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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **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 a refrigerated controlled medication (Lorazepam oral concentrate solution) was removed from active inventory when the controlled medication was discontinued on [DATE] and when six (6) of the 15 Lorazepam oral syringes were expired on [DATE]. The deficient practice was identified when one (1) of two (2) medication room refrigerators were inspected and evidenced by the following: On [DATE] at 1:37 PM, the surveyor inspected the 200 Unit medication room refrigerator in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM). The surveyor observed six (6) of 15 oral syringes of Lorazepam oral concentrate 0.5 milligram per 0.25 milliliters labelled for Resident #30 with a use by date of [DATE]. LPN/UM stated the six (6) Lorazepam oral syringes with the use by date of [DATE] should have been removed from the refrigerator. The LPN/UM added that she would have to bring the Lorazepam oral syringes to the Director of Nursing (DON) for destruction. The surveyor then reviewed the corresponding Controlled Drug Administration Record provided by the LPN/UM which reflected 15 oral syringes of Lorazepam 0.5 MG/0.25 ML were received on [DATE]. The surveyor reviewed the medical record for Resident #30.A review of the current physician's orders (PO) for Resident #30 which reflected there was no PO for Lorazepam.A review of the August electronic medication administration record (EMAR) revealed that there was no PO for Lorazepam.On [DATE] at 9:15 AM, the surveyor interviewed the DON, who stated Resident #30 was on hospice and thought there would be a PO for the Lorazepam and it would have been indicated on the EMAR. The DON added that she would have to check.On [DATE] at 11:50 PM, the DON provided the surveyor with the May and [DATE] EMARs, which revealed Resident #30 had a PO for Lorazepam with a start date of [DATE] for 14 days. The DON stated that the Lorazepam had not been used and should have been removed from the refrigerator when the PO was discontinued. The DON stated she would look for the discontinued date for the Lorazepam.On [DATE] at 12:20 PM, the DON provided the surveyor with a PO for the Lorazepam with a start date of [DATE] and an end date of [DATE].A review of the facility policy Storage of Medications dated as revised [DATE] provided by the DON reflected Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. NJAC 8:39-29.4(g)(h)(k)

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interviews and review of pertinent facility documents, it was determined that the facility failed to ensure the facility-wide assessment (used to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies) was updated to address the care and needs of a resident with a LVAD (a left Ventricular Assist Device-a mechanical pump that helps a weakened heart pump blood).On 8/7/2025 at 11:00 AM, during a resident council meeting, which included unsampled Resident #67 and two surveyors, Resident #67 stated they had a LVAD. The surveyor reviewed the electronic Medical Record for unsampled Resident #67. A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; end stage heart failure (the heart can no longer pump enough blood to meet the body's needs) and presence of a heart assist device. A review of the Order Summary Report revealed a physician order for Monitor pump parameters q-shift.LVAD team.start date 2/14/2024. The surveyor reviewed the facility provided facility assessment (FA), date of assessment or update of 9/5/24. The review did not reveal an LVAD was included in the care or services provided. On 8/7/2025 at 1:12 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), reviewed and verified the above-mentioned FA was the most recent and up to date. He stated the FA was updated at least yearly or if there was a change. On 8/13/2025 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON), who stated the FA was a break down of the history of what residents need in the building. She reviewed the above-mentioned FA in the presence of the surveyor and verified it did not include the care of a resident with an LVAD. She stated, I know we can take them (resident with an LVAD) but was unable to show the surveyor in the FA or how she knew that. At that time, the DON called the [NAME] President of Nursing (VPN) on speaker phone and questioned the VPN on the FA. The VPN stated we (the LNHA and VPN) would go to the office right now and review it. The surveyor observed the LNHA, and the VPN enter the LNHA's office and sit at the computer. The surveyor entered the office and asked if LVAD care was included in the FA. The LNHA stated he would print a new one (FA) right now. The surveyor declined a new one to be printed and asked if the care of a resident with an LVAD should be in the facility assessment, the VPN shook her head yes and stated, it should be included in the facility assessment.A review of the facility's policy Facility Assessment revised 10/2018, revealed Policy Statement: A Facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment. Policy Interpretation and Implementation:3. The facility assessment includes a detailed review of the resident population. This part of the assessment includes; a. resident census data from the previous 12 months. c. factors that affect the overall acuity of the residents.5. Conditions or diseases that require specialized care (eg., dialysis, ventilators, wound care). N.J.A.C. 8:39-5.1(a), 27.1(a)(b)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain medical records that were accurate and easily accessible for 1 of 30 residents reviewed (Resident #116). This deficient practice was evidenced by the following:On 8/12/2025 at 8:41 AM, the surveyor reviewed the closed electronic medical record for Resident #116. A review of Resident #116's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to chronic obstructive pulmonary disease (COPD, a lung disease characterized by ongoing inflammation and narrowing of the airways, leading to difficulty breathing), hypertensive heart disease (heart conditions caused by long-term high blood pressure), and benign prostatic hyperplasia (BPH, enlarged prostate, is a common condition in older men where the prostate gland enlarges, potentially causing urinary problems). A review of Resident #116's progress notes and miscellaneous section of uploaded documents did not reveal any documented attending physician progress notes. The surveyor requested from the Director of Nursing (DON) the paper medical record. A review of Resident #116's additional hybrid (paper and electronic) medical record that was provided by the facility did not reveal any documented attending physician progress notes for the residents stay from 9/30/24 until 7/4/25. On 8/12/2025 at 11:08 AM, the surveyor interviewed the DON regarding physician visits. The DON stated that the expectation was that the primary physician visited monthly but that a Nurse Practitioner could visit alternate months. The surveyor asked the DON where the physician documented their visits. The DON stated that the expectation was for the physician to document the notes in the electronic record but that they could be in the paper chart. The surveyor asked the DON to review Resident #116's paper and electronic record that was provided to the surveyor. The DON confirmed that there were no attending physician visit notes documented in Resident #116's hybrid medical record. The DON stated that she was going to reach out to the attending physician. The surveyor asked the DON if the attending physician's visit should be part of the resident's medical record. The DON stated that they should be part of the medical record. The DON confirmed that she was contacting the attending physician after surveyor inquiry. On 8/12/2025 at 2:57 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON, the [NAME] President of Nursing (VPoN) and the [NAME] President of Operations (VPoO) of the concern that Resident #116 did not have any documented attending physician visits in the hybrid medical record. On 8/13/2025 at 8:00 AM, the VPoN provided a copy of multiple visits that were performed by the attending physician during Resident #116's stay at the facility. A review of the documents revealed a printed date of 8/12/25 5:30 PM. On 8/13/2025 at 1:04 PM, the DON stated that the VPoN received the attending physician visit notes from the attending physician after surveyor inquiry and that the notes should have been in the medical record.The LNHA did not provide any additional information.A review of the facility provided policy titled Physician Services with a revised date of February 2021, included the following:Policy Statement The medical care of each resident is supervised by a licensed physician.Policy Interpretation and Implementation6. Physician orders and progress notes are maintained in accordance with current OBRA regulations and facility policy. 7. Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy. A review of the facility provided policy titled Electronic Medical Records with a revised date of March 2014, included the following:Policy Statement Electronic medical records may be used in lieu of paper records when approved by the administrator.N.J.A.C. 8:39-35.2

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the admission Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 2 residents (Resident #18) reviewed for timing of assessments and was evidenced by the following: This deficient practice was evidenced by the following: On 8/8/25, a review of the electronic health record (EHR) revealed that Resident #18 was admitted to the facility on [DATE]. The Comprehensive admission MDS, with an assessment reference date (ARD) of 2/27/25, was noted to be signed as completed on 3/18/25. On 8/8/25, the surveyor interviewed the MDS Coordinator who stated this admission MDS should have been completed by March 6th (3/6/25). She further stated that she did not have an explanation as to what happened.Review of facility policy MDS Completion and Submission Timeframes, revised July 2017 included:Policy StatementOur facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.Policy Interpretation and Implementation2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.Review of facility policy, Resident Assessments, revised March 2022, included:1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements:a. OBRA required assessments - conducted for all residents in the facility:1. admission Assessment (Comprehensive)2. Quarterly Assessment3. Annual Assessment (Comprehensive)2. The RAI User's Manual (Chapter 2) provides detailed information on timing and submission of assessments.According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2024, page 2-17, the Comprehensive admission assessment must be completed no later than admission date + 13 calendar days. NJAC 8:39-11.2 (e)

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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, review of medical records, other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 2 of 27 residents reviewed (Resident #10 and Resident #13). This deficient practice was evidenced by the following:1.On 8/6/25 at 11:54 AM, Resident #10 refused to speak with the surveyor. The resident refused to speak with the surveyor for the duration of the survey. On 8/12/25 at 10:59 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #1, who stated that Resident #10 had specific CNAs that they want and only allowed them to provide care and would shout, yell, curse, and refuse everything for others. The surveyor reviewed the Comprehensive admission MDS dated [DATE], which indicated that Resident #10 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident had an intact cognition, no behaviors or rejection of care were noted, and diagnoses included diabetes (high blood sugar), anxiety, and post-traumatic stress disorder. A review of the electronic health record (EHR) revealed a progress note dated 5/26/25, which indicated Resident #10 refused morning medications, a progress note dated 5/27/25, which indicated weekly weight was refused, and a progress note dated 5/28/25, which indicated a physician/provider visit and all medications were refused.On 8/12/25 at 11:19 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who stated that Resident #10 did refuse care and yelled at the staff. 08/12/2025 at 3:03 PM, the surveyor interviewed the (MDSC) via phone, who she stated that the Social Worker would have completed the MDS section regarding the refusals and behaviors of Resident #10 and that the MDS should reflect what was documented in the nursing notes. She further stated that the Social Worker in question was no longer at the facility. On 8/13/2025 at 12:04 PM, the surveyor interviewed the Regional MDSC, who stated that Section E of the MDS was completed by the Social Worker who was no longer at the facility. She acknowledged that there was documentation of the resident's behaviors and refusals and stated that the Social Worker did not capture the behaviors and miscoded the MDS for Resident #10. 2.On 8/6/2025 at 11:41 AM, the surveyor observed Resident #13 in their room, in bed and dressed. The resident stated their hearing aids broke but was unsure if they told anyone. The surveyor observed Resident #13 trying to put a hearing aid in their ear and showed the surveyor the battery came out.On 8/7/25 at 11:12 AM, the surveyor reviewed the Comprehensive admission MDS dated [DATE], which indicated adequate hearing, no hearing aid, a BIMS score 15 out of 15 which indicated the resident had an intact cognition and diagnoses including schizophrenia (a mental disorder that affects how people think, feel, and behave). The quarterly MDS dated [DATE], indicated moderate difficulty with hearing, no hearing aid, and a BIMS score 15 out of 15. A review of the EHR revealed the Accela Quarterly, Annual, or Significant change 7-IDT-V2 dated 1/12/24, 4/14/24, 7/14/24, 1/14/25, 4/12/25, and 7/9/25 all indicated hearing aids were in use.A review of the individual comprehensive care plan (ICCP) included a focus area initiated 2/29/24, that the resident had a communication problem related to hearing difficulty. Interventions included hearing aids that are kept at the bedside and cared for by the resident.On 8/7/25 at 12:15 PM, the surveyor interviewed the RN/UM who stated that Resident #13 was admitted with hearing aids, but these hearing aides were relatively new and that she called the vendor to come and repair the hearing aid of which the battery compartment was in disrepair. On 8/08/2025 at 11:13 AM, the surveyor interviewed the MDS Coordinator (MDSC) who stated she was unaware the resident had hearing aids. She acknowledged the care plan for them and stated she would do a modification of the MDS.Review of facility policy Electronic Transmission of the MDS, revised November 2019 included:Policy StatementAll MDS assessments (e.g., admission, annual, significant change, quarterly review, etc) and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	system in accordance with current OBRA regulations governing the transmission of MDS data. N.J.A.C 8:39-11.1

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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. **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. 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. (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 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. 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 % (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(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. 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 (continued on next page)

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Excel Care at Manalapan	104 Pension Road Manalapan, NJ 07726

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.” 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. (continued on next page)

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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 observations, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation performed on 8/7/25, the surveyor observed two (2) nurses administer medications to five (5) residents. There were 35 opportunities, and three (3) errors were observed which calculated to a medication administration error rate of 8.57 %. The deficient practice was identified for two (2) of five (5) residents, (Resident #30 and #55), that were administered medications by two (2) of two (2) nurses. The deficient practices were evidenced as follows: 1.On 8/7/25 at 8:24 AM, the surveyor observed the Registered Nurse (RN) #1 administer four (4) medications to Resident #30. The resident then stated that they wanted their cough medicine.On 8/7/25 at 8:29 AM, the surveyor observed RN #1 measure 10 milliliters (ML) of Gertussin DM (Guaifenesin Dextromethorphan) liquid. RN #1 stated Guaifenesin DM was an over-the-counter/house stock (OTC/HS) medication meaning that the facility was responsible for providing those medications to any resident with a physician's order (PO). RN #1 added the resident had an as needed (PRN) PO for the cough medicine. At that time, the surveyor with RN #1 reviewed the electronic medication administration record (EMAR) which revealed a PO for Guaifenesin liquid 100 milligrams (MG)/5 milliliters (ML), Give 10 ML by mouth every 6 hours PRN for cough. RN #1 stated that the Gertussin DM was the cough medicine that was ordered.The surveyor reviewed the electronic medical record for Resident #30.A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to, Huntington's Disease (a hereditary disorder which damages brain cells).A review of the resident's Order Summary Report (OSR) reflected a corresponding PO with a start date of 7/26/25 for Guaifenesin liquid 100 milligrams (MG)/5 milliliters (ML), Give 10 ML by mouth every 6 hours PRN for cough.On 8/7/25 at 12:29 PM, the surveyor interviewed RN #1, who stated that she only had the Gertussin DM in the medication cart as the OTC/HS cough medicine. RN #1 added that OTC/HS medications were ordered by the central supply person.At that time, the surveyor, with RN #1 reviewed the EMAR and PO which indicated Guaifenisen liquid in addition to the bottle of Gertussin DM. RN #1 acknowledged that the OTC/HS had the ingredients of Guaifenesin and DM. RN #1 stated the Gertussin DM was the only OTC/HS cough medicine that she had and thought that was the correct medication. RN #1 then stated that since the PO had not indicated DM she would have to call the physician and have the PO changed. (ERROR #1)On 8/7/25 at 12:38 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the PO must match the medication being administered. The DON added the Staffing Coordinator was in charge of the central supply and ordering of the OTC/HS medications. The DON also stated the facility had a list of OTC/HS and could order and provide OTC medications to the residents. In addition, the DON stated there were no substitutes and the physician would have to be called for an order.On 8/7/25 at 12:43 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated she had the responsibility of ordering the OTC/HS medications for the facility. The SC added that she ordered according to a list that she was provided by the facility on a weekly or monthly basis to keep an inventory. The SC added if there was a need for an OTC/HS that was not on the list then she would have to order it when it was needed. The surveyor, with the SC, reviewed the OTC/HS medications stored in the central supply room and the SC stated that the only cough medicine that was available at that moment was Gertussin DM. The SC also stated that she used three different vendors depending on who had the OTC/HS that was needed. The SC added that she would have to be told to order an OTC/HS that was not on the list and could not speak to whether Guaifenesin without the DM was ordered. The surveyor was provided an OTC/DNS List by the Director of Nursing and Guaifenesin Solution 100 MG/5 ML was on the list.A review of a Medication Pass Observation (med pass) form for RN #1 dated 6/23/25, completed by the Consultant Pharmacist (CP) revealed that an observation was completed by the CP and that RN #1 had a 4% error rate.On 8/12/25 at 12:32 PM, the surveyor interviewed the CP via (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	telephone who stated she has been the CP for approximately a year and could not speak to the OTC/HS medications the facility purchased. The CP added she had done individual nurse med pass observations but had not done an inservice for all nurses recently. The CP also stated she reviewed the Med Pass Observation form with the nurse after the observation and would do a 1:1 inservice on any errors or findings and would also review the entire form to cover any areas that were not observed. The CP added that she would give a Medication Pass handout to the nurse. The CP also stated the PO for the OTC/HS had to match the drug, dose, formulation before administering. The CP added the nurse would have to call the physician to change the PO to match the OTC/HS medication.A review of the CP Medication Pass inservice handout reflected for accuracy Right Drug-Compare the pharmacy label/package to the MAR/eMAR-the medication and strength must match exactly what is ordered.On 8/12/25 at 10:50 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, [NAME] President of Nursing (VPN) and VP of Operations (VPO). The surveyor reviewed the above concern that occurred during the medication pass.A review of the facility policy dated as revised April 2019 for Administering Medications provided by the DON reflected, The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 2. On 8/7/25 at 9:02 AM, the surveyor observed the RN #2 administer 11 medications to Resident #55, which included a Ferrous Sulfate 325 MG tablet and a Lidocaine 4% patch. RN #1 stated that according to the EMAR, the resident had a PO for the Ferrous Sulfate and Lidocaine 4% patch and both were OTC/HS medications.The surveyor reviewed the electronic medical record for Resident #55.A review of the resident's admission Record reflected that the resident had diagnoses, which included but not limited to, anemia (low red blood cells) and atherosclerosis with gangrene of left leg (thickening of the arteries with tissue death due to the lack of blood flow).A review of the resident's OSR revealed the following POs: Ferrous Sulfate Oral Tablet Delayed Release 325 (65 Active Fe) Give 1 tablet by mouth two times a day for supplement 1 tab=325 MG with a start date of 6/3/25 and Lidocaine-Menthol External Patch 4-1% (Lidocaine-Menthol) Apply to Left knee topically one time a day for pain and remove per schedule with a start date of 6/4/25.A review of the EMAR revealed corresponding POs for the above Ferrous Sulfate Delayed Release and Lidocaine-Menthol External Patch 4-1%.On 8/7/25 at 1:37 PM, the surveyor interviewed RN #2 who stated that she administered the OTC/HS medications that she had in the medication cart. The surveyor, with RN #2, reviewed the EMAR for Resident #55 for the Ferrous Sulfate Delayed Release and Lidocaine-Menthol 4-1% against the OTC/HS medications that she had administered. RN #2 was unable to speak to the Ferrous Sulfate OTC/HS medication not matching the PO for a delayed release formulation. In addition, RN #2 was unable to speak to the OTC/HS Lidocaine 4% not containing Menthol 1 %. (ERROR #2 and ERROR #3)On 8/7/25 at 12:38 PM, the surveyor interviewed the DON, who stated that the PO must match the medication being administered. The DON added the SC was in charge of the central supply and ordering of the OTC/HS medications. The DON also stated the facility had a list of OTC/HS and could order and provide OTC medications to the residents. The DON also stated there were no substitutes and the physician would have to be called for an order. On 8/7/25 at 12:43 PM, the surveyor interviewed the SC who stated she had the responsibility of ordering the OTC/HS medications for the facility. The SC added that she ordered according to a list that she was provided by the facility on a weekly or monthly basis to keep an inventory. The SC added if there was a need for an OTC/HS that was not on the list then she would have to order it when it was needed. The surveyor with the SC reviewed the OTC/HS medications stored in the central supply room and SC stated that there was Ferrous Sulfate 325 MG tablets and had no other Ferrous Sulfate tablets and only had Lidocaine 4% patches. The SC also stated that she used three different vendors depending on who had the OTC/HS that was needed. The SC added that she would have to be told to order an OTC/HS that was not on the list and could not speak to any other Ferrous Sulfate or Lidocaine patch being ordered. The surveyor was provided an OTC/DNS List by the DON and Slow Fe 45 MG tablets were on the list. In (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	addition, Lidocaine 4% patches were not listed.A review of a Medication Pass Observation form for RN #2 dated 6/23/25, completed by the CP revealed that an observation was completed by the CP and the RN #2 had a 4% error rate.On 8/12/25 at 12:32 PM, the surveyor interviewed the CP via telephone who stated she has been the CP for approximately a year and could not speak to the OTC/HS medications the facility purchased. The CP added she had done individual nurse med pass observations but had not done an inservice for all nurses recently. The CP also stated she reviewed the Med Pass Observation form with the nurse after the observation and would do a 1:1 inservice on any errors or findings and would also review the entire form to cover any areas that were not observed. The CP added that she would give a Medication Pass handout to the nurse. The CP also stated the PO for the OTC/HS had to match the drug, dose, formulation before administering. The CP added the nurse would have to call the physician to change the PO to match the OTC/HS medication. A review of the CP Medication Pass inservice handout reflected for accuracy Right Drug-Compare the pharmacy label/package to the MAR/eMAR-the medication and strength must match exactly what is ordered. On 8/12/25 at 10:50 AM, the survey team met with the LNHA, DON, VPN and VPO. The surveyor reviewed the above concerns that occurred during the medication pass. A review of the facility policy dated as revised April 2019 for Administering Medications provided by the DON reflected The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. NJAC 8:39-11.2(b), 29.2(a)(d), 29.4(c)

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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. **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 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 tray line audits to confirm tray accuracy will be conducted by the Food Service Director or designated employee.A review of the facility's Preparing the Resident for a Meal policy, revised September 2010, included: .Review the resident's care plan and provide for any special needs of the resident.NJAC 8:39-17.4(a)1

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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. 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 (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #1 wanted to clean the resident in the shower. CNA #2 stated that there were wipes that were not used and the resident was not properly cleaned. CNA #2 further stated that by using the brief to clean the resident instead of a wipe the resident could get an infection. On 8/7/25 at 11:28 AM, the surveyor interviewed Registered Nurse (RN) #1 who stated that the aides could have pressed the call bell and called for wash cloths to cleanse the resident. RN #1 further stated that there was a potential for infection because the resident had a history of urinary tract infection. On 8/7/25 at 11:36 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1, who stated that a soiled brief should not be used to do incontinence care because you must use a wet washcloth to clean the resident appropriately. The LPN/UM #1 stated that it could cause an infection if a soiled brief were used instead. The LPN/UM #1 further stated that Resident #43 has had UTIs since day one and had been going to the urologist, but they have not specified the cause of the resident's UTIs. On 8/7/25 at 12:20 PM, the surveyor interviewed the Infection Preventionist (IP), who stated that even if a section of the resident's brief that was not soiled were used to clean the resident it was still soiled and dirty. The IP stated that he would have instructed the aides to wait and get the appropriate supplies to clean the resident because there was a concern for infection, and it could cause a potential UTI. On 8/7/25 at 1:41 PM, the surveyor interviewed the Director of Nursing (DON), who stated that it was not appropriate to use a soiled brief to clean the resident. The DON stated a clean diaper maybe, or a washcloth, wipe or toilet tissue could be used to clean the resident but not a soiled diaper, until the aides showered the resident. The DON stated, A soiled brief was not clean, and it is an infection issue because there was both urine and bowel movement in the diaper and it can cause an infection. The DON stated that the doctor has deemed the resident chronic for UTI. A review of the facility's Urinary Continence and Incontinence-Assessment and Management policy, revised September 2010, included: The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. Management of incontinence will follow relevant clinical guidelines.A review of a staff in-service that was provided to staff which included CNA #2 on 7/2/25, revealed the following:.Nurses and CNA play a key role in UTI prevention through patient education and promoting healthy habits.Female Patients: Spread the labia majora and wipe down the center, using a clean part of the washcloth for each stroke. Then, clean each side, rinsing and drying the area thoroughly. Finally, have the patient turn on their side to clean the anal area.Male Patients: For circumcised males, start cleaning at the top of the penis and move downwards in a circular motion to the base. For uncircumcised males, gently retract the foreskin before cleaning and remember to reposition it afterward. NJAC 8:39-19.4