STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Mountain Hc	2385 Springfield Avenue Vauxhall, NJ 07088

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41072 Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to implement the facility's abuse policy to ensure reference checks were completed for Ten (10) of Ten (10) newly hired staff reviewed. This deficient practice was evidenced by the following: On 05/14/24, the surveyor reviewed Ten (10) randomly new employee files which revealed the following: Staff #1-a Certified Nursing Assistant (CNA), with a hire date of 09/22/22, did not have a previous employee reference on file. Two (2) undated typed personal reference letters were on file. Staff #2-a CNA, with a hire date of 04/12/24, did not have a previous employee reference on file. An emailed personal reference letter dated 05/09/24 and an undated typed personal reference was on file. Staff #3 - a Registered Nurse (RN), with a hire date of 02/27/23, did not have a previous employee reference or any personal references on file. Staff #4- a Dietary staff, with a hire date of 05/15/23, did not have a previous employee reference on file. There were two (2) undated typed personal reference letters on file. Staff #5- a Maintenance Staff, with a hire date of 11/22/22, had an undated and unsigned employer verification on file. Staff #6-a CNA, with a hire date of 04/18/24, had an emailed previous employee reference letter dated 05/08/24. Staff #7-a RN, with a hire date of 07/24/23, did not have a previous employee reference on file. Staff #8- a Dietary staff, with a hire date of 01/18/24, did not have a previous employee reference on file. One (1) undated typed personal reference letter was on file. Staff #9 -a Licensed Practical Nurse (LPN), with a hire date of 04/11/24, did not have a previous employee reference on file. One (1) undated typed personal reference letter was on file. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #10-a LPN, with a hire date of 03/21/24, had a typed previous employee reference on file dated 05/10/24. One (1) undated typed personal reference letter was on file. On 05/14/24 at 12:24 PM, the surveyor interviewed the Human Resource Director (HR) who stated that he requests 2 reference letters form the employee and they could be from a relative or co-worker. The HR stated that he does not get the reference letters prior to hiring and that he asked the employees to provide the reference letters. When asked if references should be done prior to working, the HR stated, We try to do it, it looks better. On 05/14/24 at 12:50 PM, the surveyor interviewed the Administrator (LNHA), the Director of Nursing (DON) and the Regional Registered Nurse (RRN) regarding the hiring process. The LNHA stated that prior to hiring, an application, a background check, license verification, a physical and references should be done. The RRN stated that contacting previous employers to verify employment should be done prior to hiring. On 05/15/24 at 10:29 AM, during a follow up interview with the LNHA, DON and RNN, the LNHA stated that the references could be personal or from previous employers. The RRN stated that the employee can provide a personal reference, but the facility should call and verify that reference prior to employment. The RRN further stated that the facility should attempt to contact previous employers to verify employment prior to hiring. A review of the facility's policy titled Abuse and Neglect Policy and Procedure, reviewed 11/13/23, revealed that all prospective employees will be carefully screened using the following process to identify potential risk of abuse/neglect of any resident:1. Reference Check, 2. License check and background check. NJAC 8:39-9.3(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) provide personal hygiene and provide timely assistance for 2 of 2 residents dependent on staff for incontinence care, Resident #21 and #147 and b.) provide nail care to Resident #280 who required assistance with ADL's care. This deficient practice was evidenced by the following: 1.) On 5/9/24 at 10:20 AM, the surveyor observed Resident #147 in bed, the head of the bed was elevated, and the resident was able to answer questions. Upon inquiry, the resident stated he/she had not been provided with incontinence care since last night. Resident #147 further stated that, I have asked the Certified Nursing Assistance (CNA) to change me in the morning, but they haven't. At 10:36 AM, the surveyor asked the Unit Manager (UM) to make incontinence rounds on this resident. Resident #147 was observed to have on 2 adult briefs with the inner brief saturated with urine and soiled with feces (stools). The UM closed the double briefs and told the resident, Let me call your CNA to provide you incontinence care. At 11:06 AM, the surveyor interviewed the Director of Nursing (DON) and UM, who stated, Incontinence rounds are done normally every 2 hours and the residents should not be double briefed. Due to the above observation, the surveyor and the UM continued incontinence care rounds which revealed the following: At 11:10 a.m., unsampled Resident #89 was wearing a brief and appeared to be wet. At 11:15 a.m., Resident #21 was wearing a double brief and was dry. At 11:21 a.m., unsampled Resident #65 was wearing a pull-up and was dry. At 11:25 a.m., unsampled Resident #123 was wearing a brief that did not appear to be wet but was soiled with feces. At 11:32 a.m., unsampled Resident #116 was wearing a brief and was dry. A review of the Admission Summary revealed that Resident #147 was admitted to the facility with diagnoses which included but were not limited to Type 2 Diabetes Mellitus without complications, Urinary Tract infection, site not specified, and Depression. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS), an assessment tool, dated 2/27/2024, revealed that Resident # 147's Brief Interview for Mental Status (BIMS) was 3 out of 15 which indicated the resident was severely cognitively impaired. Section GG of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #147 was totally dependent on staff for toileting hygiene. Section H of the MDS which referred to Bladder and Bowel revealed that Resident #147 was always incontinent of urine and bowel. Section M of the MDS revealed that the resident had one unhealed Stage 3 pressure ulcer. Review of the Care Plan for Resident #147 initiated on 5/10/23 with revision date of 5/23/23, revealed a focus for [name redacted] has impaired functional status r/t (related to) recent hospitalization , muscle weakness, pain, deconditioning, high fall risk, impaired mobility. The goal was for Resident #147 will show improvement in functional status evidenced by increased self-participation in ADL's. The interventions included: Toileting hygiene: Dependent X 1: Helper does ALL of the activity; resident does none of the effort to complete the activity. Further review of the Care Plan, initiated on 5/10/23 with a revision date of 4/25/24 revealed a focus for [name redacted] is at risk for skin breakdown r/t fragile skin, impaired mobility, incontinence, Hx (history): skin problems; MASD (Moisture-associated skin damage [an inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus.]) bilateral (b/l) [both] thighs resolved 11/1/23 Pressure 3 wound on Sacrum-extending to Left buttocks. A review of the form CNA Task under Toileting Hygiene (GG), Toilet transfer (GG), Bladder Incontinence and Bowel Incontinence, which revealed the last time the resident received care was on 5/8/24 at 19:08 (7:08 PM). There was no other documentation that the resident received incontinence care between 5/8/24 at 7:08 PM and the time of the above observation. On 5/15/2024 at 12:41 PM, the above concerns were presented to the DON, the Licensed Nursing Home Administrator, and the Regional Nurse. 2.) On 5/9/23 at 11:15 AM, the UM checked Resident #21 for incontinence care. The surveyor and the UM observed resident in bed, who was wearing 2 adult briefs, the resident was dry. The UM acknowledged that the residents should not be double briefed. A review of the Admission Summary revealed that Resident #21 was admitted to the facility with diagnoses which included but were not limited to Cerebral infarction, unspecified (a type of ischemic stroke that results from a blockage in the blood vessels supplying blood to the brain), Pressure ulcer of sacral region, Stage 3 (a full thickness skin loss that has progressed beyond the layers of skin and into the fatty tissue below), and muscle weakness (generalized). The Annual MDS dated [DATE], revealed that Resident #21's BIMS was 14 out of 15, indicating the resident was cognitively intact. Section GG of the MDS which referred to ADLs revealed that Resident #21 was totally dependent on staff for toileting hygiene. Section H of the MDS which referred to Bladder and Bowel revealed that Resident #147 was always incontinent of urine and bowel. At 11:32 AM, the surveyors interviewed CNA #1 and CNA #2. They both acknowledged that they make incontinence rounds twice a shift, they check their residents in the morning and if the residents are dry then check them after breakfast. They further stated, if the resident asks them to change them, they will change the resident. CNA #1 and CNA #2 also stated that they put only one brief on the resident and would tell the nurse if they saw a resident in double briefs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/2024 at 12:41 PM, the above concerns were presented to the DON, the Licensed Nursing Home Administrator, and the Regional Nurse. 27193 3. Observation on 05/08/24 at 11:22 AM, revealed Resident #280 in bed, with nails long, jagged with a black coated substances underneath the fingernails. Observation on 05/09/24 at 08:41 AM, revealed the resident eating breakfast, the fingernails were long and jagged with black coated substance underneath the fingernails. Observation on 05/10/24 at 10:10 AM, after AM care had been provided, revealed the resident in bed, The nails were still long and jagged with black coated substances underneath the fingernails. When inquired regarding nails care, Resident #280 stated that she was visually impaired. Resident #280 stated that he/she was assisted with morning care but nail care was not done. She stated that she would like the nails to be trimmed and cleaned. On 05/10/24 at 10:13 AM, during an interview with CNA #3 who cared for Resident #280, she confirmed that Resident #280 was a total care. she further stated, I have to do everything for the resident. When inquired about nails care, CNA#3 stated that nail care was part of AM care. On 05/10/24 at 10:22 AM, the surveyor escorted the Registered Nurse (RN) to the room and we both observed the fingernails long and jagged with the coated black substance underneath the fingernails. The nurse stated, Oh yes the fingernails needed to be cleaned. The resident stated, If I could do it I will clean it, but I am visually impaired. In the presence of CNA #3, Resident #280 stated, I do not want them to be cut all way down but I want them to be cleaned. On 5/10/24 at 11:30 AM, during a second interview with the RN assigned to the resident's care, she stated that Resident #280 refused the nails to be cleaned. However, the surveyor returned to the room with CNA #3 and the resident stated in the presence of the CNA #3, I do not want the nails to be cut all way down but I want them to be cleaned. The RN could not provide a care plan or documentation of Resident #280's refusal of care. On 5/10/24 at 12:15 PM, the surveyor reviewed the Electronic Medical Record (EMR) which revealed that Resident #280 had diagnosis which included Alzheimer's disease, impaired vision related to glaucoma, and anxiety disorder. Review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/06/24 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating R# 280 had moderate cognitive impairment. Further review of the MDS revealed R# 280 required substantial maximum for hygiene. Review of the care plan had a focus for impaired functional status related to muscle weakness and recent hospitalization . The goal was for Resident #280 to show improvement by increased self-participation in Activities of Daily Living (ADL's). Interventions included: Assist as needed. Encourage self participation in ADL's as tolerated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Activities of Daily Living Supporting, with revised date of 03/24, indicated, Residents will be provided with care and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's) The policy further stated that Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Under Policy Interpretation and Implementations: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: c. elimination (toileting). A review of the facility document titled, Job Description with Position: Certified Nursing Assistant, revealed Basic Function: To provide services that support the care delivered to patients/residents requiring long term or rehabilitative care. Under Duties and Responsibilities: 1.e.) Assistance is given with patient care, such as, bathing, dressing, positioning, monitoring temperature, feeding, making up beds, and toileting. k.) Familiar and able to perform all of the basic CNA skills. NJAC 8:39-27.1 (a), 27.2(d, g, h, j)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37791 Based on observation, interview, and record review it was determined that the facility failed to consistently assess a resident's dialysis access site when returning from the dialysis clinic. The deficient practice was identified for 1 of 2 residents, Resident #4, reviewed for dialysis care and services and is evidenced by the following. On 5/9/24 at 10:15 AM, the surveyor observed the resident seated in a wheelchair in their room eating breakfast. The resident was alert but refused an interview. The resident told the surveyor that they had dialysis the previous day. The surveyor reviewed the medical record for Resident #4. The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis(a complex process that involves the intrusiveness of renal dialysis, which can sustain life but doesn't cure or heal. Dialysis is a treatment that helps the body remove waste products and extra fluid from the blood when kidneys are unable to do so), major depressive disorder (a condition with a persistently low and depressed mood) and hypertension (a condition in which the force of blood against the artery walls is too high). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/19/24, reflected that the resident had a brief interview for mental status (BIMS) score of 9 out of 15, indicating that the resident was cognitively, moderately impaired. A review of the Dialysis Communication Sheets from 4/1/24 until 5/10/24 revealed that the resident's AV Fistula (Arterialvenous fistula; how patients are connected to a dialysis machine) was located on the resident's left arm and that the facility was checking the bruit/thrill (a thrill is a vibration felt when palpating a blood vessel. While a bruit is the auscultated equivalent of the thrill) pre-dialysis and at the dialysis center. The Dialysis Communication Sheets had no information showing that the bruit and thrill were being checked post-dialysis by the facility. The surveyor reviewed the facility progress notes from 4/1/24 through 5/10/24 which revealed no post-dialysis documentation. A review of the comprehensive care plan revealed a focus area of ESRD (end stage renal disease), receiving dialysis, potential for complications. A review of the interventions revealed the following interventions Monitor dialysis shunt for thrill & bruit every shift. Monitor site for s/s (sign and symptoms of) infection. If thrill or bruit not present or s/s infection are observed, notify MD (medical doctor) for prompt intervention. Monitor bleeding at site, if present, apply direct pressure with sterile gauze and notified MD. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the May 2024 Order Summary Report (OSR) revealed the following physician's order (PO) dated 3/12/24 to check blood pressure and pulse prior to leaving for dialysis and on return from dialysis. No BP (blood pressure) on left arm every shift Monday, Wednesday and Friday Pre and Post dialysis. A further review of the May 2024 OSR revealed no PO to check the AV fistula access site (bruit and thrill). A review of the April and May 2024 electronic medication administration record (EMAR) revealed no documentation showing that the AV fistula access site (bruit and thrill) was being checked every shift. On 5/13/24 at 11:40 AM, the surveyor interviewed the 2 South Registered Nurse/Unit Manager (RN/UM) who stated that a dialysis resident who had an AV access site,that it (bruit and thrill) should be checked every shift including post-dialysis. In the presence of the surveyor, the RN/UM reviewed Resident #4's medical record. The RN/UM reviewed the Dialysis Communication Sheets and acknowledge that the resident had an AV fistula on their left arm and that the bruit and thrill should be checked on every shift. The RN/UM acknowledge that they were no post-dialysis notes written on the Dialysis Communication Sheets and this documentation would have included the resident's vitals and that the resident's AV fistula access site (bruit and thrill) was checked. The RN/UM also reviewed the resident's progress notes, PO and EMAR and acknowledge that there was no documentation that showed that the resident's AV fistula site (bruit and thrill) was checked post-dialysis. The RN/UM then reviewed the resident's care plan and acknowledged that the resident's AV fistula access site (bruit/thrill) should be checked every shift. The RN/UM told the surveyor that he will try to find any additional information to show that the facility was checking the access site post-dialysis. On 5/14/24 at 11:30 AM, the surveyor interviewed the RN/UM, who had no additional information. The RN/UM stated that the resident should have had an order to check the AV fistula access site (bruit and thrill) every shift and he further stated that there was no documentation that he could provide which showed that the facility was checking the resident's bruit and thrill post-dialysis. On 5/14/24 at 12:35 PM, the surveyor presented the above concern to the administration team which included the License Nursing Home Administrator, Director of Nursing (DON) and the Regional Clinical Nurse (RCN). The RCN acknowledge that it was important to check the bruit and thrill to assure the wasn't any clotting. There was no additional information provided. A review of the facility's policy for Care of a Resident Receiving Dialysis revised on 1/5/2024, and was provided by the DON revealed the following: If a resident has an AV fistula (access site), nursing will access and palpate for thrill and auscultate for bruit every shift by a license nurse. This will be documented in the EHR (electronic health record). NJAC 8:39-27.1(a); 2.9

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 48423 Based on obervations, interviews, record review, and pertinent facility documents it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents a.) conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission and b.) were seen by the attending physician or Nurse Practitioner (NP) every thirty days with a physician visit at least every sixty days. This deficient practice was observed for 8 of 8 residents (Resident #4, #11, #23, #33, #77, #130, #135 and #147) reviewed for physician visits. This deficient practice was evidenced by the following: 1. On 5/9/24 at 12:25 PM, the surveyor observed Resident #77 sitting in her chair who stated, I have been here for almost 2 years, and I saw the doctor only 2 or 3 times. A review of Resident #77 Admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included but not limited to: Type 2 Diabetes Mellitus with diabetic neuropathy, unspecified (nerve damage caused by diabetes that affects different parts of the body), Heart failure, unspecified (when the heart muscle doesn't pump blood as well as it should), Anemia in Chronic Kidney Disease (a gradual loss of kidney function), and Dependence on Renal dialysis (A blood purifying treatment given when kidney function is not optimum). A review of the progress notes in the Electronic Medical Records (EMR) revealed the attending physician saw the resident on 1/11/23, 2/3/23, 11/29/23, 1/2/24, and 3/28/24. Further review of the EMR revealed the NP saw the resident on 6/22/23, 8/29/23, 10/24/23, 12/22/23, 1/18/24, and 2/23/24. A review of the progress notes revealed that the resident was admitted to the facility in January 2023. Resident #77 was discharged and returned to the facility in December 2023 and January 2024. Further review of the progress notes, did not reveal that the physician saw the resident upon readmission in December 2023 or upon return in January 2024 or February 2024. A review of the EMR did not reveal a Progress Note (PN) from the attending physician or the attending NP in March 2023, April 2023, May 2023, July 2023, September 2023, and April 2024 or that the physician and NP were consistently alternating monthly visits. 2. A review of Resident #23s AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), Hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness caused by brain, spinal cord or nerve problems) following cerebral infarction (that occurs when blood flow to the brain is blocked or reduced) affecting left non-dominant side and Acute respiratory failure (when your lungs cannot deliver enough oxygen or remove enough carbon dioxide from your blood) with hypoxia (levels of oxygen in the blood are lower than normal). (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the PN in the EMR revealed the attending physician saw the resident on 5/8/23, 9/29/23, 11/24/23, 1/29/24, 5/14/24. Further review of the EMR revealed the NP saw the resident on 1/11/23, 3/7/23, 4/4/23, 5/1/23, 6/16/23, 7/20/23, 10/18/23, 11/16/23, 12/20,23, 1/22/24, 2/8/24, 3/13/24, 4/1/24, and 5/8/24. A review of the PN revealed the resident was out of the facility in February 2024 and April 2024. Further review of the progress notes, did not reveal that the physician saw the resident upon readmission in February 2024, March 2024, or April 2024. A review of the EMR did not reveal a PN from the attending physician or the attending NP for February 2023 and August 2023 or that the physician and NP were consistently alternating monthly visits. 3. A review of Resident #33's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Paranoid Schizophrenia (kind of psychosis that makes you unreasonably suspicious of others), Major depression disorder, recurrent, unspecified, and Chronic obstructive pulmonary disease, unspecified (a common lung disease causing restricted airflow and breathing problems). A review of the PN in the EMR revealed the attending physician saw the resident on 1/23/23, 4/19/23, 7/13/23, 11/28/23, 2/5/24, and 4/4/24. Further review of the EMR revealed the NP saw the resident on 10/17/23, 1/3/24, 2/8/24, 3/22/24, and 4/10/24. A review of the PN revealed the resident was at the facility from January 2023. The resident was discharged and returned to the facility in December 2023. Further review of the progress notes, did not reveal that the physician saw the resident upon readmission in December 2023 and January 2024. A review of the EMR did not reveal a PN from the attending physician or the attending NP in February 2023, March 2023, May 2023, June 2023, August 2023, September 2023, or December 2023 or that the physician and NP were consistently alternating monthly visits. 4. A review of Resident #11's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Acute respiratory failure (when your lungs cannot deliver enough oxygen or remove enough carbon dioxide from your blood) with hypoxia (levels of oxygen in the blood are lower than normal), Chronic obstructive pulmonary disease, unspecified (a common lung disease causing restricted airflow and breathing problems), Pneumonia, unspecified organism (inflammation and fluid in your lungs caused by a bacterial, viral or fungal infection) and unspecified asthma, uncomplicated (a condition in which your airways narrow and swell and may produce extra mucus). A review of the PN in the EMR revealed the attending physician saw the resident on 3/10/24 and 5/5/24. Further review of the EMR revealed the NP saw the resident on 1/25/23, 3/13/23, 5/23/23, 7/19/23, 8/8/23, 9/15/23, 10/17/23, 11/8/23, 12/8/23, 1/3/24, 2/9/24, 4/23/24. A review of the PN revealed the resident was discharged and returned to the facility in August 2023. Further review of the progress notes, did not reveal that the physician saw the resident upon readmission in August 2023, September 2023 or October 2023. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the EMR did not reveal a PN from the attending physician or the attending NP for February 2023, April 2023, June 2023 or that the physician and NP were consistently alternating monthly visits. 5. A review of Resident #147's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Type 2 Diabetes mellitus without complications, Muscle weakness (generalized), Depression, and unspecified and pain in right knee. A review of the PN in the EMR revealed the resident was admitted to the facility in May 2023. A review of the PN in the EMR revealed the attending physician saw the resident on 5/26/23, 6/7/23, 7/7/23, 8/7/23, 11/29/23, 1/31/24, and 3/29/24. Further review of the EMR revealed the NP saw the resident on 9/21/23, 12/26/23, 2/22/24, and 4/25/24. A review of the EMR did not reveal a PN from the attending or the attending NP in October 2023. 41858 6. A review of Resident #130's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Unspecified Dementia (affects memory, thinking and interferes with daily life), unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety and Alzheimer's disease, unspecified (caused memory loss and other cognitive impairment). A review of the progress notes in the EMR revealed the attending physician saw the resident on 1/30/23, 5/28/23, 9/29/23, 11/24/23, 1/26/24, and 3/22/24. Further review of the EMR revealed the Nurse Practitioner saw the resident on 3/13/23, 3/30/23, 4/5/23, 4/17/23, 4/18/23. A review of the progress notes revealed the resident was readmitted to the facility in March of 2024. Further review of the progress notes, did not reveal that the physician saw the resident upon readmission in March 2024 or April 2024. A review of the EMR did not reveal a progress note from the attending physician or the attending nurse practitioner in February 2023, June 2023, July 2023, August 2023, October 2023, December 2023, February 2024 or that the physician and NP were consistently alternating monthly visits. 7. A review of Resident #135's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Polyosteoarthritis (having arthritis in five or more joints at the same time) and type 2 diabetes (results from insufficient production of insulin, causing high blood sugar). A review of the progress notes in the EMR revealed the attending physician saw the resident on 1/3/23, 2/28/23, 3/30/23, 5/23/23, 6/27/23, 8/29/23, 10/9/23, 11/16/23, 1/15/24, and 3/28/24. Further review of the EMR revealed the Nurse Practitioner saw the resident on 12/11/23. A review of the EMR did not reveal a progress note from the attending physician or the attending nurse practitioner in April 2023, July 2023, September 2023, February 2024 or April 2024. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37791 8. A review of Resident #4's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis (a complex process that involves the intrusiveness of renal dialysis, which can sustain life but doesn't cure or heal. Dialysis is a treatment that helps the body remove waste products and extra fluid from the blood when kidneys are unable to do so), major depressive disorder (a condition with a persistently low and depressed mood) and hypertension (a condition in which the force of blood against the artery walls is too high). A review of the progress notes in the EMR revealed the attending physician saw the resident on 1/8/24. Further review of the EMR revealed the Nurse Practitioner saw the resident on 1/13/23, 2/2/23, 2/23/23, 3/3/23, 3/13/23, 4/17/23, 5/1/23, 5/4/23, 5/12/23, 6/21/23, 6/30/23, 7/14/23, 7/24/23, 8/9/23, 8/28/23, 9/8/23, 10/4/23, 10/16/23, 10/31/23, 11/1/23, 11/3/23, 12/1/23, 12/11/23 ,12/26/23, 1/9/24,1/10/24, 1/12/24, 1/15/24, 1/17/24, 1/19/24, 1/22/24, 1/24/24, 2/1/24, 2/28/24, 3/6/24, 3/18/24, 4/17/24, 5/6/24, and 5/9/24. Further review of the EMR did not reveal that the physician and NP were consistently alternating monthly visits. On 05/14/24 at 11:30 AM, the surveyor interviewed the Registered Nures/Unit Manager, who stated, we inform the DON if we notice the attending has not seen the resident. He was unable to speak to the frequency of physician visits. On 05/14/24 at 12:45 PM, during a meeting with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Regional Nurse Consultant (RNC), the DON stated the attending physican for long term care alternated every 60 days. They should do the initial on admission then monthly for first 90 days, then can be seen by MD every 60 days, NP can see in between. The surveyor verified attending physician and/or the NP must see resident at least every 30 days. The LNHA, the DON, and the RNC were all in agreement. On 5/14/24 at 1:16 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager regarding physician visits, who stated, They document in the EMR every time they see a resident. The attendings are supposed to see the resident every 30 days. They have their schedule. Whenever we call them to see the resident or if the resident requests, they (the physician) come see them. A review of the facility policy Physician Visits reviewed December 2023 revealed: Policy Statement: The Attending Physician must make visits in accordance with applicable state and federal regulations. Policy Interpretation and Implementation: 1.The Attending Physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and the at least every sixty (60) days thereafter. 4.After the first ninety (90) days, if the attending Physician determines that a resident need not be seen by him/her every thirty (30) days, and alternate schedule may be established, but not to exceed every sixty (60) days. A Physician Assistant or Nurse Practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted law or regulation. NJAC 8:39-23.2 (b)(d)

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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. 37791 Complaint #: NJ00170376 Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that a resident received as needed (prn) narcotic (a controlled drug that produces pain relief) medication in accordance with the prescriber's orders and accepted professional standards. The deficient practice was identified for 1 of 6 residents (Resident #227) reviewed for medication management. The deficient practice 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 well being, 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. A review of a closed medical record revealed a Progress Note (PN) dated 04/11/23 at 1409 (2:09 PM), identified that Resident #227 complained of getting both Oxycodone and Vicodin 10 minutes apart. The note revealed that both the Director of Nursing (DON) and Unit manager was made aware of the complaint. The surveyor reviewed the closed medical record for Resident #227. The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis (a complex process that involves the intrusiveness of renal dialysis, which can sustain life but doesn't cure or heal. Dialysis is a treatment that helps the body remove waste products and extra fluid from the blood when kidneys are unable to do so), encounter for orthopedic aftercare following surgical amputation, and hypertension (a condition in which the force of blood against the artery walls is too high). A review of the admission Minimum Data Set (MDS), an assessment tool, used to facilitate the management of care, dated 4/04/24, reflected that the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident was cognitively intact. (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 April 2023 Order Summary Report (OSR) revealed the following physician's order (PO) dated 4/4/23 for Oxycodone (pain) tablet 5 mg (milligrams) give 2 tablets by mouth every 6 hours as needed for moderate pain. 2 tablets (5MG) =10 MG. May cause drowsiness/dizziness. Avoid alcohol. A further review revealed a PO dated 4/4/23 for Vicodin (hydrocodone/acetaminophen) 5/300 mg give 1 tablet by mouth every 6 hours as needed for severe pain. A review of the April 2023 electronic medication administration record (EMAR) revealed that on 4/11/23 at 0455 (4:55AM), 2 tablets of Oxycodone 5 mg was documented as being administered to Resident #227 with a pain scale of 6 (moderate pain). The April 2023 EMAR also revealed that on 4/11/23 at 0456 (4:56AM) that 1 tablet of Vicodin 5/300 was documented as being administered with a documented pain scale of 7 (severe pain). A review of a facility Medication Error Report form dated 4/11/23, revealed the following: Under description of error the facility wrote that the resident was assess having a pain level of 6 and that the nurse should have administered per the physician's order 2 tablets of Oxycodone 5 mg tablets. The nurse should have waited a hour to assess the resident. Under reason for error the facility wrote the following: Failure to read order before administering medication. Pain management therapy should have been evaluated before considering a different medication. On 5/13/24 at 1:00PM, the surveyor attempted to interview the Registered Nurse (RN) but was informed by the Director of Nursing (DON) that the nurse no longer worked at the facility. On 5/14/24 at 12:35 PM, the surveyor presented the above concern to the administration team which included the License Nursing Home Administrator, Director of Nursing (DON) and the Regional Clinical Nurse (RCN). There was no additional information provided. A review of the facility's policy for Medication Preparation for Dispensing revised on 1/31/2024, and was provided by the DON revealed the following: G. Prior to Medication Administration: 1. Verify each medication preparation that the medication is the RIGHT DRUG, at the RIGHT DOSE, the RIGHT ROUTE, at the RIGHT RATE, at the RIGHT TIME, for the RIGHT CUSTOMER. 2. Verify that the MAR reflects the most recent medication order. 3. Check expiration date on medication label. J. Medication Administration: 3. Medications are administered in a timely fashion as specified by policy. 4. As specified by federal and state regulations, controlled substances are documented as given at the time of administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	K. After Medication Administration: 1. Document necessary medication administration/treatment information (e.g., when medications are administered, medication injection site, refused medications and reason, prn medications, etc.) on appropriate forms. NJAC 8:39-11.2(b), 29.2 (a)(d) ,

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31654 Based on observation, interview and document review it was determined that the facility failed to serve hot and cold food items at appropriate and appetizing temperature for 3 of 5 resident units (1 South, 2 North and 2 South), for 1 of 1 resident reviewed for food (Resident #165) and for 3 of 5 residents who attended a resident council meeting. The deficient practice was evidenced by the following: On 05/08/24, at 11:12 AM, the surveyor interviewed Resident #165 who stated the main concern was that the hot food was cold, along with the coffee for all three meals. On 05/09/24 at 9:46 AM, during a follow up interview with Resident #165, the resident stated the temperatures were off and the hot food was not hot, and the cold food was not cold. On 05/10/24 at 10:39 AM, a surveyor conducted a resident council meeting and 3/5 residents stated the food was not hot enough and the coffee could be cold at times. Two of the five residents stated that they requested cold cereal for breakfast because they knew the hot food would be cold. Two of five residents stated the lunch and dinner were also not hot enough. A resident stated, when the food comes up, the food stays there for a few minutes and it's not going to get to you, and it will be cold when I get it. On 05/10/24 at 8:10 AM, surveyor #1 conducted a meal observation on 2-North and observed the following: -8:13 AM the meal cart was brought to the unit. -8:18 AM, 5 minutes after the cart was brought to the unit, one staff removed a tray and brought it to a resident room. -8:22 AM, the 2nd meal tray was removed from the cart. -8:36 AM, the Licensed Nursing Home Administrator (LNHA) joined Surveyor #1 for the the observation. -8:37 AM, (25 minutes after the meal truck was delivered) the surveyor and the LNHA both checked meal temperatures of the last meal tray (Resident #280) and using separate thermometers. -Vegetable Frittata surveyor LNHA 93 degrees Farenheight (F) 94 F Hot Farina (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor LNHA 128 130 F Whole Milk surveyor LNHA 50 F 47.7 F Orange juice surveyor LNHA 52 F 51.6 F Coffee surveyor LNHA 123 F 122 F On 05/10/24 at 8:47 AM, Surveyor #1, reviewed temperature logs in the kitchen with the [NAME] and Food Service Director (FSD) which revealed: Vegetable Fritatta 191 F Juice 38 F Farina 200 F At that time, the surveyor interviewed the FSD regarding what the hot food temperatures should be when they reach the resident and the FSD stated, ideally hot should be 140 F or above, and cold food should be 41 F or below which revealed the food temperatures in the kitchen were acceptable. On 05/09/24 at 8:05 AM, Surveyor #2 observed the meal cart arrive on the 1 South Unit (low side) and observed the first tray was passed at 8:09 AM. At 8:27 AM, an open meal cart arrived with the meal trays for the high side of the unit. At 8:31 AM, the staff initiated passing the trays. At 8:44 AM, the last meal tray was passed and the surveyor tested Resident #60's tray in the presence of the Unit Manager Liscened Practical Nurse, which revealed: Puree Fruit: 115.3 F Milk: 56.8 F Cheese Sauce for Farina: 109.6 F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/10/24 at 8:30 AM, Surveyor #3 observed the 2 South Sub-Acute, meal delivery and the meal truck arrived on the unit at 8:40 AM. The last tray was passed at 8:54 AM and the meal temperatures of an unsampled resident's meal tray were checked by the surveyor in the presence of a Recreation Aide which revealed: Eggs: 111.0 F Farina: 120.3 F Hot water for Tea: 115.9 F A Test Tray form provided by the LNHA on 05/10/24 at 9:00 AM revealed Acceptable Temperatures: Soup/Hot Cereal- 140 F or above; Milk/ Juice- 40- 50 F; Coffee 135-180 F; Breakfast Entree- 120 F, or above; Entree- 130 F or above. NJAC 8:39-17.4 (a)2

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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. 31654 Based on observation, interview and review of pertinent documents it was determined that the facility failed to ensure: a) a consistent system for labeling and dating was implemented to ensure all potentially hazardous foods were labeled with a use by date, b) the kitchen environment, all equipment and dishware was maintained in a clean and sanitary manner and transported appropriately, and c) staff performed appropriate hand hygiene, to limit the potential for contamination, and the risk of potential foodborne illness. The deficient practice was evidenced by the following: On 05/08/24 at 9:26 AM through 10:40 AM, the surveyor conducted a tour of the kitchen with the Registered Dietitian (RD) and the Food Service Director (FSD) and observed the following: 1. The step garbage can next to hand washing sink did not open when the foot pedal was stepped on and this was confirmed by the RD. 2. The walk-in refrigeration unit contained the following: - A metal pan on the bottom shelf contained six cabbage heads with visible darkened areas/spots. The cabbage was not labeled and did not contain a use by date. The surveyor asked the RD if the cabbage was dated and she stated, I don't see one. - A plastic type bin of uncovered celery stalks, located on a bottom shelf, had a sticker affixed to the bin with 2/27/24. When asked about the date, the RD stated, they forgot to take the label off the bin and confirmed there was no use by date on the celery when she lifted the packages and was unable to locate a use by date. - A blue colored box that contained bags of red grapes had 4-26-24 written on the box. There was no use by date. - Two boxes of mushrooms, both uncovered, were also located on the shelf, one box was labeled Medium 10 lbs with a white sticker 4/18, and the second box was labeled 4/30. Neither box contained a use by date. -The grate covering the fan located in the refrigeration unit contained black spots and soiled areas and there was black splatter type debris on the ceiling, corner, and portions of the wall areas. 3. The walk-in refrigerator contained the following: - One ten-pound box of Fully Cooked Boneless, Skinless Chicken Meat, Diced Chicken was labeled in red handwriting, 4/30. The box was labeled, Keep Frozen, there was no indication when the product was defrosted or a use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Three white boxes labeled ten pounds of Fully Cooked 1/2 Inch [NAME] Meat Chicken, two of the boxes had a date on the box 02/08/24 and there was no use by date, the third box had a handwritten date, 4/18/24 and did not contain a use by date. - A box that contained rolls of Turkey Bologna, that were not dated and the box was labeled Sell/Freeze by 11/24/23, Keep Refrigerated, another box of 19.76 pounds of Turkey Bologna rolls had a handwritten date of 11/29/23 with the same Sell/Freeze by 11/24/23 label. There was no use by dates on the items. Another Turkey Bologna roll had a printed label Date Received 1/23/24, partially over another label Sell/Freeze by 02/15/24, Keep Refrigerated. The surveyor asked the FSD what the product use by date should be. The FSD stated, seven days from the open date. The surveyor asked where the date was located on the boxes. The FSD stated, I don't see it. The surveyor asked if there should be a use by date on the products and the FSD stated, yes and he was unable to provide a use by date. -A package of opened parmesan cheese was wrapped and had a piece of paper with a handwritten date 11/28/24. There was no use by date, and the package was discarded by the FSD. -A five-pound opened container of Cottage Cheese had a sticker on it, Received 04/02/24, there was no use by date. The sell by sticker on the package indicated, 04/26/24. The surveyor asked about the use by date, the RD stated, I don't see a use by date. -Three cases of 4-ounce skim milk dated, May 7, 2024, and the surveyor asked the RD if the milk could be used and the RD stated, no. -14 cased of defrosted juices, STORE AT 0F printed on box in bold. The boxes did not contain use by dates 4. The walk-in freezer contained the folllowing: -The door gasket was ripped and pulling off door and the door curtain was ripped. -A box contained a plastic bag of breaded chicken patties which was not sealed and was open to air. The box was dated 04/16/24 and there was no use by date. -Three logs of frozen ground beef were stored on top of packages of various frozen meats. There were no use by dates. -There was a three pack of frozen turkey burgers and there was no use by date. 4. The dry storage room contained the following: a large, unsealed bin with stains on top of the bin. The bin had dark splatter type stains on the outside and in the inside of the bin. The top of the bin had Coconut Shredded, Open 05/01/24 written on the top of the lid. There was a white shredded product in the bin. The FSD confirmed that there was no use by date. -The floor in the dry storage room had debris in the corners of the room. The surveyor asked the FSD about a cleaning schedule for the kitchen and the FSD stated there was no schedule yet, as he was new to the facility and was working on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-17 individual four-ounce containers of thickened cranberry juice cocktail were located on a shelf in the dry storage room. The juice had a best if used by date of 4/4/24. -Splatters of various colored debris were observed on the ceiling in the dry storage room. -A large fan inside the kitchen to the outside had a grate covered with dust like debris. -The can opener that was affixed to the metal table was very soiled with dark debris on the base and blade. The FSD confirmed as he observed that the base of the can opener was difficult to remove due to debris. On 05/10/24 at 8:52 AM, during a second kitchen observation conducted with the FSD, the surveyor observed the large slicer covered with plastic, which was identified as clean, and when the FSD removed the plastic there were several areas of food debris on the base and blade area. On 05/08/24 at 12:10 PM, during a lunch meal observation on the second floor, the surveyor observed the [NAME] transporting dishware and other supplies from the hallway into the dining room on a three tiered black cart. The bottom tier of the cart contained eight dishes, face up, that were uncovered during transit. 05/08/24 at 12:21 PM, during the same meal observation on the second floor, the [NAME] was observed using paper towels to wipe perspiration off of his head, then proceeded to place gloves on his hands without first performing hand hygiene, and proceeded to plate food on the uncovered dishes from the cart. The Handwashing/Hand Hygiene Policy, revised December 2023, revealed This facility considers hand hygiene the primary means to prevent the spread of infection. 6. Waterless alcohol products are preferred method for hand hygiene except for the following situations: a. When hands re visibly soiled . 8. Use an alcohol-based hand rub containing at least 62 % alcohol; or alternatively, soap and water for the following: . f. Before donning sterile gloves. The Storage Areas Policy, undated, revealed .Food is stored in an area that is clean, dry and free from contaminants. Food is stored, prepared, and transported at appropriate methods designed to prevent contamination or cross contamination. 4. All containers must be legible and accurately labeled and dated. 6. Schoops must be provided for bulk foods. Scoops are not to be stored in food or ice containers, but are kept covered in a protected area near the containers. 8. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods. a. Old stock is always used first (first in-first out method). c. Food should be dated as it is placed on the shelves. Date marking top indicate the date or day by which a ready to eat, potentially hazardous food should be consumed, sold or discarded will be visible on all high risk food. 14. Refrigeratged Food Storage. a. All refrigerator units are kept clean and in good working condition at all times. f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable) or discarded. 15. Frozen Foods: d. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. NJAC 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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41858 Based on interview and review of other facility documentation, it was determined that the facility Quality Assessment and Performance Improvement (QAPI) committee, that identified quality concerns, failed to utilize the Facility Performance Improvement Plan to follow the facility process to measure and utilize data acquired for frequency of physician visits. This deficient practice was evidenced by the following: On 05/16/24 at 9:40 AM, the surveyor reviewed the facility provided QAPI Plan Primary physicians' documentations compliance Effective Date: February 26, 2024 which revealed Design and Scope: Statements and Guiding Principles: PMD's (primary medical doctor)/NP's (Nurse Practitioner) Federal documentations compliance. Other Services Provided: Nursing and medical record staff will monitor physician visits compliance and informing the upper management. Feedback, Data Systems and Monitoring: Monitoring Process: Audit physicians and their NP's progress notes every other month for compliance x 6 months. Conduct meetings with the physician and and their NP's every time there's issues to address. Goal is 100% compliance 3 months. At 10:32 AM, during a meeting with the surveyor, the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) regarding the results of the above mentioned QAPI Plan, the DON stated she presented the QAPI Plan at the April QAPI meeting. She stated audits were done but she was unable to provide the surveyor with an audit tool or evidence that the audits were being done according to the Monitoring Process of auditing physician and NP's progress notes every other month for compliance since being self-identified on 2/26/24 or that the audit results were presented at the QAPI meeting. She was also unable to show the surveyor that the facility was progressing toward the Goal of 100% compliance in 3 months. The DON stated she sent an email or a text to the physicians that were identified. The LNHA stated, the purpose (of a QAPI plan) was to show improvement, identify issues, how we are going to work on them and if they are working. Regarding the purpose of audits, the RNC stated, so we can identify if it is working. We continue with what is working if not we come up with a plan to change it. The LNHA and the DON both confirmed that they were unable to quantify the audits that were completed. Therefore, they were unable to show a monitoring system to show that their QAPI Plan was working. A review of the facility policy Performance Improvement-QA Committee last revised 1-2024, revealed: Policy: .The committee will implement quality assurance and performance improvement programs (PIP) for the facility . The committee .Any ongoing concerns will be discussed, and PIP will be started to rule out route cause. PIP will be revised and updated as schedule. Staff will be educated as needed. NJAC 8:39-33.1(a)(b)(c)(e)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 41858 Based on interview and review of pertinent facility documentation, the facility failed to ensure the required committee members, the Infection Preventionist (IP), was present for four of six Quality Assurance and Performance Improvement (QAPI) meetings and was evidenced by the following: On 05/16/24 at 9:53 AM, the surveyor reviewed the facility provided QAPI book, that included the quarterly sign in sheets for the QAPI meetings, which revealed: - Employee In-Service Education; Date: Jan (January) 2023; Subject: QAPI the IP did not sign in as being in attendance. - Daily Department Head Meeting; Date: 7/26/23; Subject: QAPI 2nd Quarter April-June 2023 the IP did not sign in as being in attendance. - Employee In-Service Education; Date: 10/17/23; Subject: QAPI the IP did not sign in as being in attendance. - Daily Department Head Meeting; Date: 1/31/24; Subject: QAPI 4th Quarter 2023 the IP did not sign in as being in attendance. On 05/16/24 at 10:08 AM, during a meeting with the surveyor, the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Regional Nurse Consultant (RNC), the LNHA stated that the required members that should attend the QAPI meeting included but were not limited to; the Administrator, the DON, the medical director, department heads, and the Infection Preventionist. At 10:17 AM, in the presence of the surveyor, the LNHA, the DON, and the RNC reviewed the signatures on the January 2023 sign in sheet and were unable to determine who the IP was at that time or that the IP had attended the meeting. The LNHA reviewed the sign in sheets for July 2023, October 2023, and January 2024 and was unable to verify that the IP was in attendance. The LNHA stated, the purpose of the sign in sheets was to keep a record of who was there at that time. The RNC stated, the purpose of the IP attending was to review infection control, identify any trends or outbreaks we are having. A review of the facility policy Performance Improvement-QA Committee last revised 1-2024, revealed: Procedure: The Performance Improvement Committee shall be composed of, but not necessarily limited to the following personnel: -Administrator -Medical Director -Director of Nursing -Infection Preventionist (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-33.1(a)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48423 Based on observation, interviews and review of pertinent documentation, it was determined that the facility failed to a.) adhere to accepted standards of infection control practices for donning (put on) the required Personal Protective Equipment (PPE) prior to providing care to residents on isolation and Enhanced Barriers Precautions. (Resident #23 and #279) and b.) perform appropriate hand hygiene according to the Center for Disease Control (CDC) and the facility's policy. The deficient practice was evidenced by the following: 1. On 5/8/23 at 10:30 AM, during initial tour on unit 1 North, the surveyor observed a white signage posted at Resident #23's door. The door was closed and there was a PPE bin with yellow disposable gowns, outside the room. The surveyor observed the Contact Precautions signage which included but were not limited to; Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. On 5/9/23 at 12:34 PM, the surveyor observed a Certified Nursing Assistant (CNA) #1 take a lunch tray into Resident #23's room. CNA#1 did not don a yellow gown as the sign on the resident's door indicated before entering the room. Upon exiting Resident #23's room, The surveyor conducted an interview with the CNA. The CNA acknowledged that she did not have a gown on when entering the resident's room and she stated, I had gloves on and they didn't tell us to put a gown on before entering into this room when we are passing out trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:40 PM, the surveyor brought the Licensed Practical Nurse/Nurse Manager (LPN/UM) to the door of Resident #23 and asked what the Stop Contact Precautions signage meant. The LPN/UM stated that everything on the sign should be done before you enter the room. The LPN/UM stated that the resident was on contact isolation for Methicillin-resistant Staphyloccus Aureus (MRSA-a bacteria that causes infection) in the nares. She confirmed that CNA #1 should have donned a gown before entering the room. The LPN/UM stated that We need to gown up and put gloves on every time we go in this room because the staff is going to have contact with the patient the purpose of PPE was to prevent the spread of infection. The LPN/UM further explained to CNA #1, for contact isolation rooms, you need to put PPE for everything. The surveyor reviewed the medical records for Resident #23 which revealed the following: The Admission Record (AR) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Methicillin Resistant Staphylococcus Aureus infection as the cause of diseases classified elsewhere and Metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body). A review of the Order Summary Report indicated a physician order, dated from 5/7/24 to 5/10/24 and from 5/10/24 to 5/13/24 for Maintain Contact Precautions for MRSA every shift until 5/13/2024 15:00 (3:00 PM). A review of the May 2024 Treatment Administration Record (TAR) under Maintain contact precautions for MRSA every shift revealed that nursing had signed the TAR as completed for the Day, Eveni (evening) and Night shifts. A review of Nursing Progress Notes (PN) dated 5/8/24 at 00:22 (12:22 AM) revealed, on isolation precautions for unspecified MRSA. On 5/15/24 at 12:10 PM, during an interview with the Infection preventionist nurse (IPN), the IPN stated, Anyone going into contact isolation room, must have PPE and expectations from the staff are to do what the posted sign says. On 05/15/24 at 12:41 PM, the Director of Nursing(DON) , The Licensed Nursing Home Administrator (LNHA) and the Regional Nurse were informed of the above concerns. 27193 2. On 05/08/24 at 10:25 AM, the surveyor toured the Subacute Extension Unit (SAE) and observed signage posted at the door for enhanced barrier precautions which included but were not limited to; Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Care Activities. Dressing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy Wound Care: any skin opening requiring a dressing. The surveyor observed an isolation bin containing gowns, gloves and surgical mask in the hallway at the door entrance. On 05/08/24 at 10:30 AM, the surveyor entered the room and observed Resident #279 in bed. The head of the bed was elevated and the resident was resting with the eyes closed. The resident had a Foley Catheter (medical device that helps drain urine from the bladder) contained in a dignity bag and hung on the bedrail. On 05/08/24 at 11:37 AM, the surveyor observed 2 staff members in the room assisting Resident #279 with care. One staff was changing the bed linen and the other staff was assisting the resident with dressing. Both staff were observed with mask and no gown on. During an interview with staff #1 at 10:45 AM, she identified herself as a CNA (#2) and informed the surveyor that staff #2 was an orientee Nursing Assistant (NA). The CNA stated that Resident #279 had a Foley catheter, wore a leg bag during the day. On 05/10/24 at 10:30 AM, the surveyor knocked at the door, and the staff prompted the surveyor to enter the room. The curtain was drawn and the surveyor observed the NA at the beside assisting Resident #279 with care. The NA had a mask and gloves on. The NA did not have a gown on as required by the signage posted at the door. On 05/10/24 at 10:45 AM, the surveyor interviewed the Registered Nurse/Unit Manager regarding the above observation. The RN/UM revealed that the NAs should not be working alone. They just came in, they should be working with another CNA. The UM further stated that all staff should have on the required PPE while providing care. On 05/10/24 at 11:30 AM, review of the electronic medical record (EMR) reflected that Resident #279 was admitted to the facility with diagnoses which included, but were not limited to; muscle weakness and urinary tract infection, site not specified. A review of the Order Summary Report for May 2024, revealed the following orders for Resident #279: Foley Catheter Care every shift. Maintain Enhanced Barrier Precautions related to: Foley Catheter Use every shift for Disrupt potential spread of MDROs (Multi-drug Resistant Organisms.) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/15/24 at 08:53 AM, the surveyor interviewed CNA #2 who was observed in the room with the Orientee and not wearing the required PPE. The CNA stated that she was not aware that she had to have a gown on while changing the linen and could not provide the rationale for not wearing the required PPE while at the bedside providing care. On 05/15/24 at 1:15 PM, the facility was informed of the above concerns and requested the policy for Enhanced Barrier Precautions (EBP). 41858 4. On 05/09/24 at 11:32 AM, the surveyors entered an unsampled resident's room with CNA# 1 and CNA #3 for an incontinence care check. In the presence of the surveyors, CNA#1 performed hand washing as follows: she turned on the water, wet her hands, applied soap, lathered, and rubbed hands together for a total of 12 seconds outside of the running water, she rinsed her hands under the water, obtained a paper towel and dried her hands. CNA #3 walked over to the sink with the running water and performed hand washing as follows: she wet her hands, applied soap, lathered and rubbed hands together for a total of 11 seconds outside of the running water, she rinsed her hands under the water, obtained a paper towel, dried her hands and used a clean paper towel to turn off the water. Both CNA's donned gloves and proceeded with the incontinence check. 05/09/24 at 11:35 AM, after CNA# 1 and CNA# 3 exited the resident's, the surveyors interviewed them regarding hand washing. CNA#3 stated she sings the Happy Birthday song once while lathering her hands and then sings it again while rinsing her hands. She stated, It (lathering hands with soap) should be done for at least 20 seconds. CNA #1 agreed. CNA #3 stated, she counted in her head for 20 seconds while lathering. On 05/09/24 at 11:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated hand hygiene should be done before and after care, before and after medication administration and in between residents. She stated you turn on the water, wet hands, lather hands with soap for 30 seconds before rinsing. LPN#1 further stated you sing happy birthday 2 times while rubbing hands with soap, then rinse them, dry hands with a paper towel and take another paper towel to turn off the water. On 05/14/24 at 11:07 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN) regarding hand washing. She stated, hand hygiene should be done before any care, after eating, and after touching soiled things. The IPN stated hand washing was done with soap and water as follows: turn on the water, rub hands for 20 seconds with the soap, rinse hands, dry and use a clean paper towel to turn off the water. She stated staff could sing happy birthday a couple of times and sing it again while rinsing your hands. On 05/14/24 at 12:42 PM, during a meeting with the DON, the RNC and the LNHA, the surveyor presented the above concerns. The DON stated, you handwash every time you touch the patient, during care, in between patients and when hands are soiled. She stated, you turn on the water, wet hands, apply soap, lather and rub hands for 20 seconds, rinse hands, use a paper towel to dry and get another one to turn off the faucet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided Employee In-Service Education dated 4/18/24, Objective: Infection Control-Isolation Precautions + Hand Washing . revealed that CNA #1, CNA #2 and CNA #3 attended. A review of the facility provided annual Hand Hygiene Competency revealed a Yes under Competent for Hand Hygiene with Soap & Water .4. Vigorously rubs hands for at least 20 seconds including palms, back sides of hands between fingers, thumbs, and wrists for CNA #1, dated 6/6/23 and CNA #2, dated 6/5/23. On 05/16/24 at 8:15 AM, the Director of Nursing (DON) provided the policy for Enhanced Barrier Precautions. The following were noted: Purpose To outline the implementation of Enhanced Barrier Precautions to disrupt the potential spread of multidrug-resistant organisms. Procedure: EBP is used in conjunction with standards precautions and expand the use of PPE to don a gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Examples of high- contact resident care activities requiring gown and gloves use for Enhanced Barrier Precautions include: Dressing Providing hygiene Changing Linens . Indwelling medical devices examples include central lines, urinary catheters, feeding tubes and tracheostomies. EBP should be used for any residents who met the above criteria, wherever they reside in the facility . The policy was not being followed. A review of the facility's policy Handwashing/Hand Hygiene dated December 2023 revealed: Policy Interpretation and Implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Procedure: Washing hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) . Applying and removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's provided policy un-titled with revised date April 2024 revealed: Contact Precautions- are a type of Transmission-Based Precaution that is intended to prevent transmission of infectious agents, that are spread by direct or indirect contact with the resident or the resident's environment. Contact Precautions require the use of a gown and gloves on every entry into a resident's room. The resident is given dedicated equipment and is placed into a private room as available, cohorted, or grouped together. The facility will post clear signage on the door or wall outside of the resident room indicating the type of precautions and required person protective equipment (PPE), e.g., gown and gloves, along with the high-contact resident care activities requiring PPE. NJAC 8:39-19.4 (a) (1) (2) (5)