STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at Manalapan	104 Pension Road Manalapan, NJ 07726

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #401653, #401655Based on observation, interview and record review, it was determined that the facility failed to ensure medications were administered in accordance with professional standards of nursing practice. This deficient practice was identified for 3 of 7 residents reviewed for medication management, (Resident #9, #120 & #57), and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.1.On 8/7/2025 at 11:00 AM, during a resident council meeting which included Resident #9 and two surveyors, Resident #9 stated they had not received their pain patch or pain gel that morning. The surveyor reviewed the electronic medical record (EMR) for Resident #9. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; general anxiety disorder, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life), schizoaffective disorder, bipolar type (characterized by the presence of mood episodes, including mania or mixed mania and depression, along with psychotic symptoms such as delusions or hallucinations), pain in left knee and low pack pain unspecified. A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/9/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 14 out of 15, indicating the resident was cognitively intact. Further review reviewed the resident received a scheduled pain medication regiment. (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the individual comprehensive care plan (ICCP) revealed a Focus: has (acute/chronic) pain r/t (related to) RHEUMATOID ARTHRITIS; Unspecified osteoarthritis, unspecified site…Date Initiated: 11/2/2023 and included Interventions: Administer analgesia as per orders . Date Initiated: 11/02/2023 Revision on: 1/26/2024 and anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Date Initiated: 11/2/2023. A review of the Order Summary Report (OSR) revealed physician orders (PO) for the following: - Voltaren External Gel 1 % (Diclofenac Sodium (Topical)) Apply to left knee topically one time a day for pain Apply 4grams to left knee one time a day, Dated 10/23/24. -Lidocan External Patch (Lidocaine) Apply to Lower Back topically one time a day for Lower Back Pain 4% Lidocaine Patch and remove per schedule; Dated 2/27/25. A review of the August 2025 electronic Medication Administration Record (eMAR) revealed the above POs for the Voltaren External Gel had been signed as administered as ordered on 8/7/25 at 0900 (9:00 AM), site: Lknee (left knee) and the Lidocan External patch had been signed as applied as ordered on 8/7/25 at 0900 by Licensed Practical Nurse (LPN) #1. On 8/7/2025 at 1:55 PM, the surveyor interviewed LPN #1, who stated that she had given Resident #9 all their medications that morning. The surveyor asked if the resident received anything for pain, any gels or patches? LPN #1 responded “Yes, I didn’t put them on yet. I am getting to my treatments now. ” She stated the medications were in the treatment cart not the medication cart. LPN #1 reviewed the EMR in the presence of the surveyor and stated all the medications in green meant that they were given. She verified the orders for the Lidocan patch and the Voltaren gel were green, but stated they were not given. The surveyor asked if the physician was informed that the medications were not given, and she stated “I haven’t gotten to it yet. It’s not an important medication so I don’t think anything should be done.” On 08/7/2025 at 2:01 PM, the surveyor interviewed LPN/Unit Manger (LPN/UM) #1, who stated her expectation for a 9 AM medication was the medication could be given an hour before or after the time and if it was within the parameters, it should be given. She stated if a medication was not in the cart, then the nurse should check the backup medications. She verified the Lidocaine patch 4 percent and the Voltaren gel was available in the back up. LPN/UM #1 stated, “I know 100 percent both are in stock in the back up.” She stated if the nurse signed the eMAR for the medication, it meant it was given. The surveyor made LPN/UM#1 aware LPN #1 said she didn’t give the medications, but she signed she did. LPN/UM #1 stated, “It is a medication error and the nurse should be written up for it and a medication error sheet should be done.” On 8/7/2025 at 2:11 PM, LPN #1 informed the surveyor, in the presence of LPN/UM#1, that she had retrieved the medications and reported to the physician that the medications were not given this morning. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/25 at 2:50 PM, the surveyor interviewed the Director of Nursing (DON), who stated 9 AM medications can be given up to an hour before or up to an hour after. She stated if they (medications) are not given within the time period, then the physician should be called. She further stated if medications were not in the medication cart, the nurse should check the back up system and contact pharmacy. She confirmed if a medication was in green it meant the medication was given at the correct time and that medication should not be signed as given if it was not given. On 8/12/2025 at 2:48 PM, the surveyor, in the presence of the survey team, made the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Nursing (VPN), the DON, and the [NAME] President of Operations aware of the above concerns. 2. The surveyor reviewed the electronic closed medical record for Resident #120. A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to, Rheumatoid Arthritis (RA) (chronic inflammatory disorder affecting the joints). A review of the resident's electronic medication administration record (EMAR) for November revealed on 11/12/25 a physician’s order dated 11/12/25 for “Voltaren External Gel 1 % (Diclofenac Sodium (Topical) Apply to knees, hands, shoulder topically every shift for arthritis pain apply 4 grams. ” The “Night” dose was not administered and was indicated by LPN #2 with the number “5” which corresponded to “Hold/see progress notes.” A review of the resident’s electronic progress notes (EPN) revealed there was no corresponding progress note to correlate with the number “5” for Voltaren gel not being administered on 11/12/25 at night. Further review of the EPN revealed on 11/13/25 at 6:24 AM there was a nursing note from the LPN #2 “Resident alert and oriented. At 5:45 am resident complain [redacted] did not get [redacted] last night medicine writer explain to [redacted] that [redacted] only medication [redacted] take at this time is for GERD (gastroesophageal reflux disease-irritation caused by stomach contents flowing back up into the esophagus), resident get upset saying [redacted] did not get [redacted] evening medication and night medication steroid….” Further review of the EMAR revealed a PO dated 11/13/24 for “Methylprednisolone oral 4 MG (Methylprednisolone) Give 2 tablet by mouth at bedtime for arthritic pain.” There was no time of administration indicated on the EMAR for the evening of 11/12/24. According to an After Visit Summary from an emergency room hospital visit dated 11/11/24, the resident had instructions to start 11/12/24 Methylprednisolone 4 MG tablet, commonly known as Medrol Dosepak, take as directed on package. Indications: pain with history of RA, start tomorrow 11/12/24. On 8/7/25 at 10:00 AM, the surveyor requested from the DON any investigations regarding Resident #120. On 8/12/2025 at 9:20 AM, the surveyor attempted to interview LPN #2 via the telephone and left a voicemail. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/2025 at 9:55 AM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who stated that she had been the CP for approximately a year. The CP stated that if a medication was not available the nurses should check the backup supply, call the pharmacy provider and call the physician for follow up. The CP added that the nurses cannot just document that the medication was not available. On 8/12/25 at 11:00 AM, the surveyor interviewed LNHA regarding Resident #120. The LNHA was unable to speak to any concerns or investigations regarding Resident #120. On 8/12/2025 at 1:24 PM, the surveyor interviewed the DON, who stated for a new admission there was a backup supply for some medications and there was also the possibility to call an emergency pharmacy if the provider pharmacy could not deliver a medication right away and the provider pharmacy also made multiple deliveries at different times of the day. In addition, the DON stated that medications if brought from home in a prescription vial or properly labelled were verified then the facility would be able to use the medications brought from home. The DON was unable to speak to Resident #120 not receiving their medications on the night of 11/12/24 because she was not the DON at that time. In addition, the DON was unsure if LPN #2 was still employed. On 8/12/25 at 2:48 PM, the survey team met with the LNHA, DON, VPN and [NAME] President of Operations. The DON stated she would expect to see in the progress notes why medications were not administered and any follow up from a physician. The VPN provided a timeline for Resident #120 which indicated Resident #120 was admitted at the end of the day shift on 11/12/25 and “Medications finished around 6:00 pm.” There was no explanation for the evening dose of Voltaren gel not being administered or the PO for Methylprednisolone not being administered the evening of 11/12/25. There was no further documentation provided for Resident #120. 3. On 8/6/25 at 11:30 AM, the surveyor observed Resident #57 in their room with a staff member cleaning out the resident’s personal refrigerator. The surveyor was unable to interview the resident. The surveyor reviewed the electronic medical record for Resident #57. A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to, dementia, major depressive disorder, recurrent, in partial remission and gastro-esophageal reflux disease without esophagitis (stomach acid irritates the lining). A review of the most recent comprehensive quarterly MDS, dated [DATE], reflected the resident had a BIMS score of 14 out of 15, indicating that the resident had an intact cognition. A review of the resident's EMAR for August 2025 revealed the following: 1. A PO with a start date of 7/28/25 for “Cefuroxime Axetil Oral Tablet 250 MG (Cefuroxime Axetil) Give 1 tablet by mouth two times a day for UTI (urinary tract infection) for 6 days 2 tabs=500 MG. Notify MD (physician) of signs and symptoms adverse reaction.” On 8/1/25 at the time of administration for 1700 (5 PM) indicated the number 9 by LPN #3 which corresponded to “other/see nursing progress notes. ” (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A PO with a start date of 7/29/25 for “Escitalopram Oxalate Oral Tablet 5 milligrams (MG) (Escitalopram Oxalate) Give 1 tablet by mouth one time a day for Depression 1 tab=5 MG.” The time of administration was 9:30 AM and on 8/12/25 the medication was not signed as administered and there was the number 9 noted by LPN #4 which corresponded to “other/see progress notes.” 3. A PO with a start date of 7/29/25 for “Pantoprazole Sodium Oral Tablet Delayed release 40 MG (Pantoprazole Sodium) Give 1 tablet by mouth one time a day for GERD 1 tab=40 MG, Do not crush.” The time of administration was 9:00 AM and on 8/12/25 the medication was not signed as administered and there was the number 9 noted by LPN #3 which corresponded to “other/see progress notes.” A review of the electronic progress notes (EPN) for Resident #55 revealed the following eMAR administration notes: 1. On 8/1/25 at 18:29 (6:29 PM) the LPN #3 documented “awaiting delivery” for the Cefuroxime 500 MG dose. 2. On 8/12/25 at 9:02 AM the LPN #4 documented “awaiting delivery” for the Escitalopram 5 MG dose. 3. On 8/12/25 at 9:03 AM the LPN #4 documented “awaiting delivery” for the Pantoprazole 40 MG dose. There were no progress notes regarding the physician being notified. On 8/13/2025 at 11:02 AM, the surveyor interviewed LPN #5 who stated that she was the nurse administering medications to Resident #55 that day but was not here yesterday. LPN #5, in the presence of the surveyor, reviewed the medication cart and removed Escitalopram 5 MG and Pantoprazole 40 MG labelled for Resident #55. LPN #5 stated they were in the bottom drawer of the medication cart. LPN #5 added that sometimes agency nurses do not look for the medications. On 8/13/2025 at 11:25 AM, the surveyor interviewed Resident #55 in their room. The resident stated that the nurses brought their medications and had no concerns. The resident added that they had a lot of medications and was unable to speak to which medications or what times the nurses gave them their medications. On 8/13/2025 at 11:50 AM, the surveyor interviewed the DON, who stated that she would have to educate the nurses who indicated “awaiting delivery” for Resident #55’s medications. The DON stated that Cefuroxime, Escitalopram and Pantoprazole were medications stocked in the back up supply and should have been administered. The DON added that she would expect the nurses to notify a supervisor if a medication was not available and there would be follow up such as getting the medication from the backup system, calling the provider pharmacy, or emergency pharmacy. The DON stated that the goal was to get the medication and administer it and if that was not possible then the physician needed to be notified for follow up. A review of the electronic medication back up supply list reflected that Cefuroxime 250 MG tablets, Escitalopram 10 MG tablets and Pantoprazole 20 MG tablets were available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy dated as revised April 2019 for “Administering Medications” provided by the DON reflected “Medications are administered in a safe and timely manner, and as prescribed.” In addition, the policy interpretation and implementation included but not limited to; “4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).” NJAC 8:39-11.2(b), 29.2(a)(d)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** NJ401652Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to effectively accommodate the needs and preferences of residents during dining. This deficient practice was identified for 1 of 10 residents (Resident #43) reviewed for tray accuracy during dining and was evidenced by the following: On 8/6/25 at 10:34 AM, the surveyor observed Resident #43 lying in bed asleep, with the head of the bed elevated, on an air mattress. The resident did not respond when the surveyor knocked on the door or in response to verbal stimuli. The surveyor observed a sign that hung over the resident's bed which indicated, No Straws and Thickened liquids, do not leave thickener packets with the resident. The surveyor reviewed the medical record for Resident #43. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool dated 5/23/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS indicated that the resident required a mechanically altered diet (e.g., pureed food, thickened liquids), and a therapeutic diet (e.g., low salt, diabetic, low cholesterol) and had no identified weight loss or weight gain. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 6/30/25, that the resident had a swallowing problem r/t (related to) oral dysphagia (difficulty swallowing); I am on Nectar thick liquids. Interventions included: Instruct me to eat in an upright position, to eat slowly, to chew each bite thoroughly, refer for Swallowing Evaluation as needed.A review of the Order Summary Report (OSR), dated as of 3/26/25, including the following Physician's Order (PO):A PO, dated 3/26/25, for a No Concentrated Sweets (NCS) diet Ground texture, Nectar consistency.A review of a Speech Therapy Discharge summary dated [DATE], included: Skill: Interventions Provided: .instruction in no straw precautions.On 8/6/25 at 12:50 PM, the surveyor observed Resident #43 seated in a wheelchair eating independently accompanied by another resident. The surveyor reviewed the resident's meal ticket which indicated, NCS-Ground, Nectar Thick Liquids. Further review of the meal ticket specified, NO STRAW at the bottom of the resident's meal ticket. A straw that was sealed in paper was placed to the left of the resident's meal tray. At that time, Registered Nurse (RN) #1 presented to the resident's table. When the surveyor asked RN #1 why the resident was provided with a drinking straw when the meal ticket specified otherwise RN #1 stated, But, it was not opened. RN #1 further stated that the resident needed to be assisted with meal set up but could feed themselves independently. On 8/7/25 at 11:28 AM, the surveyor interviewed RN #1, who stated that the aides were informed of the resident's care needs and there were signs on the resident's wall in their room which indicated thick liquids, no straw. RN #1 stated that the resident could aspirate (food or fluids get into the airway), so a straw should not have been given to the resident if it specified no straw on the resident's meal ticket. On 8/7/25 at 11:54 AM, the surveyor observed Resident #43 seated in a wheelchair in the main dining room with a drinking straw on his/her place mat. On 8/7/25 at 11:57 AM, the Infection Preventionist (IP) walked over to Resident #43's table and removed the straw from the resident's place mat. When interviewed at that time, the IP stated that he removed the straw from the resident because the resident was on a list of residents who received thickened liquids. On 8/7/25 at 12:00 PM, the surveyor interviewed Activity Aide (AA) #1, who stated that the dietary department put the place mat, napkin and straw on each table. On 8/7/25 at 12:03 PM, the surveyor interviewed the Registered Dietician (RD), who stated that the meal ticket specified no straw if the resident were ordered thickened liquids. The RD further stated that the aide, or the nurse could identify if the ticket specified no straw upon review for tray accuracy and remove it at that time if indicated. On 8/7/25 at 12:08 PM, the surveyor interviewed the Food Service Director (FSD), who stated that the staff usually fed the resident, and the nurse should have noticed the straw at that time. The FSD stated that the resident should not have been provided with a drinking straw because the resident was ordered thickened liquids. The RD who was present at that time, stated that the reason that the resident was not permitted to have a straw had something to do with their swallowing, but she did not know the correct answer. On 8/7/25 at 1:41 PM, the surveyor informed the Director of Nursing (DON) of the concerns with Resident #43 who received a drinking straw on their tray during the lunch meal service on 8/6/25 and 8/7/25, despite the meal ticket indicating No Straw.A review of the facility's undated Tray Accuracy included: Routine

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJ401661, NJ401667, NJ401652Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to follow appropriate infection control procedures during the provision of incontinence care for a resident who was previously identified to have been at risk for recurrent urinary tract infection.This deficient practice was identified for 1 of 1 resident (Resident #43) reviewed for bladder and bowel incontinence and was identified by the following: On 8/6/25 at 10:34 AM, the surveyor observed Resident #43 lying in bed asleep, with the head of the bed elevated, on an air mattress. The resident did not respond when the surveyor knocked on the door or in response to verbal stimuli.The surveyor reviewed the medical record for Resident #43. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to: urinary tract infection, site not specified, overactive bladder, other specified noninfective gastroenteritis and colitis (conditions that affect the gastrointestinal tract). A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 5/23/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS revealed that the resident was frequently incontinent of urine and was always incontinent of bowel. On 8/6/25 at 10:42 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated that she was assigned to eleven residents today and she had not yet provided any care to Resident #43 yet because she planned to give the resident a shower today and the resident required assistance from two staff members to get out of the bed. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, with a revision date of 7/18/25, that the resident had bowel incontinence related to dementia. Interventions included: Check resident every two hours and assist with toileting as needed and provide peri care after each incontinent episode. Further review of the ICCP included a focus area, with a revision dated of 7/18/25, that the resident was at risk for chronic urinary tract infection related to incontinence. Interventions included: Resolved: Check at least every 2 (two) hours for incontinence. Wash, rinse and dry soiled areas (resolved date 3/19/25), and encourage adequate fluid intake, and monitor/document/report to MD (medical doctor) PRN (as needed) for s/sx (signs and symptoms) of UTI: Frequency, urgency, malaise (a general feeling of discomfort), foul smelling urine, dysuria (painful or difficult urination), fever, nausea and vomiting, flank (side) pain, supra-pubic (lower part of the abdomen above the genitals) pain, hematuria (presence of blood in urine), cloudy urine, altered mental status, loss of appetite, behavioral changes (date initiated 6/30/25). A review of the Order Summary Report, included the following physician order (PO):A PO dated, 7/24/25, for Macrobid oral capsule 100 MG (milligrams) (Nitrofurantoin Monohyd Macro) Give 1 (one) capsule by mouth two times a day for UTI for 10 (ten) days.A review of an Incident Note dated 7/24/25 at 11:07 PM, indicated that the resident was on Macrobid Oral Capsule 100 MG for UTI for 10 days. No c/o (complaint of) pain or discomfort noted during the shift. PO (oral) fluids encouraged.Safety precautions in place. On 8/6/25 at 11:07 AM, the surveyor observed CNA #1 and CNA #2 as they prepared to assist Resident #43 with incontinence care. CNA #1 stated that she did not know when the resident's brief was changed last. CNA #1 then stated that CNA #2 went to get supplies to change the resident. At that time, CNA #2 returned to the room without any supplies to change the resident. The resident wore a green brief that was opened by CNA #2, who then assisted the resident to turn towards the right side of the bed towards CNA #1. The resident had a small amount of urine and liquid stool in their brief. CNA #2 stated that the stool looked fresh. CNA #2 then proceeded to use the brief to cleanse both the stool and urine from the resident's skin. When the surveyor asked if it were permissible to use the brief to clean the resident with the soiled brief instead of a washcloth CNA #1 stated that it was okay since the resident was going to get a shower anyway. CNA #2 then continued to clean the resident with the soiled brief and prepared the resident to shower. On 8/7/25 at 10:30 AM, the surveyor interviewed CNA #3 who stated that Resident #43 was changed today at 9:30 AM and was not saturated with urine. CNA #3 stated that he obtained all supplies needed before he rendered care to the resident. CNA #3 stated that the facility offered both disposable and washable wash cloths for incontinence care. CNA #3 stated that two wash cloths were needed for incontinence care for a female, and it was important to clean from front to back so that it would not get contaminated. CNA #3 stated that if we used a soiled brief to wipe a resident it was not appropriate for infection control purposes because the resident could get an infection. On 8/7/25 at 11:19 AM, the surveyor interviewed CNA #2 who stated that she used the resident's soiled brief to clean Resident #43's urine and stool because it was there, and CNA