STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palace Rehabilitation and Care Center, The	315 West Mill Road Maple Shade, NJ 08052

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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 observations, interviews, and review of other facility documentation, it was determined that the facility failed to maintain kitchen and equipment areas in a manner to prevent microbial growth and cross contamination. This deficient practice was evidenced by the following:On 2/17/26 at 9:30 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and the Regional Licensed Nursing Home Administrator (RLNHA) During the kitchen tour the surveyor observed the following: 1.The surveyor took a white paper town to wipe down the white plastic ice guard in the ice machine which guided the ice into the large bin. When the surveyor looked at the paper towel it was left with red and brown substance. When the surveyor visualized the white plastic guard in the ice machine, the red and brown substance was noted on the white guard. The surveyor reviewed the ice machine cleaning log which showed the ice machine was cleaned weekly and the last cleaning was 2/9/26. The surveyor asked the RLNHA if weekly cleaning was sufficient based on what was seen and he stated, No. 2.A large bin of rice with the scoop laying inside of the rice (large clear scoop with attached handle). The surveyor asked the FSD if the scoop should be stored within the product and the FSD stated no. 3.The lid of a large flour bin had a large amount of black and brown substance smeared on the top. The surveyor asked the RLNHA if the container appeared clean and he stated no. 4.A seven pound can of cranberry sauce with a large dent in dry storage area. 5. A can opener blade, when lifted from the hold, had a large amount of black debris. 6.During tray line temperature checks, the surveyor observed, in the water of the steam table, a large amount of rectangular shaped pasta and yellow brown sediment on the bottom of the water holder and floating in the water. Pasta was not being served on the day of observation. The FSD immediately said We have to empty that. A policy regarding kitchen cleanliness was not provided by the FSD when requested. 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

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of debris and failed to cover 2 of the 4 dumpsters. This was evidenced by the following:On 2/17/26 at 9:30 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and the Regional Licensed Nursing Home Administrator (RLNHA). During the kitchen tour, the surveyor, in the presence of the FSD and the RLNHA, observed four outside dumpsters located behind the kitchen. Two of the four dumpsters had open lids. Surrounding the front of the four dumpsters were multiple cardboard boxes on the ground. To the right of the dumpsters there was a fence with a grassy area extending down the back of the building. The surveyor observed multiple debris including papers and paper cups scattered on the ground. The surveyor interviewed both the RLNHA and the FSD who told the surveyor it was both the dietary staff and the housekeeping staff who were responsible for ensuring the area was kept clean. No policy regarding the outside dumpster area was provided to the surveyor. NJAC 8:39-19.7 (b), 31.5 (a)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and review of facility documentation, it was determined that the facility failed to provide immediate access to records and requested information necessary to conduct the survey.The deficient practice was evidenced by the following: On 2/17/26 at 10:10 AM, during the entrance conference, the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON), the Regional LNHA, and the Regional DON, was informed that the survey team required all employee personnel and medical files for staff hired or terminated since the last recertification on 10/29/24. Also at that time, the Survey Team Coordinator requested the LNHA to complete the AAS-11 (Daily Nursing Staff Report used to track actual hours worked by shift) and AAS-12 (Facility Census and Care Evaluation used to track resident acuity and specialized clinical needs) for the facility staffing and return them via email by 2/18/26.1.) On 2/19/26 at 1:15 PM, the survey team started reviewing the personnel portion of the employee files but there was no evidence of the medical files. At that time, the Director of Social Services (DSS) stated that the Infection Preventionist (IP) kept the health files and confirmed the survey team only received the personnel portion of the employee files. On 2/20/26 the survey team reviewed the 55 employee personnel files and medical files. On 2/20/26 at 1:16 PM, the survey team reviewed the employee files with the LNHA and the DON which revealed that there were new hire records missing reference checks, background checks, license verification, and had incomplete health physicals. 2.) On 2/18/26 at 4:32 PM, the survey team received the AAS-11 and AAS-12 forms via email. A review of the AAS-11 and AAS-12 forms completed by the Staffing Coordinator (SC), and signed by the DON, revealed inconsistent numbers on the forms. The Survey Team Coordinator returned the forms to the LNHA for correction. On 2/19/26 at 2:23 PM, the LNHA returned the forms with corrections that still contained data-entry errors. On 2/19/26 at 4:11 PM, the SC emailed the forms with corrections that again contained inconsistent numbers on the forms. On 2/20/26 at 9:20 AM, the surveyor met with the LNHA, the DON, and the SC to identify continued findings of inconsistent data entry. The SC appeared to correct the data on her computer in the presence of the surveyor and emailed the final forms at 11:36 AM, which were determined to be inaccurate again. On 2/20/26 at 11:36 AM, the SC returned the forms, and the DON signed the forms, but the daily census was missing on the forms. On 2/20/26 at 1:20 PM, the LNHA sent the forms to the survey team for the last time for Department of Health review. On 2/24/26 at 10:20 AM, the surveyor interviewed the LNHA who stated she was responsible for everything and the overall function of the facility. A review of the Administrator's Job Description, included, the primary purpose of the position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities.6. Represent the facility in dealings with outside agencies .9. Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed.10. Delegate a responsible staff member to act in your behalf when absent from facility. Personnel Function 8. Assure that appropriate documentation is filed in the employee's personnel record in accordance with current regulations. N.J.A.C. 8:39-9.2(a)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that all residents that maintained a Personal Needs Account (PNA) received a written notification when approaching the limit that could jeopardize a resident's eligibility for Medicaid or Supplemental Security Income (SSI).This deficient practice was identified for 11 of 11 residents (Resident #1, #8, #55, #65, #73, #108, #110, #142, #156, #159 and #171) reviewed for PNA and was evidenced by: On 2/17/26 at 12:30 PM, the Licensed Nursing Home Administrator (LNHA) provided the PNA balances as of 2/17/26. A review of the facility's PNA Quarterly Statement from 10/1/25 to 12/31/25 revealed 11 residents had balances that ranged from $1877.71 to $2316.28. A review of the facility's Trial Balance as of 2/17/25 revealed the 11 residents still had pending balances that ranged from $1,800.25 to $1,800.71. On 2/18/26 at 10:44 AM, the surveyor interviewed the Director of Social Services (DSS) who stated that the PNA statements were provided quarterly to the residents and/or resident's representatives who were also provided ways to spend down the balances. She further stated the PNA Quarterly Statements included the name of the resident or representative who received the statement. At that time, the surveyor requested all the documentation that the DSS stated she did for the 11 residents. On 2/18/26 at 11:16 AM, the DSS provided emails and other pertinent facility documents that included clothing purchases from October 2025 and prepaid funeral arrangements from 2022 and 2023. A further review of the email dated 1/27/26, for Resident #65, reflected the Office of Public Guardianship (OPG) reached out and requested the PNA balance to be spent down for Medicaid purposes. On 2/19/26 at 10:48 AM, during a follow up interview, the DSS explained ways the facility spent down PNA balances such as buying clothing or prepaying funeral arrangements. She further stated she discussed with the residents and/or the representative on ways to spend down their PNA balances. When asked if a written notification was provided when the PNA balances were approaching the limit that could jeopardize a resident's eligibility for Medicaid or SSI, the DSS stated that she did not document it in the resident's chart, but she went over the statements quarterly and if the balance was approaching $2000.00, then she purchased items to spend down the balance. On 2/19/26 at 1:18 PM, the surveyor interviewed the Regional Licensed Nursing Home Administrator (LNHA) who stated that the DSS would sit with the residents to spend down their PNA balance. He further stated he was unsure if there was a written notification but would look. There was no evidence of a written notification when approaching the limit that could jeopardize the 11 residents' eligibility for Medicaid or SSI prior to surveyor inquiry. On 2/20/26 at 9:38 AM, the DSS stated in the presence of the Regional LNHA and the survey team that they reviewed the regulations and that they ensured the residents were not going over the $2000.00 maximum for Medicaid. At that time, the Regional LNHA acknowledged that they should have provided a written notification of approaching the limit. When ask was there was a specific amount at which the resident should be notified, the Regional LNHA stated they did not have a specific amount but that if it was approaching $2000.00, there should be a written notification. The DSS stated after surveyor inquiry she reached out to each resident and the OPG of their PNA balance and the need for it to be spent down. On 2/20/26 at 9:48 AM, the surveyor interviewed the LNHA who stated the DSS notified the families on how to spend the PNA balance down when they were nearing $2,000.00. The LNHA stated it was important to inform the residents they were approaching $2000.00 because they could be cut from Medicaid. A review of the facility's Personal Needs Allowance policy, revised July 2025, did not include a written notification when approaching the limit that could jeopardize a resident's eligibility for Medicaid or SSI. A review of the regulations the facility provided NJ Admin Code 10: 166-1.16 - Utilization of resident's income for cost of care in the Nursing Facility (NF) and for PNA, included: 1. If the NF is handling the PNA, the facility shall closely monitor the PNA account and inform the beneficiary and/or his or her representative when the amount comes within $200.00 of the resource eligibility cap. NJAC 8:39-9.5

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interviews, it was determined that the facility failed to maintain the most recent State of New Jersey inspection results in a place readily accessible to the residents, families, and the public. This deficient practice was evidenced by the following: During the Resident Council Meeting on 2/18/26 at 10:30 AM, five of five alert and oriented residents (#32, #40, #86, #89, and #104), said they were not aware of the location of the State Survey results, that the facility had not spoken to them about the results, and that they were interested in reading the reports. On 2/19/26 at 11:55 AM, the surveyor toured the A-Wing Unit to locate the State Survey results, but the State Survey Book was not readily accessible. When the surveyor asked Unit Manager/Registered Nurse (UM/RN #2 and other floor staff where the State Survey results could be found, they had difficulty locating the State Survey Book. When found, the surveyor reviewed the State Survey book, but the most recent survey results were not current and were dated 6/5/23. On 2/19/26 at 12:04 PM, the surveyor toured the B-Wing Unit, but the State Survey Book was not readily accessible. When located by UM/RN #1, the surveyor reviewed the survey book and found the most recent survey results were not current and were dated 6/5/23. On 2/19/26 at 12:12 PM, the surveyor toured the C-Wing Unit. The UM/LPN #1 and her staff were unable to locate the State Survey book. During the survey, there were no signs posted to direct the residents to the location of the State Survey results. In addition, the State Survey results book in the front lobby was not readily accessible to residents due to the locked door that required a four-digit code to enter between the lobby and residents' units. During an interview with the surveyor on 2/24/26 at 11:27 AM, the LNHA was informed that the State Survey results were behind the nurse's station and not readily accessible by the residents without having to ask staff. The surveyor also explained that only two (2) out of the three (3) units had Survey Result Books and that they were not current. The facility provided a policy, Resident Rights, with a revision date of July 2025, that included the statement, Federal and state laws guarantee certain basic right to all residents of this facility. These rights include the residents' right to: F. Examine survey results. NJAC 8:39-9.4(b)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and homelike environment by providing adequate lighting. This deficient practice was identified on 1 of 3 nursing units (C-Wing) toured and was evidenced by the following: On 2/17/26 at 10:51 AM, on initial tour of the facility, the surveyor entered room [ROOM NUMBER], located on the C Wing. The surveyor observed Resident #87 sitting on the side of the bed and the resident told the surveyor that the bathroom light did not work. The surveyor entered the bathroom and there was no cover on a ceiling light. When the surveyor turned the light switch on, the light did not turn on. The resident was in a semiprivate room, and both residents used the bathroom independently. Resident #87 utilized a rolling walker to ambulate. The resident told the surveyor that maintenance was aware of the problem and had not fixed it yet. The surveyor asked how long the light did not work and the resident stated, Maybe two weeks. On 2/18/26 at 11:10 AM, the surveyor observed the Resident #87 in bed in his/her room. The resident told the surveyor that the light was not fixed, and It's pretty hard going to the bathroom at night. On 2/18/26 at 11:15 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #2 regarding the maintenance process. She told the surveyor there was a maintenance log that the staff write in and maintenance checked the log, I think every day, but don't quote me. The surveyor then interviewed Unit Manager/Licensed Practical Nurse (UM/LPN) #1 regarding the process for repairs from maintenance. She told the surveyor there was a logbook any staff could write in any issue, and maintenance checked the book daily and they also communicated through an app on the phone if they needed them right away. On 2/18/26 at 11:28 AM, the surveyor reviewed the maintenance book. On 2/9/26 there was an entry for room [ROOM NUMBER], Resident #87's room number. It was documented as bathroom light out. The column in the book where maintenance would sign when the issue was repaired was blank. On 2/18/2026 at 12:48 PM, the surveyor interviewed the Maintenance Technician (MT) regarding the process for repairs in residents' rooms. The MT stated every unit had a book they wrote in their issues, and he checked the book in the morning. When the repairs were done, he then signed the book. He told the surveyor he checked the book three (3) more times each day. The surveyor asked about the 2/9/26 request for the bathroom light to be fixed and he stated the facility was waiting on an order. The surveyor asked what the plan was until the order arrived as the resident was in the dark at night and he stated the plan was to get another light in the meantime. The surveyor explained it had been nine (9) days since the light stopped working, and the MT had no response. The surveyor requested to see the order for the new light, but the MT did not provide one to the surveyor. On 2/20/26 at 10:56 AM, the surveyor requested a policy for homelike environment from the Licensed Nursing Home Administrator (LNHA). The LNHA stated the facility did not have one. On 2/24/26 at 11:00 AM, the surveyor asked the Regional LNHA for a copy of the invoice for the light ordered on 2/9/26, but the facility was unable to provide one. NJAC 8:39-31.2 (e)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure newly hired employees were properly screened for a history of abuse, neglect, exploitation, or misappropriation and failed to implement policies and procedures related to pre-employment screening. Specifically, the facility did not complete required license verifications, reference checks, or criminal background checks prior to the start of employment. This deficient practice was identified in 10 of 55 employee files reviewed (Employees #1 through #10). The deficient practice was evidenced by the following:On 2/17/2026 10:10 AM, the surveyor requested that the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), the Regional DON and the Regional LNHA provide personnel files for all employees hired since the last annual recertification survey 10/29/24, regardless of current employment status. The requested documentation included the department of hire, date of hire, license verification, reference checks, criminal background checks, and pre-employment medical documentation, including physical examinations and two-step Mantoux test results.On 2/20/26 at 9:15 AM, the surveyors began reviewing the personnel files of 55 newly hired employees. Of the personnel files reviewed, there was no evidence that license verifications, reference checks, or criminal background checks were completed prior to the start of employment for 10 of the employee files. The review of the personnel files of all newly hired employees revealed the following: Employee # 1, a Certified Nursing Assistant (CNA) with date of hire (DOH) of 11/3/25. There was no evidence that a reference check was completed prior to the start of employment.Employee # 2, a CNA with DOH 9/8/25. There was no evidence that a reference check or a certification verification was completed prior to the start of employment.Employee # 3, a CNA with DOH 11/24/24. There was no evidence that a reference check was completed prior to the start of employment.Employee # 4, a Registered Nurse (RN) with DOH 8/11/25. There was no evidence that a reference check was completed prior to the start of employment.Employee # 5, a LNHA with DOH 6/1/25. There was no evidence that a license verification was completed prior to the start of employment.Employee # 6, a CNA with DOH 10/20/25. There was no evidence that a certification verification was completed prior to the start of employment.Employee # 7, an RN with DOH 10/6/25. There was no evidence that a reference check was completed prior to the start of employment.Employee # 8, a CNA with DOH 3/24/25. There was no evidence that a reference check was completed prior to the start of employment.Employee # 9, a Smoke Aide with DOH 1/25/25. There was no evidence that a background check was completed prior to the start of employment.Employee # 10, a Housekeeper with DOH 1/7/25. There was no evidence that a background check was completed prior to the start of employment. On 2/20/26 at 1:00 PM, the surveyor interviewed the Director of Human Resources (DHR) in the presence of the DON and LNHA, who stated she had been employed for one (1) week and was still in training. The LNHA stated that the onboarding process included a completion of an employment application and verification of references, vaccination records, applicable licenses, and a criminal background check prior to orientation. The LNHA further stated that it was important that all documentation must be completed prior to the employee working on the floor to ensure staff are physically fit and properly credentialed. A review of the facility's Residents/Patient rights-Abuse, Neglect, Mistreatment, or Misappropriation of Resident/Patient's Property policy, revised July 2025, revealed that the facility will be thorough in the investigation of past histories of individuals hired, This will be done through: a. inquiry of State Aide Registry, b. inquiry of licensing authorities, when appropriate and c. references will be checked. NJAC 8:39-9.3(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that the facility failed to ensure an accurate assessment of a resident with a history of falls in the resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 1 of 5 residents (Resident #79) reviewed for accidents and was evidenced by the following:On 2/17/26 at 10:48 AM, the surveyor observed Resident #79 in bed with eyes closed. The surveyor observed a fall mat on the right side of the bed and the left side of the bed was against the wall. On 2/17/26 at 11:16 AM, the surveyor walked past Resident #79's room and observed a Certified Nursing Assistant (CNA) sitting in a chair in the doorway. The surveyor asked if the CNA was there to observe the resident because of a fall history and she stated yes. A review of the admission Record revealed the resident was admitted to the facility with medical diagnoses which included, but were not limited to, dementia, chronic kidney disease, abnormal gait and mobility, and falls. A review of the quarterly MDS, dated [DATE], indicated Resident #79 had a Brief Interview of Mental Status (BIMS) of 00 of 15, meaning the resident had severe cognitive impairment. Review of section J1800 of the MDS for any falls since admission to facility was documented as zero, meaning the resident had no falls since admission to facility. A review of Resident #79's incidents and accidents showed that Resident #79 had falls on 4/5/25, 4/18/25, 5/2/25, 11/12/25, 12/20/25, and 1/8/26. A review of the Individualized Comprehensive Care Plan (ICCP) included a focus for falls initiated on 4/5/25. Review of the interventions revealed that the care plan was revised following each fall with new interventions related to fall prevention. On 2/20/26 at 10:25 AM, the surveyor interviewed the Minimum Data Set Coordinator (MDSC) regarding Resident #79's MDS. The surveyor asked how the MDSC was updated if residents had falls. The MDSC stated that falls would be a quarter look back, meaning the number of falls which happened in the previous three months would be added to the quarterly MDS being completed. The surveyor asked how she would be made aware if a resident were to have a fall and she stated, in the morning meeting, or I would look at the risk assessment. The surveyor had the MDSC review the Electronic Medical Record (EMR) for Resident #79 and the MDSC stated she did not know how she missed it. The surveyor asked if any falls should be on the 12/24/25 quarterly MDS and she stated, Yes. The facility did not have an MDS policy to provide to the surveyor. NJAC 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 the facility failed to revise an Individual Comprehensive Care Plan (ICCP) for a resident no longer receiving tube feedings. This deficient practice was identified in 1 of 1 resident (Resident #164) reviewed for tube feeding and was evidenced by the following: On 2/17/26 at 10:10 AM, Resident #164 was observed in bed in his/her room. The resident was not receiving any tube feeding at the time of the observation and there was no feeding pump in the room. A review of the admission Record revealed Resident #164 had diagnoses which included, but were not limited to, bipolar disorder, gastrostomy tube (feeding tube), dementia, anxiety, and failure to thrive. A review of the Physician Order Summary Report showed an order for regular diet, regular texture, thin consistency and super cereal at breakfast. The order was dated 12/1/25 and remained active. There was also an order for Ensure Plus (oral liquid supplement shake) three times a day given by mouth, ordered on 12/1/25 and remained an active order. Further order review showed an order to cleanse feeding tube site daily with soap and water and cover with a drain sponge, an active order dated 12/2/25. The surveyor did not locate any orders for tube feeding formula. A review of the ICCP showed a focus for the need for a feeding tube and resident refuses feedings at times. The care plan was initiated on 5/15/23 with a revision date of 10/22/24. Interventions included, but were not limited to, administer tube feeding formula, hydration, and flushes per orders, and encourage compliance with tube feedings, hydrations, and flushes as ordered. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 12/7/25, revealed the resident had a Brief Interview of Mental Status of 4 of 15, meaning the resident had severe cognitive impairment. Review of Section K for nutritional status was marked as yes for having a feeding tube, and yes for receiving a therapeutic diet. On 2/20/26 at 9:56 AM, the surveyor interviewed Unit Manager/Licensed Practical Nurse (UM/LPN) #1 of C Wing regarding care plans. The UM/LPN#1 told the surveyor that when any type of care focus was resolved, such as a completed tube feeding, the care plan would be revised to include a resolved under that specific focus. UM/LPN#1 stated that the Nursing Supervisor, Minimum Data Set Coordinator (MDSC), and nursing staff were all responsible for care plans but the UM/LPN #1 and the MDSC were the most responsible to ensure they were completed. A review of the facility's Interdisciplinary Care Planning Protocol policy, undated, included, that nursing provides overview of medical and nursing care regimes and problems established by the team with resident/family input must be specific and individualized. The policy did not address care plan revisions. NJAC 8:30-27.1 (a)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility did not ensure the daily nurse staffing report was updated and posted each day in a location accessible to the public. This deficient practice was evidenced by the following: On 2/17/26 at 8:56 AM, upon initial entrance to the facility, while the survey team was in the lobby awaiting facility administration, the surveyor observed the posted daily staffing sheet located in the lobby was dated 2/5/26. During an interview with the surveyor on 2/20/26 at 12:50 PM, the Staff Coordinator (SC) stated that staffing information was required to be updated to reflect any changes and posted daily in the facility lobby in a location accessible to the public. During an interview with the surveyor on 2/20/26 at 1:10 PM, the Licensed Nursing Home Administrator (LNHA) stated that the daily staffing sheet was required to be updated to reflect any changes and was to be posted each day in the facility lobby in a location accessible to the public. When asked by the surveyor to provide the facility's staffing policy, the LNHA stated that the facility followed the state staffing regulations and did not maintain a separate written staffing policy. The facility was unable to provide a written policy regarding daily staffing postings. NJAC 8:39-41.2 (a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure accurate medication dispensing and administration for 1 of 6 residents (Resident #50) observed during the medication pass. This deficient practice was evidenced by the following:On 2/18/26 at 8:22 AM, the surveyor observed Licensed Practical Nurse (LPN #1) dispense five medications for Resident #50. As the LPN pulled the medications from the medication cart, she handed them to the surveyor. The LPN handed the surveyor an over-the-counter (OTC) pill bottle of calcium citrate 200 milligrams (mg) and then the LPN dispensed one pill from the bottle into the medication cup. When the LPN finished dispensing the medications, she locked the medication cart and turned on the privacy screen on the monitor. Before the LPN entered the resident's room, the surveyor asked the LPN to review the resident's medications. The LPN verified the resident had the following physician's order: calcium citrate-vitamin D 315-5 milligrams (mg)-micrograms (mcg) give one table by mouth one time a day. At that time, the LPN acknowledged that she dispensed the incorrect calcium citrate medication and used a drug buster to destroy the medication. She looked in the medication cart for the correct medication but was unable to locate it. The LPN then asked Licensed Practical Nurse/Unit Manager (LPN/UM) #2 to find the correct medication in the facility's OTC supply. On 2/18/26 at 8:37 AM, the surveyor interviewed LPN #1 who stated the process for medication administration included reading the physician's order and checking the medication against the order. The LPN explained this process was important to prevent medication errors. When asked about the calcium citrate-vitamin D order, the LPN stated she only read the part of the order that said, calcium citrate. The surveyor reviewed the medical record for Resident #50. According to the admission Record, an admission summary, the resident had diagnoses which included, but were not limited to, dementia and disorders of bone density and structure. A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 11/18/25, included the resident had a Brief Interview for Mental Status score of 5 out of 15 which indicated the resident's cognition was severely impaired. A review of the Order Summary Report, as of 2/18/26, included the following physician's order (PO):A PO, dated 5/31/23, for calcium citrate-vitamin D oral tablet 315-5 mg-mcg, give one tablet by mouth one time a day for supplement. On 2/18/26 at 8:48 AM, the surveyor interviewed LPN/UM #2 who stated that during medication pass, the nurses should check the physician's order against the medication to ensure the right medication is given. The LPN/UM further stated that if the nurse could not find the correct medication, she should notify the physician. When asked about the calcium citrate-vitamin D, the LPN/UM stated she was unable to locate the medication in the facility's OTC supply and would notify the physician. On 2/18/26 at 9:17 AM, the surveyor interviewed the Director of Nursing (DON) who stated that during medication pass, the nurses should read the physician's order and then check the medication against the order three times to make sure the medication was correct and to prevent a medication error. On 2/18/26 at 10:25 AM, during a follow-up interview, the surveyor informed the DON of the above medication error. The DON acknowledged that LPN #1 should have read the physician's order thoroughly before dispensing or administering the medication. A review of the facility's Administering Medications policy, dated 7/2025, included, Medications must be administered in accordance with the physician's orders, and, The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. NJAC 8:39-27.1(a)NJAC 8:39 - 29.2(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to ensure that a medication was secured in a locked compartment accessible only to authorized personnel with a key. This deficient practice was identified for 1of 1 resident (Resident #143).On 2/17/26 at 11:15 AM, the surveyor observed Resident #143 seated in his/her wheelchair in their bedroom, waiting to go to therapy. A nebulizer medication vial was noted on the bedside table. The resident stated that he/she administered their own breathing treatments after the nurses leave the medication for him/her. The surveyor reviewed the medical record for Resident #143. A review of the admission Record, indicated the resident was admitted to the facility with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) (long-term lung disease that makes it hard to breathe). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 1/15/26, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. A review of the Individual Comprehensive Care Plan (ICCP) included a focus area dated 1/8/26 indicating that Resident #143 was at risk for respiratory impairment. Interventions included, administering medications and treatments as ordered per physician orders. A review of the Order Summary Report (OSR), dated as of 2/19/26, included the following physician orders (PO): A PO, dated 9/22/25, for Albuterol Sulfate Nebulization Solution (2.5 milligrams (mg)/3 milliliters (mL) 0.083%, 3mL inhale orally via nebulizer every 6 hours as needed for COPD. A PO, dated 12/3/25, for Budesonide inhalation Suspension (0.5 mg/2mL), 2 mL inhale orally two times a day for COPD. A PO, dated 12/3/25, for Ipratropium-Albuterol Inhalation Solution 0.5 -2.5 (3) mg/3 mL inhale orally three times a day for COPD. During an interview with the surveyor on 2/18/26 at 12:25 PM, the Registered Nurse/Unit Manager #2 (RN/UM #2) stated that Resident #143's nebulizer medication vial should not have been left on the bedside table, the resident did not have a care plan to self-administer medications, and for safety reasons. During an interview with the surveyor on 2/18/26 at 12:30 PM, the Licensed Practical Nurse #1 (LPN #1) stated that she usually leaves Resident #143's nebulizer medication vials at the bedside, and the resident places the medication into his/her nebulizer mask and turns on the nebulizer machine. The LPN #1 stated that she returns in approximately 10 to 15 minutes to ensure the resident has completed the nebulizer treatment. She further stated that if the resident was not care planned to self-administer medications, the medication should not be left at the bedside, and she should administer the medication to ensure the breathing treatment was completed for the safety of the resident. A review of the facility's Storage of Medications policy dated July 2025, included, The nursing staff be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. A review of the facility's Medication Administration policy dated July 2025, included, Licensed nursing professionals will administer medications according to times of administration determined by the facility. NJAC 8:39-29.2(d)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interview, and review of pertinent facility documentation it was determined that the facility failed to follow the planned written menu for 2 of 2 meals observed. This deficient practice was evidenced by the following:On 2/19/26 at 11:10 AM, the surveyor entered the kitchen during lunch preparation. The menu for lunch was crispy baked chicken, macaroni and cheese, and roasted zucchini. The surveyor observed a vegetable mix cooking on the stove top which had cauliflower, carrots, and zucchini. It was simmering in a stainless-steel pan with water on the stove top. At that time, the surveyor interviewed a [NAME] who stated the lunch was chicken and the alternate lunch was glazed ham. During the observation the [NAME] was cleaning chicken thighs. The surveyor asked about the menu process for resident choices and the [NAME] stated that the Food Service Director (FSD) hanged the menus on the units an hour before lunch was served and residents could choose the main meal, the alternate, or the always available options. On 2/19/26 at 12:33 PM, the surveyor went into the kitchen with the FSD. The tray line temperatures were checked by FSD in the presence of the surveyor. During the observation, the surveyor observed the chicken being placed in a deep fryer. The surveyor asked the [NAME] if all the chicken was fried or if baked chicken was an option, and he stated that all the chicken was fried. On 2/20/26 at 10:41 AM, the surveyor reviewed the breakfast menu for the day. The menu provided to the surveyor and the menu posted on the A, B, and C wing indicated the residents would receive orange juice, farina, egg and spinach frittata, apple cinnamon muffin, whole milk and coffee. At that time, the surveyor interviewed a Certified Nursing Assistant (CNA) on C wing regarding what was served on the breakfast trays. She said scrambled eggs, bacon, English muffin, and coffee. The surveyor then interviewed an unsampled resident on C wing who stated they received scrambled eggs, bacon, English muffin and coffee and milk. The surveyor then interviewed a CNA on B wing who stated all the residents' received eggs, bacon, English muffin, and coffee. The surveyor then interviewed an unsampled resident on A Wing who stated breakfast included scrambled eggs, bacon, English muffin, and coffee. On 2/20/26 at 11:54 AM, the surveyor interviewed the Regional Dietician (RD) regarding menus. The surveyor asked why it was important for a facility to follow the menu for residents. The RD replied, Because when menus are developed a nutrient analysis is done, and if you are changing menu, it may not meet the nutritional needs of the residents. On 2/24/26 at 11:50 AM, the surveyor interviewed the Regional Licensed Nursing Home Administrator (RLNHA), who stated that the facility found a fault in the kitchen that caused incorrect meals/menus. The surveyor asked why following a planned menu was important for the facility and he stated that it was important due to meeting the residents' preferences and to ensure nutritional value was being met. The facility did not provide any documentation on meal substitutions or menu changes. NJAC 8:39-17.4 (a) 3

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on observations and interviews it was determined that the facility failed to ensure the Licensed Nursing Home Administrator (LNHA) and the Medical Director's (MD) licenses were visibly displayed. This deficient practice was evidenced by the following:On 2/20/26 at 12:15 PM, two surveyors toured the facility and there was no evidence that the current MD (MD #1) or the LNHA's licenses were visibly displayed. During the tour, the two surveyors observed in the facility's copier room a copy of MD #2's license on the bulletin board. On 2/20/26 at 12:30 PM, the surveyor interviewed the Director of Nursing (DON) who stated that MD #2 was the previous Medical Director and MD #1 was the current Medical Director. At that time, the Regional DON, the Director of Social Services (DSS), and the DON, with the surveyor, looked in the main hallway and they stated that the license was previously visibly posted. They all confirmed it was not currently posted and would have to see where it went. The DSS stated that one of the bulletin boards fell and they put it somewhere. The DSS further stated, we just have to find it. On 2/20/26 at 12:38 PM, the surveyor interviewed the LNHA who stated the DON had a copy of the MD's license in her office and that she personally kept hers. The LNHA confirmed the MD and her license were not currently visibly posted and that it should be posted in the main hallway. She then stated the licenses were previously posted but she was not sure what happened. On 2/20/26 at 12:56 PM, the LNHA stated the MD's license was posted visibly in the main hallway after surveyor inquiry. On 2/24/26 at 10:20 AM, the LNHA showed the surveyor her license was now posted visibly in the main hallway. She stated that the bulletin with the licenses in the main hall was taken down to put up a new time clock that needed to be connected through the wall. She stated the time clock was completed about three weeks ago. The LNHA acknowledged the MD and the LNHA's licenses should have been visible to the public prior to surveyor inquiry. No additional documents were provided. NJAC 8:39 - 5.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility did not ensure a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to a.) follow appropriate hand hygiene practices for 1 of 2 nurses who administered medications to 3 of 6 residents (Resident #42, Resident #50, and Resident #59) during the medication pass, and b.) properly store a nebulizer mask leaving the mask exposed to air on a bed table for 1 of 1 resident (Resident #143) reviewed for respiratory care. This deficient practice was evidenced by the following:1.) On 2/18/26 at 8:15 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 exit a resident's room and return to the medication cart. The surveyor explained to the LPN that the surveyor would be observing the medication pass and the LPN informed the surveyor that she was going to prepare Resident #59's medications. At that time, without performing hand hygiene, the LPN dispensed five medications into a medicine cup and then administered them to Resident #59. When the LPN returned to the medication cart, she did not perform hand hygiene. At 8:22 AM, LPN #1 moved her medication cart to Resident #50's room and without performing hand hygiene, the LPN dispensed five medications, removed an incorrect medication from the medicine cup and destroyed it, and then administered the remaining medications to Resident #50. When the LPN returned to the medication cart, she did not perform hand hygiene. At 8:30 AM, LPN #1 moved her medication cart to Resident #42's room and without performing hand hygiene, the LPN dispensed six medications into a medicine cup and then administered them to Resident #42. When the LPN returned to the medication cart, she did not perform hand hygiene. On 2/18/26 at 8:37 AM, the surveyor interviewed LPN #1 who stated hand hygiene should be performed before and after administering medications to prevent the spread of germs. When asked about her hand hygiene during the medication pass, LPN #1 acknowledged that she did not perform hand hygiene during the medication pass observation. On 2/18/26 at 8:48 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that during the medication pass, nurses should use hand sanitizer between each resident to prevent the spread of germs. On 2/18/26 at 9:17 AM the surveyor interviewed the Director of Nursing (DON) who stated the nurses should perform hand hygiene before dispensing medications and after administering medications by either washing their hands with soap and water or using hand sanitizer for infection control purposes. On 2/18/26 at 10:25 AM, the surveyor informed the DON of LPN #1's lack of hand hygiene during the medication pass observation and the DON stated LPN #1 should have used the hand sanitizer that was available on her medication cart. A review of the facility's Administering Medications policy, dated July 2025, included, Staff shall follow established facility infection control procedures (e.g., handwashing.) for the administration of medications, as applicable. A review of the facility's Handwashing/Hand Hygiene policy, dated July 2025, included, In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following situations: a. Before and after direct contact with residents;. d. Before preparing or handling medications;. 2.) On 2/17/26 at 11:15 AM, Surveyor #2 observed Resident #143 seated in his/her wheelchair in his/her bedroom, waiting to go to therapy. A nebulizer mask was left on the bedside table, exposed to air. The surveyor reviewed the medical record for Resident #143. According to the admission Record, the resident had diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD) (long-term lung disease that makes it difficult to breathe). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 1/15/26, 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. A review of the Individual Comprehensive Care Plan (ICCP) included a focus area dated 1/8/26 that the resident was at risk for respiratory impairment. Interventions included, but were not limited to: administering medications and treatments as ordered per physician orders. A review of the Order Summary Report (OSR), dated as of 2/19/26, included the following physician orders (PO): A PO, dated 9/22/25, for Albuterol Sulfate Nebulization Solution (2.5 milligrams (mg)/3 milliliters (mL) 0.083%, 3mL inhale orally via nebulizer every 6 hours as needed for COPD. A PO, dated 12/3/25, for Budesonide inhalation Suspension (0.5 mg/2mL), 2 mL inhale orally two times a day for COPD. A PO, dated 12/3/25, for Ipratropium-Albuterol Inhalation Solution 0.5 -2.5 (3) mg/3 mL inhale orally three times a day for COPD. During an interview with the surveyor on 2/18/26 at 12:25 PM, the Registered Nurse/Unit Manager #2 (RN/UM #2) stated that Resident #143's nebulizer mask should not have been left on a bedside table exposed to air and should have been placed in a plastic bag after use for infection control purposes. During an interview with the surveyor on 2/18/26 at 12:30 PM, the Licensed Practical Nurse #1 (LPN #1) stated that Resident #143's nebulizer mask should not have been left at bedside after use and should be placed in a plastic bag to prevent exposure to germs. A review of the facility's Oxygen Therapy policy, dated July 2025, revealed that When not in use, the nasal cannula or oxygen mask will be placed in a plastic bag. The plastic bag will be labeled with the resident's name and dated. The plastic bag will be changed when the cannula/mask and humidifier bottle are changed weekly. NJAC 8:39-19.4(a)(1)