (3) medication carts (Second floor, Low Cart), and the Automated Medication System (AMS) (an automated system, including robotic and intelligent dispensing cabinets to store and manage medications and supplies) in the First Floor Medication Room that was inspected during the medication storage observation. And for 2 of 4 residents (Resident #22 and #116) on 2 of 3 nursing units (First Floor and Second Floor) reviewed during the medication administration observation d) for 1 of 4 residents (Resident # 18) observed for medication administration timeliness. This deficient practice was evidenced by the following:1) On 8/21/25 at 10:45 AM, during the initial tour of the facility, the surveyor observed Resident #22 lying in their bed awake. The resident stated they had a concern with their medications being administered late. On 8/22/25 at 11:05 AM, the surveyor reviewed the medical record for Resident #22. A review of the admission Record, an admission summary, reflected that the resident was admitted to the facility with diagnoses that included but not limited to; generalized anxiety disorder (feeling extremely worried or nervous), hypothyroidism (thyroid gland does not make enough thyroid hormone), and asthma (airways become inflamed). A review of the most recent comprehensive MDS(Minimum Data Set), an assessment tool dated 7/20/25, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of 15, which indicated an intact cognition. The surveyor reviewed the Physician's Order Summary Report (OSR), dated as of 8/26/25, which revealed the active orders for Resident #22 which included the following Physician's Orders (PO): A PO, dated 5/23/22, for Baclofen (used to treat spasms) Tablet 10 milligram (MG) give one tablet by mouth three times a day for musculoskeletal. A PO, dated 2/14/24, for Colace capsule 100 MG (Docusate Sodium) Give 1 (one) tablet by mouth two times a day for constipation. A PO, dated 7/30/25, for Colchicine Tablet 0.6 MG Give 1 (one) tablet by mouth one time a day for gout flares (form of arthritis that causes severe pain). A PO, dated 5/20/22, for Cranberry-Vitamin C capsule 450-125 MG Give 1 (one) capsule by mouth two times a day for supplement. A PO, dated 2/24/25, for Cyanocobalamin tablet 500 microgram (MCG) Give 1 (one) tablet by mouth one time a day for for supplement B12. A PO, dated 5/1/25, for Guaifenesin Oral Tablet 200 MG (Guaifenesin) give 1 (one) tablet by mouth (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every eight hours as needed for cough. A PO, dated 8/12/25, for Hydroxyzine HCL tablet 25 MG Give 1 (one) tablet by mouth three times a day for itching. A PO, dated 12/4/24, for Levothyroxine Sodium Oral Tablet 25 MCG Give 1 (one) tablet by mouth one time a day for hypothyroidism (abnormal thyroid gland function that affects metabolism). A PO, dated 11/2/24, for Lipitor Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 (one) by mouth at bedtime for prophylaxis. A PO, dated 5/30/24, for Metformin HCL ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCL) Give 1 (one) tablet by mouth in the evening for diabetes mellitus(DM), diabetes, a chronic metabolic disease characterized by high blood sugar (glucose levels). A PO, dated 8/28/24, for Metformin HCL Oral Tablet 500 MG (Metformin HCL) Give 0.5 tablet by mouth one time a day for DM half tablet for DM 1/2 tab=250 MG. A PO, dated 2/20/25, for Metoprolol Tartrate Tablet 25 MG Give 1 (one) tablet by mouth every 12 hours for HTN (hypertension, high blood pressure) Hold for HR (heart rate) less than 60; SBP (systolic blood pressure, the top value in a blood pressure reading) less than 110. A PO, dated 6/15/22, for Mobic Tablet 15 MG Give 1 (one) tablet by mouth one time a day related to for idiopathic gout (unknown cause of elevated uric acid levels). A PO, dated 9/12/24, for Multivital M Tablet (Multiple Vitamins-Minerals) Give 1 (one) tablet by mouth in the evening for supplement (Must be separate from Synthroid). A PO, dated 2/20/25, for Norvasc Oral Tablet 10 MG (Amiodipine Besylate) Give 1 (one) tablet by mouth in the morning related to Essential (Primary) Hypertension (elevated blood pressure). Hold for SBP less than 110. A PO, dated 5/19/22, for Potassium Chloride Crys ER Tablet Extended Release 20 MEQ Give 2 (two) tablets by mouth one time a day for supplement. A PO, dated 8/8/25, for Prednisone tablet 5 MG Give 3 (three) tablets by mouth one time a day for inflammation. Admin (administer) meds with food or meals. A PO, dated 6/6/25, for Tylenol Extra Strength Oral Tablet 500 M (Acetaminophen) Give 2 (two) tablets by mouth two times a day for joint pain/headache. A PO, dated 2/24/25, for Victoza Subcutaneous (under the skin) Solution Pen-Injector 18 MG/3 ml (milliliters) subcutaneously one time a day for DM, CV (cardiovascular) and Renal (kidney) risk reduction, obesity. A PO, dated 5/15/25, for Vitamin D3 Tablet 2,000 Unit (Cholecalciferol) Give 1 (one) tablet by mouth in the morning for supplement. A PO, dated 8/11/25, for Zyloprim Tablet 100 MG (Allopurinol) Give 3 (three) tablets by mouth one (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time a day for Gout. A review of Resident #22's August 2025 Medication Administration Record (MAR) revealed that it appeared that all the resident's medications were given as scheduled at 0800 (8:00 AM), 0900 (9:00AM), 1300 (1:00 PM), 1700 (5:00 PM), 1800 (6:00PM), and 2100 (9:00 PM). On 8/22/25, the surveyor requested to view Resident #22's Medication Admin Audit Report (MAAR, a document that detailed the exact time of medication administration not detailed on the MAR) for August 2025. A review of the MAAR revealed that on the day shift from 8/1/25 to 8/22/25 there were 255 medications administered late out of 420 opportunities. A further review of the MAAR revealed that on the evening shift from 8/1/25 to 8/21/25 there were 127 medications administered late out of 189 opportunities. A review of Resident #22's Progress Notes failed to contain documented evidence that the resident's physician was notified that the resident received their scheduled medications beyond the scheduled administration time. There was also no documented rationale within the resident's electronic health record (EHR) to explain why the medication was not administered timely as required. On 8/25/25 at 1:10 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated that medications should be administered one hour before or one hour after the prescribed time. LPN #1 further stated that medication administration documentation is completed in the EHR after the resident took the medication. LPN #1 further stated that if a medication is administered late, she would notify the primary provider. On 8/26/25 at 12:35 PM, the surveyor interviewed the Director of Nursing (DON) #2, who stated that medications should be administered as close to the ordered time. DON #2 stated that the nurses have one hour before or an hour after the scheduled administration time. The DON #2 stated that nursing should notify the provider if a medication was not administered on time. The DON #2 confirmed with the surveyor that there were multiple medications administered late in the month of August 2025. The DON #2 further stated that the medications should have not been administered late. On 8/27/25 at 10:03 AM, the DON #2, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, acknowledged that medications should be administered within one hour of their prescribed time. 2) On 8/26/2025 at 12:17 PM, the surveyor, accompanied by the Licensed Practical Nurse (LPN) #3, reviewed the second floor, Low Cart narcotic logbook. On the Record of Narcotic, Barbituate (sedative and sleep inducing drug) Use Drug Count (RNBDC) log (a log that shows accountability for narcotics and barbituates for each shift) for August 2025, the nurse's signatures were missing as follows: The outgoing nurse on 8/21/2025 for the 7:00 AM to 3:00 PM (day) shift. The outgoing nurse on 8/25/2025 for the 7:00 AM to 3:00 PM shift. The incoming and outgoing nurse on 8/25/2025 for the 3:00 PM to 11:00 PM (evening) shift. The incoming nurse on 8/26/2025 for the 7:00 AM to 3:00 PM shift. At that time, LPN #3 stated that today (8/26/2025), she conducted a shift-to-shift narcotic count (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the outgoing nurse but did not sign the incoming 7:00 AM signature slot on the RNBDC. A further review of the narcotic logbook revealed that the resident-specific declining inventory logs had discrepancies as follows: Resident #6 should have had 13 tablets of oxycodone IR (immediate release) 5 (mg) milligram (a controlled medication used to treat pain), but only 12 tablets were on hand. Resident #11 should have had 25 tablets of oxycodone IR 5 mg, but only 24 tablets were on hand. Resident #32 should have had 14 tablets of oxycontin ER (extended release) 10 mg (used to treat moderate to severe pain), but only 13 tablets were on hand. Resident #37 should have had 18 tablets of lyrica 200 mg (used to treat neuropathic pain) , but only 17 tablets were on hand. Resident #75 should have had 42 tablets of tramadol 50 mg (used to treat pain), but only 41 tablets were on hand. Resident #76 should have had 11 tablets of oxycontin ER, but only 10 tablets were on hand. Resident #89 should have had 14 tablets of tramadol 50 mg, but only 13 were on hand. Resident #145 should have had eight tablets of oxycodone IR 30 mg, but only seven tablets were on hand. The same resident should have had 9 bottles of methadone 210 mg (used to treat opioid use disorder), but only 8 bottles were on hand. At that time, LPN #3 stated that she administered all the above medications during the morning medication pass. She further noted that the narcotics should have been signed out on the declining inventory sheet once it was removed from the bingo card and administered. A review of the Medication Administration Record (MAR) for the residents above and their corresponding medications also indicated that the medicines were administered that morning. On 8/26/2025 at 12:53 PM, the surveyor and Licensed Practical Nurse/Unit Manager (LPN/UM) #1 reviewed the Low Cart RNBDC log and the resident-specific narcotic declining inventory log. LPN/UM #1 confirmed the above findings. At that time, the LPN/UM stated that after the incoming nurse gets the shift-to-shift resident report, they are supposed to conduct the narcotic count with the outgoing nurse, then both nurses should sign in their respective slots. She further stated that the nurse should sign the resident-specific declining inventory log after removing and administering the medication. On 8/26/2025 at 1:16 PM, the surveyor, accompanied by LPN/UM #1 and #2 entered the first floor medication storage room to conduct a narcotic count of the AMS. Upon review of the narcotic logbook for the AMS, there was no shift-to-shift narcotic accountability log for August 2025. At that time, LPN/UM #1 and #2 both confirmed the above finding. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/2025 at 2:03 PM, the surveyor interviewed the Director of Nursing (DON) #2 who stated that the narcotic count should take place each shift between the oncoming and outgoing nurses and each nurse should sign the shift-to-shift log for accountability. The DON #2 also stated that today (8/26/2025) was her second day at the facility as the DON #2 and that she did not have access to the AMS. The DON also stated that LPN/UM #1 and #2 were the only two nurses with access to the AMS. She further stated that she was unaware of how often the narcotics in the AMS should be counted. She also noted that she does not believe a process was in place. On 8/27/ 2025, at 9:07 AM, the surveyor conducted a follow-up interview with LPN/UM #2, who stated that prior to today (8/27/2025), she had no involvement in the AMS narcotic count, as her assigned unit was the farthest away from it. On 8/27/2025 at 9:12 AM, the surveyor conducted a follow-up interview with LPN/UM #1, who stated that before yesterday (8/26/2025), she was not counting the narcotics in the AMS, and was unsure how often they should have been counted. She further noted that when the previous DON was employed at the facility, she would count the AMS narcotics with her once in a while. 3) On 8/22/25 at 8:44 AM, during the medication pass observation the surveyor observed Licensed Practical Nurse (LPN) #4 as she reviewed the medication orders, and prepared and administered four oral medications to Resident #116. LPN #4 sought the assistance of a second staff member to pull the resident up in the bed into an upright position prior to medication administration. On 8/22/25 at 10:52 AM, the surveyor completed a medication reconciliation (a process of comparing a patient's medication orders to all medication orders on record) which revealed that Resident #116 had a physician's order dated 4/20/25, for Lidocaine Pain Relief 4 (four) % Patch (a topical anesthetic applied to skin to relive pain by blocking nerve signals). Apply to back topically one time a day related to muscle wasting and atrophy (to shrink) and remove per schedule. A review of the Electronic Medication Administration Record (EMAR) revealed that the medication order was not signed out at 9:00 AM, to indicate the administration status of the medication and the entry was left blank without a signature status. Further review of the EMAR revealed that the Lidocaine Pain Relief 4 (four) % Patch was scheduled for removal at 9:00 PM. On 8/22/25 at 12:54 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #4 and asked why a Lidocaine Pain Relief 4 (four) % Patch was not offered to the resident during the medication pass observation. LPN #4 stated that the resident did not have their Lidocaine Patch on, but they should. LPN #4 stated that she normally administered all medications first, and then went back and administered treatments, even though a Lidocaine Patch was technically a medication. LPN #4 stated that the medication was not time released, and the next shift would pull it off the resident at 9 (nine) PM. LPN #4 further stated that she would have put it on the resident around 10:30 AM, but she had gotten behind in her work. On 8/22/25 at 1:07 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that nursing had one hour before and one hour after a scheduled medication time to administer a Lidocaine Pain Patch. The LPN/UM #1 stated that the Lidocaine Pain Patch should have been offered to the resident at the scheduled time, otherwise, it was considered a medication error because the nurse neglected to give the resident their Lidocaine Patch that was ordered for pain relief. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/25 at 2:01 PM, the surveyor interviewed the Director of Nursing (DON) #1 who stated that a Lidocaine Pain Patch should be offered to a resident if ordered for pain management. The DON #1 stated that if it were not administered as ordered, it could hinder the resident's movement and productivity and could also affect the resident emotionally if their pain was not relieved. The DON #1 further stated that the medication should have been administered as scheduled an hour before or an hour after the scheduled time in accordance with the facility policy. The DON #1 further stated that the nurse was required to offer the medication to the resident. The DON#1 stated that the order should have been signed out as administered or not administered to reflect the administration status of the medication. The DON #1 stated that the nurse was not in compliance with the medication pass if the Lidocaine Patch that was scheduled for 9:00 AM, was still not offered by lunch time as the medication was time sensitive. On 8/25/25 at 12:03 PM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that if a Lidocaine Patch were not offered, it would be considered a missed item, and it was considered a medication error. The CP stated that the medication was scheduled, because the medication was to be removed in 12 hours. The CP stated that the resident could have pain, and it was a quality-of-life issue if the lidocaine patch were not applied timely. The CP further stated that the Lidocaine Patch was a transdermal patch and was absorbed through the skin at a certain rate and was to be removed within 12 hours of scheduled application at 9:00 PM. On 8/26/25 at 1:26 PM, in the presence of the survey team the surveyor informed the Licensed Nursing Home Administrator (LNHA) of the concern related to the failure of LPN #4 to offer Resident #116 a physician prescribed Lidocaine Pain Patch at 9:00 AM and document the outcome during the medication pass observation. 4) On 8/22/25 at 8:11 AM, the surveyor observed Licensed Practical Nurse (LPN #3) prepare medications for Resident #18, which included two 4 % pain patches to be applied to the left knee and to the right knee. The surveyor observed LPN #3 remove the pain patches form the package and initialed and dated both patches. LPN #3 then removed the pain patches from Resident #18's right and left knees prior to applying the pain patches to the resident's right and left knee. On 8/22/25 at 11:09 AM, the surveyor interviewed LPN #3 who confirmed that, during the medication observation, she had removed pain patches form Resident #18's knees prior to applying the new pain patches. LPN #3 checked the physician orders in the medication administration record (MAR) and stated that the pain patches from both knees were scheduled to be removed at 9:00 PM and confirmed the MAR indicated that the pain patches were signed out as removed on 8/21/25 at 9:00 PM. The surveyor reviewed the medical record for Resident #18. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, muscle weakness, rheumatoid arthritis (causes pain, swelling, and irritation in the joints), and chronic pain syndrome. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated7/20/25, 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. The MDS further revealed that the resident received pain medication and had frequent pain at a moderate pain level. (continued on next page)

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Aristacare at Cherry Hill	1399 Chapel Ave West Cherry Hill, NJ 08002

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the individual comprehensive care plan (ICCP), dated 1/12/2022, included a focus that the resident had pain to bilateral (both) knees. Interventions included: Administer analgesia (pain medication) as ordered. A review of the Order Summary Report (OSR), with an order range of 8/1/25-8/31/25, included the following physician orders (PO): A PO, dated 8/5/25, for Lidocaine Pain relief external Patch 4% (Lidocaine) apply to Left knees topically one time a day for pain and remove per schedule. A PO, dated 8/5/25, Lidocaine Pain relief external Patch 4% (Lidocaine) apply to Right knees topically one time a day for pain and remove per schedule. A review of the August 2025 Medication Administration Record (MAR) included the above PO with administration times as follows: Lidocaine Pain relief external Patch 4% (Lidocaine) apply to Left knee was scheduled to be applied at 9:00 AM and to be removed at 9:00 PM. Lidocaine Pain relief external Patch 4% (Lidocaine) apply to Right knees was scheduled to be applied at 9:00 AM and to be removed at 9:00 PM. A review of the August MAR revealed that the pain patches to both knees were signed out as removed on 8/21/25 at 9:00 PM. On 8/25/25 at 11:30 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that evening shift should have removed the pain patches at 9: 00 PM. Pian patches should only be placed on the resident for 12 hours and after 12 hours the pain medication was not effective. On 8/26/25 at 11:33 AM, the surveyor interviewed the Director of Nursing (DON #2) who stated the pain patches should have been removed after 12 hours and as scheduled at 9:00 PM. DON #2 further stated that after 12 hours the pain patches lose their efficacy (effectiveness). A review of the facility's Administering mediations policy, undated, included medications shall be administered in a safe and timely manner, and as prescribed.medications must be administered in accordance with the orders, including any required time frame.medications may not be prepared in advance and must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall click N on the eMAR and then document as prompted by the [name redacted] computer software.the date and time the medication was administered is time stamped within the system. A review of the facility's AUTOMATED MEDICATION SYSTEM (or BACK-UP SUPPLY), revised 2014 revealed, Controlled substances must be checked and documented by a licensed professional every 24 hours. A review of the facility's Controlled Substances undated policy revealed, [Facility Name redacted] shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances.7. Nursing staff must count (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They document and report any discrepancies to the Director of Nursing Services. 8. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility [sic.] parties, and shall give the Administrator a written report of such findings. A review of the facility's undated Administering Medications policy, included: Medications shall be administered in a safe and timely manner, and as prescribed. .Medications must be administered in accordance with the orders, including any required time frame. .If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall click N on the EMAR (Electronic Medication Administration Record) and then document as prompted. A review of the facility's Administering Medications policy, undated, revealed that medications must be administered in accordance with the orders, including any required time frame. NJAC 8:39-29.7(c); 29.2(d); 29.3(a)5

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a physician's order for an as needed (PRN) psychotropic drug was limited to 14 days for 1 of 5 residents (Resident #5) reviewed for unnecessary medications. This deficient practice was evidenced by the following:On 8/22/25 at 9:00 AM, the surveyor observed Resident #5 with his /her eyes closed sitting in a reclining chair in the day room. The surveyor reviewed the medical record for Resident #5.A review of the admission Record, (an admission summary), revealed the resident had diagnoses which included, but were not limited to, dementia, and encephalopathy (a medical condition that affects brain function, leading to changes in mental state, behavior, and cognitive abilities).A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/8/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated that the resident's cognition was severely impaired. Further review of the MDS revealed the resident received antianxiety medications.A review of the resident's individual comprehensive care plan (ICCP) did not include a care plan entry for an antianxiety medication.A review of the order Summary Report (OSR), with an order date range of 7/2/25-8/31/25, included the following physicians' orders (PO):A PO, dated 7/2/25, for Lorazepam Oral tablet 1 (one) milligram (MG) give 1 tablet by mouth every 8 (eight) hours as needed for anxiety. Further review of the above PO did not have a stop date of 14 days. A review of August 2025 electronic Medication Administration Record (eMAR) revealed a PO with a start date of 7/3/25 and a discontinue (d/c) date of 8/4/25, for Lorazepam 1 (one) mg, give 1 (one) tablet by mouth every 8 (eight) hours as needed for anxiety. Further review of the eMAR revealed the resident was administered the Lorazepam as needed after the 14 day period.On 8/25/25 at 12:15 PM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that the 7/2/25 PO for Lorazepam should have had a 14 day stop date. The CP confirmed that the 7/3/25 Electronic Pharmacist information Consultant (EPIC) report recommended the first order of prn (as needed) psychoactive medications was limited to 14 days, then after a rationale from the provider, the medication could continue with a duration of the 30, 60, or 90 days. The CP confirmed this was recommended again on the monthly CP report on 7/28/25.On 8/26/25 at 10:12 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) #2 who stated that the initial order for Lorazepam needed a 14 day stop date. On 8/26/25 at 11:33 AM, the surveyor interviewed the Director of Nursing (DON) #2 who stated that the new order for Lorazepam should have had a 14 day stop date. On 8/26/25 at 1:21 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON #2 of the concern that Resident #5's PRN order for lorazepam did not have a 14 day stop. A review of the facility's Psychotropic Medications policy, undated, revealed that PRN psychotropics medications are limited to fourteen (14) days and include: antidepressants, anti-anxiety and hypnotics. If the prescriber wants the PRN order to be extended, then he/she must document rationale in the medical record and indicate the duration of the PRN order. N.J.A.C. 8:39-27.1(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. Intake ID: 393868Based on interview, record review, and review of facility documents, it was determined that the facility failed to report an allegation of misappropriation of property to the New Jersey Department of Health (NJDOH) immediately, within two hours, or within 24 hours of the allegation if no harm occurred and submitted the outcome of the investigation within five working days in accordance with state and federal requirements. This deficient practice was identified for 1 of 5 residents (Resident #33) reviewed for abuse and was evidenced by the following:On 8/25/2025 at 12:23 PM, the surveyor reviewed the closed medical record of Resident #33. A review of the admission Record, an admission summary, revealed that the resident had diagnoses which included: fusion of spine, lumbar (five vertebra in the low back) region, pathological (caused by disease or illness) dislocation of right knee, not elsewhere classified, heart failure, not elsewhere classified, other bipolar disorder (a mental disorder characterized by periods of elevation and depression), and other specified anxiety disorders. A review of the resident's most current comprehensive Minimum Data Set (MDS), an assessment tool, included the resident had a Brief Interview for Mental Status Score of 15 out of 15, which indicated that the resident was cognitively intact. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 6/11/2025, included the resident reported that he/she was missing money implicating staff took it. Interventions included: .Provide a lock box for valuables . A review of the progress notes failed to include any documentation that pertained to the resident's allegation of misappropriation of property that reportedly occurred on 6/12/2025. On 8/25/25 at 4:43 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with an Incident Report dated 6/12/25 at 2:00 PM. A review of the Incident Report detailed that on 6/12/25, the resident reported that he/she had money missing and that the Certified Nursing Assistant (CNA) #4 took it. The resident did not see her take the money, but she was acting funny. Further review of the Incident Report revealed that the resident was provided with education to use the lock box in their room for which the resident had a key, the resident's family was notified, the CNA was removed from the schedule, statements were gathered, the Care Plan was updated, and the Ombudsman was notified on 6/14/25 at 6:59 AM. A review of an undated Investigational Summary and Conclusion revealed that on 6/12/25 at 2:00 PM, the resident reported that they had an undisclosed amount of money missing and that CNA #4 took it. The resident was unable to provide any time frames when interviewed. Action: .An investigation was immediately initiated. The Facility administrator, MD (Medical Director), DOH (Department of Health), Ombudsman, and family contact for the resident was notified of the incident.CNA #4 was sent home and suspended pending investigation. The Social Worker interviewed eight cognitively intact residents who all denied any abuse, neglect, or intentional mishandling of any kind. The investigation failed to include a statement that was written by CNA #4. A review of the Conclusion revealed that after a thorough investigation was conducted by the facility and based on statements gathered, we concluded that we are unable to substantiate the allegations of an attempt of misappropriation of resident funds. When interviewed, Resident #33 was unable to provide dates or time frames, and after further questioning, stated that they were just upset at the aide, and she was acting funny. He/She had no further concerns about money being taken. At this time, there are no substantiated findings of abuse, neglect or misconduct by CNA #4. On 8/26/2025 at 9:04 AM, the surveyor interviewed the LNHA who stated that the resident admitted that the accusation was retaliatory in response to an event that occurred in the smoking yard prior. The LNHA stated that the CNA no longer worked at the facility, and that she only worked one more shift after the accusation was made and then she resigned. The Director of Nursing (DON) #1 who completed the investigation terminated employment with the facility on 8/22/25 and was unavailable for an interview. The LNHA stated that he was involved with the investigation and could answer any related questions. At that time, the surveyor requested proof that (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the summary, conclusion and all supporting documentation was sent to the DOH within the required time frame for reporting. On 8/26/2025 at 11:30 AM, in a later interview with the LNHA, he stated that he was unsure if the summary and conclusion were sent out to the DOH. The LNHA stated that CNA #4 was called, was suspended and taken off the schedule. The LNHA further stated that CNA #4 returned to work on 8/16/25, after the investigation was complete.The LNHA further stated that an allegation of abuse, with no harm was required to be phoned into the facility within 24 hours. He stated that then we have five days to submit the completed investigation. The LNHA stated that we do not necessarily document these incidents in the progress notes as we document in the incident report, and do not put allegations in a nursing note. On 8/27/25 at 10:03 AM, the surveyor interviewed the LNHA in the presence of the survey team who stated that DON #1 was required to report any allegation of abuse immediately or not greater than two hours. The LNHA stated that he also found emails from the DOH requesting outstanding information with mention of a site visit if the information was not presented from facility when requested. The LNHA acknowledged that the investigation and related summary and conclusion was not reported within the required time frames in accordance with state and federal requirements. A review of the facility's undated Abuse Prevention Program included: .When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the Administrator/Designee will notify the following persons or agencies of the incident:New Jersey Dept. of Health & Senior Services.Ombudsman (residents over age of 60) .The policy failed to include the required timeframes for reporting any allegations of abuse.NJAC 8:39-9.4(e) (2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to develop an individual comprehensive care plan to include a resident's a.) anti-anxiety medication and, b.) history of diabetes mellitus.This deficient practice was identified for 1 of 5 residents (Resident #5) reviewed for unnecessary medications and evidenced by the following:On 8/22/25 at 9:00 AM, the surveyor observed Resident #5 with his /her eyes closed sitting in a reclining chair in the day room. The surveyor reviewed the medical record for Resident #5.A review of the admission Record, (an admission summary), revealed the resident had diagnoses which included, but were not limited to, dementia, and encephalopathy (a medical condition that affects brain function, leading to changes in mental state, behavior, and cognitive abilities) and Type 2 diabetes mellitus.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/8/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated that cognition the resident's cognition was severely impaired. Further review of the MDS revealed the resident received antianxiety and hypoglycemic (low blood sugar) medications.A review of the resident's individual comprehensive care plan (ICCP) did not include a care plan entry for antianxiety medication or for a diagnosis of diabetes mellitus including the medication Metformin (an oral diabetes medicine). A review of the order Summary Report (OSR), with an order date range of 7/2/25-8/31/25, included the following physicians' orders (PO):A PO, dated 7/2/25, for Lorazepam Oral tablet 1 milligram (MG) give 1 tablet by mouth every 8 hours as needed for anxiety. A PO, dated 7/3/25, for Metformin HCL oral Tablet 500 mg, give 1 tablet by mouth two times a day for diabetes. Administer with meals. On 8/26/25 at 10:12 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated residents who were receiving antianxiety and diabetic medications should have a care plan. The LPN/UM #2 further stated that it was important that care plans were updated for the resident's continuation of care and they showed the residents level of care. The LPN/UM #2 stated that the anti-anxiety medication and diabetes diagnosis should have been included in the comprehensive care plan completed 14 days after admission. On 8/26/25 at 11:33 AM, the surveyor interviewed the Director of Nursing (DON #2) who stated Resident #5 should have had a care plan for receiving anti-anxiety and diabetic medications. The DON#2 further stated that it was the responsibility of the nurse on the cart, the unit manager and the DON to update the care plans. DON #2 stated that care plans were important because they are an accurate reflection of the resident and should capture everything about the resident. On 8/26/25 at 1:21 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON #2 of the concern that Resident #5's care plan did not include the antianxiety medication or the diagnosis of diabetes mellitus. A review of the facility's Care Plans policy, undated, included that the interdisciplinary team, in coordination with the resident, his/her family or representative develops and maintains a care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident's comprehensive care plan has been designed to: a.) incorporate identified problems; b) incorporate risk factors associated with identified problems;. N.J.A.C.8:39 - 11.1

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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. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan (ICCP) for a resident with an order for a tracheostomy (a surgically created hole, also called a stoma, in your windpipe, also known as your trachea). This deficient practice was identified for 1 of 2 residents reviewed for respiratory care (Resident #14), and was evidenced by the following:On 8/21/25 at 11:13 AM, during the initial tour of the facility, the surveyor observed Resident #14 seated in their wheelchair in their room watching television. The surveyor did not observe a tracheostomy for Resident #14. On 8/22/25 at 12:45 PM, the surveyor observed Resident #14 seated in their wheelchair in their room. Resident #14 stated that when they were admitted to the facility he/she had a tracheostomy in place, but it was removed a couple years ago. On 8/22/25 at 10:42 AM, the surveyor reviewed the medical record for Resident #14. A review of the admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; tracheostomy (surgical procedure to create an opening through the neck into the trachea), paralysis of vocal cords and larynx (vocal cords lose the ability to move impacting the voice), and dysphagia (difficulty swallowing). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 6/26/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. A further review of section O respiratory treatments, revealed that Resident #14 did not have tracheostomy care.A review of the individualized comprehensive care plan (ICCP) included a focus area with a revision date of 10/16/20, resident has a tracheostomy related to impaired breathing mechanics. The ICCP included interventions to ensure that trach ties were secured at all times, suction as necessary and use universal precautions as appropriate.On 8/25/25 at 1:10 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1, who identified that a ICCP should be updated as changes occurred in the resident's plan of care. LPN #1 stated that focus areas on the care plan included items specific to the resident such as falls, pain, code status, tracheostomy, and their diagnosis. LPN #1 stated that care plans should be updated or revised when there is a change in the resident's plan of care. LPN #1 confirmed that the resident no longer had a tracheostomy. LPN #1 stated that the resident's tracheostomy had been removed a few years ago. She acknowledged that the residents care plan should have been updated when the tracheostomy was discontinued to ensure proper patient care. On 8/26/25 at 12:31 PM, the surveyor interviewed the Director of Nursing (DON) #2, who stated that care plans were updated when there was any change in the resident's care. DON #2 confirmed that Resident #14's care plan should have been updated when the resident no longer had a tracheostomy. DON #2 further stated that it was the responsibility of the nurse on the cart, the unit manager and the DON to update the care plans. DON #2 stated that care plans were important because they are an accurate reflection of the resident and should capture everything about the resident.On 8/27/25 at 10:03 AM, the DON #2, in the presence of the Licensed Nursing Home Administrator (LNHA), and the survey team, acknowledged that a care plan should be updated and revised as soon as they are aware of any changes in the resident's care. DON #2 further stated that the importance of updating a resident's care plan is to know the residents current plan of care. A review of the facility's Care Plans policy, undated, included that care plans are revised as changes in the resident's condition may dictate. Care plans are reviewed at least quarterly. NJAC 8:39-27.1(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, review of medical records and facility documents, it was determined that the facility failed to ensure that residents with decreased range of motion and mobility received prescribed treatments to prevent contractures for 1 of 3 residents (Resident #6) reviewed for limited range of motion. This deficient practice was evidenced by the following:On 8/22/25 at 1:34 PM, the surveyor observed Resident #6 lying in bed awake. When interviewed, the resident stated that he/she had a history of a stroke and could not move their left arm. The resident stated that he/she had a splint in one of the drawers, but the staff had not put it on for a long time. The resident's left upper extremity was covered with a thin blanket. On 8/22/25 at 1:47 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) #3 who stated that she had just finished providing personal care to Resident #6. CNA #3 further stated that the resident did not have any contractures and their skin was intact.On 8/22/25 at 1:18 PM, the surveyor reviewed the medical record for Resident #6. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to; Cerebral infarction (stroke), hemiplegia (paralysis on one side of the body) and hemiparesis (one sided weakness).A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 6/25/25, included that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was fully intact. Further review of the MDS revealed that in the past seven calendar days, the resident had zero splint or brace assistance. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 1/16/24, with a goal of; I will tolerate appropriate splint and ROM (range of motion) for mobility. Interventions included: ROM/ Manual therapy, Contracture therapy. A review of the Order Summary Report (OSR), dated as of 3/6/24, included the following Physician's Order (PO): Apply left resting hand splint with AM care and remove in PM. Perform skin care checks before and after application and report to nurse any redness or abnormalities every day shift for splint. A review of the Treatment Administration Record (TAR) revealed a PO with a start date of 3/6/25 and a Discontinue Date of 8/25/25 to Apply Left resting hand splint in the AM and remove in the PM. It had been signed out as 'administered' daily from 8/1/25 through 8/25/25. On 8/25/2025 at 2:23 PM, the surveyor observed the resident lying in bed with their left hand lightly clenched in a fist without a splint on. The resident's nails were noted to be long bilaterally (both sides). The resident stated that the splint had not been applied for months. On 8/25/25 at 2:27 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #5 who stated that she was covering the nursing unit while the resident's assigned nurse was away from the unit. LPN #5 stated that she had cared for the resident once prior. At that time, LPN #5 accompanied the surveyor into the resident's room and looked for the resident's left resting hand splint in the resident's drawers with resident permission. The resident stated it was blue. LPN #5 found the blue resting hand splint on top of a hamper between the resident's bed and the nightstand. LPN #5 stated that the splint was needed because the resident's left hand was contracted, and the splint was like a cushion to keep the resident's nails from digging into their skin and prevent further contracture. On 8/25/25 at 2:36 PM, the surveyor asked LPN #5 to review the resident's TAR in the presence of the surveyor. LPN #5 displayed the resident's TAR on the computer screen and stated that there was a green check mark on the TAR. At that time, the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 presented and assisted LPN #5 to review the order with the surveyor. LPN/UM #1 stated that it looked like the resting hand splint was signed out as administered, but the resident sometimes refused, and nursing should then document the refusal. At that time, the LPN/UM #1 accompanied the surveyor into the resident's room. The LPN/UM #1 stated that the resident was supposed to have the splint on. The resident stated, It was not offered to me today. LPN/UM #1 then proceeded to put the resident's splint on the residents left hand. On 8/26/2025 at 10:45 AM, the surveyor observed the resident lying in bed with the left resting splint on. (continued on next page)

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	315245	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Cherry Hill	1399 Chapel Ave West Cherry Hill, NJ 08002

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident voiced satisfaction.On 8/26/2025 at 11:59 AM, the surveyor interviewed the Director of Nursing (DON) #2 who stated that she had only worked at the facility for two days, but she expected that they would abide by the order from the therapy department for splint usage. DON #2 stated that the purpose of the splint was to improve or prevent further decline of a contraction. The DON #2 stated that if the splint were removed due to resident intolerance, it would have to be documented in a progress note so that therapy could address the situation appropriately. On 8/26/25 at 1:23 PM, in the presence of the survey team, the surveyor voiced the resident's concern to the Licensed Nursing Home Administrator (LNHA) and DON #2 regarding the lack of splint application despite the nursing documentation on the TAR which indicated that the resident's splint was applied daily from 8/1/25 through 8/25/25. On 8/27/23 at 10:03 AM, in the presence of the LNHA and the survey team, DON #2 stated that she did confirm that the resident wanted their splint and the nursing staff's falsification of documentation on the TAR regarding splint application was addressed.A review of the facility's undated Splinting policy included: Splints, either custom made or prefabricated, are used to provide proper body support, prevent unwanted motion, contracture management or reduction, pain management and facilitate motor activity.Process: Apply splint as ordered.Remove splint as ordered. If refusal occurs, document refusal. Check skin before and after splint use for any changes. A review of the facility's undated Charting and Documentation policy included: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.Entries may only be recorded in the resident's clinical record by licensed personnel.In accordance with state law and facility policy. NJAC 8:39-27.2(m)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to place a resident's urinary catheter drainage bag inside of a privacy bag to maintain resident dignity. This deficient practice was identified for 1 of 1 resident reviewed for urinary catheters (Resident #90), and was evidenced by the following:On 8/21/25 at 10:56 AM, during the initial tour of the facility, the surveyor observed Resident #90 lying in their bed awake. The resident stated that they had an issue with their suprapubic catheter (a type of indwelling catheter that drains urine from the bladder into a collection bag). The surveyor observed the indwelling catheter drainage bag secured to the bed frame, not placed in a privacy bag, exposing the contents (urine) in the bag. The surveyor was able to observe the urine in the resident's catheter drainage bag from the hallway. On 8/21/25 at 11:40 AM, the surveyor observed Resident #90 lying in their bed awake. The resident stated that the facility used to put their catheter drainage bag in a privacy screen, but they have not recently. The resident stated that it bothered them when the catheter drainage bag is not placed in a privacy bag. The surveyor observed the indwelling catheter bag secured to the bed frame, not placed in a privacy bag, exposing the contents (urine) in the bag. The surveyor was able to observe the urine in the resident's catheter drainage bag from the hallway. On 8/22/25 at 9:00 AM, 8/25/25 at 9:44 AM, and on 8/26/25 at 10:34 AM, the surveyor further observed the indwelling catheter bag secured to the bed frame, not placed in a privacy bag, exposing the contents (urine) in the bag. The surveyor was able to observe the urine in the catheter drainage bag from the hallway. On 8/25/25 at 10:11 AM, the surveyor reviewed the medical record for Resident #90. A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; urinary tract infection (infection of the urinary system) and neuromuscular dysfunction of bladder (nerves controlling bladder function were damaged). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 6/5/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating a cognitively intact cognition. A further review of the MDS revealed the resident had an indwelling catheter. A review of the Order Summary Report included a physician's order (PO) dated 5/4/24, for a catheter: 18 French (Fr; size of the indwelling catheter) suprapubic (S/P) catheter. A further review revealed a PO to change suprapubic catheter with 18 French with 10 cubic centimeter (cc) balloon (a balloon inflated to keep catheter in place) monthly on the 28th and as needed. A review of the individual comprehensive care plan (ICCP) included a focus area dated 3/12/24, that the resident had a suprapubic catheter due to urinary retention. Interventions included but were not limited to; 18 French suprapubic catheter with 10 cc balloon, change and irrigate foley catheter as needed and as per facility policy, encourage fluids, and monitor for patency every shift. On 8/26/25 at 9:15 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #1 who stated the process for caring for a urinary catheter is to empty the catheter bag and to place it in a privacy bag. The CNA #1 further stated the importance of placing a catheter drainage bag into a privacy bag was for the privacy of the resident. On 8/26/25 at 10:38 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated that catheter drainage bags should be placed into a privacy bag. The LPN #1 further stated the importance of the catheter drainage bag to be in a privacy bag was for the resident's dignity. On 8/26/25 at 11:33 AM, the surveyor interviewed the Director of Nursing (DON #2), who stated that the catheter drainage bag should always be in a privacy bag for resident dignity reasons. On 8/27/25 at 10:03 AM, the DON #2, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, acknowledged that the catheter drainage bags should be maintained in privacy bags for dignity reasons. A review of the facility's Urinary Catheter Management Policy undated, included.this policy ensures residents receive care that minimizes infection risk, maintains catheter patency, and promotes dignity and comfort. A review of the facility's (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Rights policy, undated, included.Dignity, the facility will treat you with dignity and respect in full recognition of your individuality. NJAC 8:39-4.1(a)(12)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that oxygen was administered in accordance with a physician's order. The deficient practice was identified for 2 of 2 residents (Resident #1 and #122) reviewed for Respiratory Care and was evidenced by:1.) On 8/21/25 at 11:13 AM, during the initial tour the surveyor observed Resident #122 awake and alert lying in bed wearing oxygen via nasal cannula (prongs that are placed in the nostrils) at three (3) liters (L). On 8/22/25 at 9:11 AM, the surveyor observed Resident #122 lying in bed with their eyes closed wearing oxygen via nasal cannula at 3L. On 8/25/25 at 9:00 AM, the surveyor reviewed the medical record for Resident #122. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, acute and chronic respiratory failure with hypoxia (lack of sufficient oxygen reaching the body's tissues or an environment with low oxygen levels) and dependence on supplemental oxygen. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/3/25, included that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. Further review of the MDS revealed the resident used continuous oxygen. A review of the Individual Comprehensive Care Plan (ICCP) included a focus area, undated included, the resident was on oxygen therapy related to (r/t) chronic obstructive pulmonary disease (COPD-lung diseases that cause ongoing inflammation and damage to the airways). Interventions included: oxygen settings: humidified oxygen (O2) via nasal prongs at four (4) L continuous. A review of the Order Summary Report (OSR), dated as of 8/1/25 to 8/31/25, included the following physician orders (PO): A PO, dated 6/26/25, for oxygen at 4L O2 via nasal cannula with humidification every shift for COPD. On 8/25/25 at 9:48 AM, the surveyor observed Resident #122 awake and alert wearing oxygen via nasal cannula at 3L. On 8/25/25 at 11:03 AM, the surveyor observed the resident's oxygen concentrator set at 3 1/2 liters. At that time, the surveyor interviewed the resident, who stated that he/she had not touched the oxygen concentrator but had an extended oxygen tubing via nasal cannula to ambulate in the room. Resident #122 reiterated that they did not touch the oxygen level and then stated that they thought the oxygen level was set too high. On 8/25/25 at 11:06 AM, the surveyor and the Licensed Practical Nurse (LPN) #1 reviewed the physician's order (PO) in the electronic medical record (EMR). At that time, LPN #1 confirmed the oxygen should be set at 4L. At that time, LPN #1 and the surveyor entered the resident's room. LPN #1 confirmed the oxygen concentrator was set at 3 1/2 L and that it should have been set at 4 L. She stated the nurses should (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be checking the oxygen concentrator to ensure the oxygen was on the correct liters of oxygen every shift. On 8/26/25 at 10:30 AM, the surveyor interviewed the Director of Nursing (DON) #2, who stated the nurses should check the resident's oxygen order at the beginning of the shift, so when they conducted rounds, they checked the concentrator to ensure it was on the correct setting. DON #2 stated that it was important the resident received the oxygen as ordered to maintain the sustainability of arrhythmic (irregular heartbeat) breathing and to ensure they had adequate oxygen flow, so they did not go into respiratory failure (not enough oxygen or too much carbon dioxide in the body). On 8/27/25 at 10:09 AM, the LNHA, in the presence of DON #2 and the survey team, stated that the oxygen concentrator should be set accurately. 2.) On 8/22/25 at 12:29 PM, the surveyor observed Resident #1 lying in bed with a tracheostomy tube (a surgical opening in the neck directly into the trachea [windpipe]). The resident did not respond to the surveyor when spoken to and the resident's oxygen concentrator (a medical device that extracts and concentrates oxygen from ambient air) was set at 30%, with humidification noted, delivered through a tracheostomy mask (a medical device that fits over a tracheostoma to deliver oxygen or aerosolized medication directly to the patient's trachea). On 8/22/25 at 9:06 AM, the surveyor reviewed the medical record for Resident #1. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to; acute respiratory failure with hypoxia (oxygen deficient), and chronic obstructive pulmonary disease (lung condition characterized by airflow obstruction). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/24/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated that the resident's cognition was severely impaired and was rarely/never understood. A review of the Individual Comprehensive Care Plan (ICCP) included a focus area, dated 4/25/24, included that the resident had an altered respiratory status/difficulty breathing with an intervention to administer medication (oxygen) as ordered and maintain a clear airway. A review of the Order Summary Report (OSR), included the following physician orders (PO): A PO, dated 8/7/25, for oxygen, Change Humidifier Bottle when empty. Ensure bottle is always filled. Label and date. Use Sterile Water for Aerosol (humidification) Bottle. A review of the Treatment Administration Record (TAR) revealed that the above PO for changing the humidification bottle was signed out as administered on 8/25/25 for the day shift. On 8/25/25 at 09:05 AM, the surveyor observed Resident #1 lying in bed with their eyes closed. The oxygen concentrator was set to deliver the ordered 30% oxygen via tracheostomy collar, and the humidification bottle was noted to be empty. On 08/25/2025 at 11:55 AM, the surveyor observed Resident #1 in bed, with their eyes closed on tracheostomy collar at 30% oxygen with no humidification noted, the bottle was still empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/25/2025 at 1:05 PM, the surveyor observed Resident #1 in bed with their eyes open, but the resident was non-verbal, on a tracheostomy collar at 30% oxygen, and the humidification bottle was noted to be empty. On 8/26/25 at 12:37 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that nursing carried out respiratory care ordered by the doctor. When asked about the importance of humidification of oxygen for a patient with an order for it LPN/UM #1 stated that humidification keeps the mucus membranes moist and intact. LPN/UM #1 was then asked to verify the oxygen and humidification order for Resident #1 with the surveyor, which she confirmed was 30% oxygen on trach collar with humidification to be replaced when empty. When presented with timestamped pictures of the oxygen and humidification setup, LPN/UM #1 stated that the bottle is empty in the pictures and that it should contain the ordered sterile water for humidification. On 8/26/25 at 12:53 PM, the surveyor interviewed the Director of Nursing (DON) #2 who stated that nursing is responsible for carrying out respiratory orders and should have assessed the humidification bottle as determined by the physician's order. The DON #2 stated that when the order for humidification was signed out by the nurse on the TAR, it indicated that the nurse had looked at the humidification bottle and replaced it if necessary. DON #2 and the surveyor verified and confirmed the current orders for Resident #1 then reviewed the pictures taken on 8/25/25. The DON #2 stated that the pictures showed an empty humification bottle and that humidification is important to keep the airways and nares (nostrils) moistened and reduced irritation. On 8/26/25 at 1:14 PM, the surveyor made the Licensed Nursing Home Administrator (LNHA) aware of the concerns that were identified with the resident's humidification orders. On 8/27/25 at 10:21 AM, the LNHA in the presence of DON #2 and the survey team stated that the humidification container should not be empty per the doctor's orders. A review of the facility's Oxygen Administration policy, undated, included 1. Verify that there is a provider order for this procedure. Review the physician's orders or facility protocol for oxygen administration . .Check the mask, tank, bubbler humidifier or refillable oxygen humidifier bottle, etc, to be sure they are in good working order and are securely fastened. Be sure there is distilled or sterile water in the bubbler humidifier or refillable oxygen humidifier bottle and that the water level is high enough that the water bubbles as oxygen flows through. Periodically re-check water level in bubbler humidifier or refillable oxygen humidifier bottle. NJAC 8:39-27.1(a)