STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315275	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Healthcare & Rehabilitation Center	963 Ocean Ave Lakewood, NJ 08701

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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. Repeat DeficiencyBased on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent foodborne illness, b.) store unused disposable beverage accessories in a manner to prevent foodborne illness, and c.) maintain kitchen sanitation in a safe and consistent manner to prevent foodborne illness.This deficient practice was evidenced by the following:On 4/6/2026 at 5:05 PM, the surveyor conducted an initial tour of the kitchen and food storage areas with Cook.Findings include:1. A large grey plastic trash bin lined with clear plastic bag was uncovered with the lid on the floor. The bin was located next to the walk-in refrigerator. There were no staff using the trash bin at that time. [NAME] stated that there was nothing there. The surveyor observed several stalks of celery, a plastic container of seasoning, and water bottles on top of other trash inside the bin. The surveyor asked the cook if the bin should be covered. The cook put the lid on the bin.2. The surveyor observed another uncovered trash bin propping the kitchen door to the hallway across the dining room. There were no staff using the trash bin at that time. The plastic liner of the trash bin was touching the handle of a black bussing cart. The cart contained 4 unopened soda cans and 1 unopened bottle of water on the upper shelf. On the middle shelf of the cart, there was an aluminum tray containing unused packets of sugar, wipes, paper napkins, and individually wrapped plastic cutlery sets. The bottom shelf of the cart contained another aluminum tray holding several unused disposable plastic cups. 3. Inside the bulk/ dry storage area, the surveyor observed a large box of overripe browned bananas. [NAME] stated, it is garbage and proceeded to take the box out of the storage area.4. Inside the bulk/ dry storage area, the surveyor observed a green plastic crate on the floor. The crate was lined with an untied plastic bag containing several red, medium to large size onions. The plastic liner was spread out around the crate and touching the floor. [NAME] #1 did not say anything when asked if the onions should be on the floor.5. A large brown carton box stained into dark brown color with blackish areas of mottling was observed on top of a plastic wrapped beverage dispenser. The staining was very greasy to touch. Inside the box were unused paper coffee filters with diameter size of 13 inches x 5 inches. The cook did not reply to the surveyor when asked about the greasy box.On 4/7/2026 at 9:26 AM, during a revisit tour of the bulk/dry storage area with the Food Service Director (FSD), the surveyor smelled a strong banana odor upon opening the door. The surveyor observed a large box of overripe brown bananas. The FSD stated that it is used for baking banana cakes.On 4/9/2026 at 8:48 AM, during an interview with the surveyor, the FSD stated that trash bins are allowed to be uncovered while cleaning the kitchen or being used. The FSD also stated that food on the floor is not acceptable. The FSD stated that they ordered ahead the bananas because of the [name of holiday redacted]. The FSD stated that if it is not the [holiday redacted], they only order once a week.A review of the undated facility policy titled Disposal of Garbage and Refuse included under Policy Explanation the following: 2.) Garbage and refuse containers shall be durable, cleanable, and free from cracks or leaks and covered when not in use.A review of the undated facility policy titled Food Storage included under Policy the following: Dry storage areas will be kept in a condition which protects stored food from infestation. Included under Procedure were the following: 1.) All items must be stored at least 6 (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	inches off the floor. 6.) Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods. N.J.A.C. 8:39 - 17.2 (g)

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and review of other facility documents, 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 and parking area free of garbage and debris and failed to have a cover over the opening of 2 of 2 garbage containers/dumpsters.This deficient practice was evidenced by the following:On 4/6/2026 at 5:01 PM, the surveyor observed 2 green, 1 blue, and 1 grey plastic milk crates scattered in the parking lot next to a grey sports utility vehicle (SUV).On 4/6/2026 at 5:26 PM, during the tour of the designated garbage area with the Administrator in Training (AIT), the surveyor observed a green garbage dumpster/ compactor. The dumpster was half-open. There was no staff loading any trash in the dumpster. The surveyor observed [NAME] rolled the lid on the green dumpster. The AIT stated that [NAME] had been working in the area with them. Prior to this, [NAME] was actually with the surveyor on the initial tour of the kitchen and food storage areas.On 4/6/2026 at 5:27 PM, the surveyor observed several plastic milk crates on the ground along with 2 grey plastic carts near the dumpsters area.On 4/6/2026 at 5:28 PM, the surveyor observed a red dumpster designated for recyclable trash. One of the 2 plastic lids was in the open position. Nobody was loading anything in the dumpster. The lid was lifted by the AIT to cover the dumpster. The area surrounding the dumpster was observed to have garbage on the ground. The garbage included an untied red plastic bag, milk crate, folded cardboard boxes and other unidentified debris.On 4/9/2026 at 8:48 AM, during an interview with the surveyor, the Food Service Director (FSD) stated that dumpsters should be covered at all times except when being used.A review of undated facility policy titled Disposal of Garbage and Refuse included under Policy Explanation the following: 7.) Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized. N.J.A.C. 8:39 - 19.3 (c)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to administer enteral nutrition through tube feedings (delivery of nutrients directly into the stomach through a surgical opening) according to Physician's Order (PO). This deficient practice was identified for 2 of 2 residents (Resident #8 and Resident #41) reviewed for receiving nutrition via Tube Feeding (TF).This deficient practice was evidenced by the following:1.) On 4/6/2026 at 6:02 PM, the surveyor observed Resident #8 in bed. A tube feeding pump was located to the left of the resident's bed. The pump was observed off. There was no nutritional formula or free water being administered to the resident at this time. On 4/7/2026 at 8:55 AM, the surveyor observed the resident in bed. Certified Nursing Assistant (CNA) was observed shaving the resident's face. The TF pump was observed off. There was no nutritional formula or free water hanging in the TF pole.The surveyor reviewed the medical record for Resident #8.A review of the admission Record (admission summary) reflected that Resident #8 was admitted to the facility with diagnoses that included but not limited to traumatic brain injury, ileus (disruption of intestinal movement), and protein-calorie malnutrition. There was no documented medical condition for which the feedings were ordered.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 3/31/2026, indicated that Resident #8 had short-term memory problem and moderate impairment of cognitive skills. The MDS also indicated that the resident received nutrition through TF.A review of the Order Summary Report (OSR) started on 4/4/2026 and active as of 4/7/2026, included the following order: Start and hang feeding at 4 PM, Jevity 1.5 (a tube feeding formula) 80 milliliters per hour (ml/hr) until total volume of 1,000 ml infused, one time a day for enteral nutrition support. The resident also had a physician diet order for NPO (nothing by mouth) diet, NPO texture, NPO consistency. A review of the corresponding April 2026 Medication Administration Audit Report revealed that the formula feeding was administered late on the following dates and specific times:On 4/4/2026, the feeding formula due at 4 PM, was signed administered/ hung at 10:42 PM by Registered Nurse (RN) #1. There was no documented reason why the feeding was administered late.On 4/5/2026, the feeding formula due at 4 PM, was signed administered/ hung at 6:21 PM by RN #1. There was no documented reason why the feeding was administered late.On 4/6/2026, the feeding formula due at 4 PM, was signed administered/ hung at 7:49 PM by RN #1. A note by RN #1 dated 4/6/2026, indicated that the resident was put to bed after dinner service and that their TF was started at 7 PM.A review of the individualized comprehensive care plan initiated on 1/22/2026, included a focus for potential complications r/t (related to) enteral feeding and hydration via G-tube (TF). One of the interventions included the following: Administer tube feeding as ordered initiated on 1/22/2026.On 4/8/2026 at 11:15 AM, during an interview with the surveyor, Licensed Practical Nurse/ Unit Manager (LPN/ UM) stated that resident refusal for TF is documented in the nurses' notes. LPN/ UM also stated that physician orders should be administered an hour before and after. LPN/ UM stated that if the administration is habitually late, they would address the issue with the nurse and educate the nurse.On 4/8/2026 at 11:39 AM, during an interview with the surveyor, the Registered Dietician stated that the expectation for a TF ordered to be administered at 4 PM, was to be given at 4 PM so it does not interfere with activities or care, plus or minus an hour. On 4/9/2026 at 9:46 AM, during an interview with the survey team, RN #1 stated that they should be documenting the progress notes when TF are administered late or when residents refuse their TF. RN #1 further stated that they do not always have the time to document.On 4/9/2026 at 12:31 PM, during an interview with the survey team, the Director of Nursing (DON) stated that if tube feedings are administered late, it should be documented in the patient's record and that it is generally put in the progress notes.A review of the facility policy revised in February 2026, titled Enteral Nutrition indicated the following under Purpose: To provide adequate nutritional support (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through enteral nutrition is provided to residents as ordered. N.J.A.C. 8:39 - 25.2 (c) 2; 27.1 (a) 2.) On 4/6/2026 at 6:07 PM, the surveyor observed Resident #41 in bed. A tube feeding (TF) pump was located to the left of the resident's bed. The surveyor observed the pump to be off. There was no nutritional formula or free water being administered to the resident at this time. A private aide was with the resident. The resident mentioned to the surveyor that they can eat food. The private aide stated to the surveyor that the resident does not eat. On 4/7/2026 at 8:47 AM, the surveyor observed the resident in bed with TF of Jevity 1.5 infusing at 50 cubic centimeter/hour (cc/hr) simultaneous w/ water hydration.The surveyor reviewed the medical record for Resident #41.A review of the admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to dysphagia (difficulty swallowing), gastrostomy status (a surgical procedure used to directly provide nutrition to the stomach through a flexible tube, often referred to as a G-tube), and dementia.A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 2/23/2026, indicated that the resident had severely impaired cognition and that they received nutrition though TF.A review of the Order Summary Report (OSR) started on 3/2/2026 and discontinued on 4/1/2026, included the following order: Start &hang feeding at 6 PM Jevity 1.5 @ 30 ml/hr via G-Tube pump, run feeding until total volume infused of 720 ml, one time a day for Enteral Nutrition Support. On 3/7/2026, the PO was modified to the following: Start &hang feeding at 6 PM Jevity 1.5 @ 40 ml/hr via G-Tube pump, run feeding until total volume infused of 720ML, one time a day for Enteral Nutrition Support.A review of the corresponding March 2026 Medication Administration Audit Report revealed that the formula feeding was administered late on the following dates and specific times:On 3/2/2026, the feeding formula due at 6 PM, was signed administered/ hung at 10:42 PM by RN #1. TF was documented held in the day shift due to vomiting.On 3/3/2026, the feeding formula due at 6 PM, was signed administered/ hung at 10:04 PM by RN #1. There was no documented reason for late administration of TF.On 3/5/2026, the feeding formula due at 6 PM, was signed administered/ hung at 10:14 PM by LPN #1. Multiple attempts to administer the TF were documented refused by the resident.On 3/6/2026, the feeding formula due at 6 PM, was signed administered/ hung at 10:56 PM by RN #2. TF was documented refused due to nausea and vomiting.On 3/7/2026, the feeding formula due at 6 PM, was signed administered/ hung on 3/22/2026 at 6:10 PM by RN #1. There was no documented reason why the order was signed administered 15 days after the scheduled administration.On 3/8/2026, the feeding formula due at 6 PM, was signed administered/ hung on 3/22/2026 at 6:05 PM by RN #1. There was no documented reason why the order was signed administered 15 days after the scheduled administration.On 3/9/2026, the feeding formula due at 6 PM, was signed administered/ hung at 11:05 PM by RN #1. There was no documented reason why the TF was administered late.On 3/17/2026, the feeding formula due at 6 PM, was signed administered/ hung at 10:50 PM by RN #1. There was no documented reason why the TF was administered late.On 3/18/2026, the feeding formula due at 6 PM, was signed administered/ hung at 10:07 PM by RN #1. There was no documented reason why the TF was administered late.On 3/30/2026, the feeding formula due at 6 PM, was signed administered/ hung at 10:33 PM by RN #1. There was no documented reason why the TF was administered late.A review of the Order Summary Report (OSR) started on 4/2/2026 and active as of 4/7/2026, included the following order: Start &hang feeding at 4 PM Jevity 1.5 @ 50 ml/hr via G-Tube pump, run feeding until total volume infused of 720 ml, one time a day for Enteral Nutrition Support. The resident also had a physician diet order for Pleasure diet with mechanical soft texture and thin liquid.A review of the corresponding April 2026 Medication Administration Audit Report revealed that the formula feeding was administered late on the following dates and specific times:On 4/4/2026, the feeding formula due at 4 PM, was signed administered/ hung at 10:26 PM by RN #1. There was no documented reason why the TF was administered late.On 4/5/2026, the feeding formula due at 4 PM, was signed administered/ hung at 10:29 PM by RN #1. RN #1 documented in the progress notes that the resident refused the TF due to nausea and vomiting.On 4/6/2026, the feeding formula due at 4 PM, was signed (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered/ hung at 10:19 PM by RN #1. There was no documented reason why the TF was administered late.A review of the individualized comprehensive care plan initiated on 8/18/2025, included a focus for TF related to protein calorie malnutrition. One of the interventions included the following: Monitor/document/report to MD PRN (as needed): Aspiration- fever, SOB (shortness of breath), tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration.On 4/8/2026 at 11:15 AM, during an interview with the surveyor, Licensed Practical Nurse/ Unit Manager (LPN/ UM) stated that resident refusal for TF is documented in the nurses' notes. LPN/ UM also stated that physician orders should be administered an hour before and after. LPN/ UM stated that if the administration is habitually late, they would address the issue with the nurse and educate the nurse.On 4/8/2026 at 11:39 AM, during an interview with the surveyor, the Registered Dietician stated that the expectation for TF ordered to be given at 4 PM so it does not interfere with activities or care, plus or minus an hour. On 4/9/2026 at 9:46 AM, during an interview with the survey team, RN #1 stated that they should be documenting the progress notes when TF are administered late or when residents refuse their TF. RN #1 further stated that they do not always have the time to document.On 4/9/2026 at 12:31 PM, during an interview with the survey team, the Director of Nursing (DON) stated that if tube feedings are administered late, it should be documented in the patient's record and that it is generally put in the progress notes.A review of the facility policy revised in February 2026, titled Enteral Nutrition indicated the following under Purpose: To provide adequate nutritional support through enteral nutrition is provided to residents as ordered. N.J.A.C. 8:39 - 25.2 (c) 2; 27.1 (a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure that the medication error rates was not 5% or greater. This deficient practice was identified for 1 of 7 residents (Resident #80), observed during the Medication Administration task. The deficient practice was evidenced by the following:On 04/07/2026 at 10:05 AM on the B Unit, the surveyor observed Registered Nurse (RN) #1 prepare Resident #80's medications for administration. At that time, RN #1, removed one Metoprolol Tartrate 25mg tablet (used to treat high blood pressure), two Sacubitril-Valsartan 15-16 mg Sprinkle Capsules (used to treat heart failure), one furosemide 20mg tablet (used to help the body get rid of extra fluid), and one Apixaban 2.5mg tablet (used to thin the blood to prevent formation of blood clots) and place them in the medication cup. At that time, the surveyor observed the Electronic Medical Administration Record (EMAR) on the medication cart computer with RN #1. The EMAR revealed that the Metoprolol was scheduled to be given at 8:00 AM and the Entresto, Furosemide and Eliquis at 9:00 AM.On the same date at 10:32 AM the surveyor then observed RN #1 enter Resident #80's room and administered the medications. On the same date at 10:34 AM during an interview with the surveyor, RN # 1 acknowledged that the medication was administered late. During an interview with the surveyor on 04/09/2026 at 12:30 PM the Director of Nursing (DON) stated that medications should be given up to one hour before to 1 hour after their scheduled time. A review of the policy titled, Administering Medications, revised February 2026, revealed under Policy Interpretation and Implementation number 4., Medications are administered in accordance with prescriber orders, including any required time frame. The policy further revealed under number 7., Medications are administered within one hour of their prescribed time.N.J.A.C.8:39-29.2(d)

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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, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate use of Personal Protective Equipment (PPE) during care to residents who required a.) Enhanced Barrier Precautions (EBP) (an infection control strategy focused on reducing the spread of multidrug-resistant organisms [MDRO] in nursing homes) and b.) Contact Precautions (CP), to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was identified for 1of 2 residents (Resident #8) reviewed for Tube Feeding and 1 of 3 residents (Resident #7) reviewed for urinary catheter use.This deficient practice was evidenced by the following:Reference: Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.htmlReference: Providing hygiene refers to practices such as brushing teeth, combing hair, and shaving. Many of the high-contact resident care activities listed in the guidance are commonly bundled as part of morning and evening care for the resident rather than occurring as multiple isolated interactions with the resident throughout the day. Isolated combing of a resident's hair that is not otherwise bundled with other high-contact resident care activities would not generally necessitate use of a gown and gloves. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.htmlReference: Contact Precautions require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident. The resident is given dedicated equipment (e.g., stethoscope and blood pressure cuff) and is placed in a private room. When private rooms are not available, some residents (e.g., residents with the same pathogen) may be roomed together. Residents on Contact Precautions are recommended to be restricted to their rooms except for medically necessary care, including restriction from participation in group activities. Contact Precautions are generally intended to be time limited and, when implemented, should include a plan for discontinuation or de-escalation. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html1.) On 4/7/2026 at 8:55 AM, the surveyor observed an EBP signage on Resident #8's door. A PPE bin was located on the right side of the doorway. The surveyor observed Certified Nursing Assistant (CNA) shaving Resident #8 and wiping their face with a wet towel from the right side of the resident's bed. CNA was wearing gloves but was not wearing a gown. The surveyor observed CNA leaning against the mattress to reach the resident's right side of the face. CNA's scrub suit was observed touching the bed sheet on the mattress.On 4/7/2026 at 9:40 AM, CNA opened the door of Resident #8's room. The surveyor asked CNA what care they provided the resident. CNA stated that they washed the resident in bed and changed them. The surveyor pointed to the EBP signage on the door. CNA stated to the surveyor, I need to wear a gown.The surveyor reviewed the medical record for Resident #8.A review of the admission Record revealed Resident #8 was admitted to the facility with diagnoses which included but not limited to Extended Spectrum Beta- Lactamase (ESBL) Resistance, neuromuscular dysfunction of the bladder, and unspecified open wound of the penis.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 3/31/2026, indicated that Resident #8 had short-term memory problem and moderate impairment of cognitive skills. The MDS also indicated that the resident received nutrition through Tube Feeding (TF) (delivery of nutrition through a surgical opening directly into the stomach or intestines). The MDS specified that the resident had an indwelling urinary catheter.A review of the Order Summary Report (OSR) active as of 4/7/2026, included the following orders: Start and hang (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feeding at 4 PM, Jevity 1.5 (a tube feeding formula) at 80 milliliters per hour (ml/hr) until total volume of 1,000 ml is infused, one time a day for enteral nutrition support; Foley catheter change every shift; and Maintain Transmission Based Precautions - EBP due to G-tube (TF) and Foley catheter.A review of Resident #8's comprehensive care plan initiated on 1/21/2026, indicated a focus for Foley catheter requirement due to neurogenic bladder (nerve damage that prevents the bladder from properly storing or emptying urine). The interventions included EBP. Another focus was for potential for complication related to enteral feeding (TF) and hydration. One of the interventions included EBP.2.) On 4/8/2026 at 11:54 AM, the surveyor observed the signage outside Resident #7's door that indicated the resident was on Contact Precautions. Outside the door was a PPE bin. The surveyor and the Registered Dietician performed hand hygiene and donned disposable yellow gown, gloves, and surgical masks and entered the resident's room to look at the resident's feeding tube pump. While inside the room, the surveyor observed Phlebotomist wheeling their rolling container inside the room. The phlebotomist wore gloves with no gown and mask and proceeded to put a blue tourniquet around the resident's right upper arm to draw blood. The surveyor called the attention of the phlebotomist and pointed the signage on the door. Phlebotomist said that they did not see the signage.The surveyor reviewed the medical record for Resident #7.A review of the admission Record revealed Resident #7 was admitted to the facility with diagnoses which included but not limited to Methicillin-resistant Staphylococcus aureus (MRSA) (a bacteria resistant to several antibiotics) infection, gastrostomy status (presence of surgical opening in the stomach for delivery of nutrition), and sepsis due to MRSA. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 3/17/2026, indicated that Resident #7 had long-term and short-term memory problems and moderate impairment of cognitive skills. The MDS also indicated that the resident received nutrition through Tube Feeding (TF). The MDS specified that the resident had an indwelling urinary catheter, 1 stage 3 pressure ulcer wound, and a central intravenous (IV) line.A review of the Order Summary Report (OSR) active as of 4/7/2026, included the following orders: Contact precautions related to MRSA of the blood.A review of Resident #7's comprehensive care plan initiated on 1/5/2026, indicated a focus for actual skin breakdown in the sacrum, enteral feeding, and Foley catheter use with interventions that included EBP.On 4/9/2026 at 8:58 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated that employees and visitors are alerted to any precautions by signages at the door and PPE at the doorway.On 4/9/2026 at 12:31 PM, during an interview with the survey team, the Director of Nursing (DON) stated that vendors are asked by staff to follow signages for transmission-based precautions.A review of facility policy updated in February 2026, titled Enhanced Barrier Precautions under Policy Interpretation and Implementation included the following: 3.) Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .d.) providing hygiene. N.J.A.C. 8:39 - 19.4 (a)