STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 03115 15879 42440 Based on observation, interview, record review, facility policy review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure three residents (Resident (R) 107, R129, and R92) out of 32 sampled residents had an accurate Minimum Data Set (MDS) assessment. This had the potential to cause the residents to have unmet care needs. Findings include: 1. Review of R107's Admission Record, located in the electronic medical record (EMR) under the Profile tab revealed the resident was initially admitted to the facility on [DATE] and had diagnoses that included osteomyelitis, personal history of transient ischemic attack (TIA), and cerebral infarction. Review of R107's Medication Administration Record (MAR) for January 2025 revealed an order for oxygen at 4 LPM [liters per minute] via trach signed off each shift from 01/21/25 to 01/31/25. Another order for tracheostomy care every shift was signed off from 01/21/25 to 01/31/25. Review of R107's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/31/25 and located in the resident's EMR under the MDS tab, documented R107 received no oxygen therapy nor tracheostomy care. The resident was rarely/never understood, and the Staff Assessment for Mental Status documented memory impairment. Review of R107's Care Plan located in the Care Plan tab of the EMR revealed a focus area, dated 02/17/25, The resident has a tracheostomy r/t [related to] impaired breathing mechanics. During an observation on 02/23/25 at 11:45 AM, R107 had a tracheostomy tube in place with oxygen flowing at 4 LPM via a tracheostomy mask. During an interview on 02/25/25 at 2:23 PM, the Regional Nurse stated she expected the MDS to reflect tracheostomy cares and oxygen use for someone who received them in the facility in the seven days prior to the MDS ARD date. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/25 at 1:06 PM, the Director of Nursing (DON) expected that MDSs were coded accurately. 2. Review of R129's EMR revealed she had an Admission Record located in the Profile tab which revealed she was admitted to the facility on [DATE] with diagnosis of multiple fractures of pelvis with stable disruption of pelvic ring, fusion of spine, encounter screening of human immunodeficiency virus, mononeuropathy, retention of urine, pain, laceration of the liver, and laceration of right kidney. According to the Miscellaneous information section of the Admission Record, the resident was discharged on [DATE] at 12:42 AM to a private home/apartment with home health services. Review of R129's discharge MDS with an ARD date of 12/19/24 and located in the MDS tab of the EMR revealed it was coded under Discharge Status that she went to a short-term general hospital. During an interview on 02/25/25 at 12:55 PM, Licensed Practical Nurse (LPN) 4 was interviewed. She stated the resident was picked up by her grandmother and was discharged either to her mother's home or her grandmother's home. She stated the resident did not go to the hospital. During an interview on 02/25/25 at 2:22 PM, the Regional Nurse. stated the MDS was inaccurately coded because the resident was discharged to a private home and was not discharged to a short-term hospital. 3. Review of R92's Admission Record face sheet located in the EMR under the Admission Record tab revealed he was admitted to the facility on [DATE] after hospitalization with diagnoses which included quadriplegia, hypertension, and sepsis. Review of the admission assessment dated [DATE] and located under the Progress Notes tab of the EMR, revealed R92 had redness to the sacral area. Review of the skin assessment on 12/02/24 located under the Progress Notes tab of the EMR, revealed the sacral area had an area that was two-three centimeters but was not staged. Review of the Nurse Practitioner (NP) progress notes for 11/29/24 and located under the Progress Notes tab of the EMR, revealed R92 had impaired skin integrity with deep tissue injury and a wound consultation was ordered. Review of R92's admission MDS assessment located in the MDS tab of the EMR with an ARD of 12/04/24 revealed R92 did not have a BIMS score available. Review of the MDS further revealed R92 did not have any unhealed pressure ulcers and was not at risk for developing pressure ulcers. Review of the MDS revealed R92 did not have any other ulcers, wounds, or skin problems. Review of the MDS revealed R92 had nutrition or hydration interventions to manage skin problems, treatments of pressure ulcer/injury care, application of non-surgical dressings other than to feet, and applications of ointments and medications other than to the feet were checked as applicable for R92. Review of the physician orders dated 12/04/24 and located under the Orders tab of the EMR, revealed R92 had an order for wound care to the right buttock wound. Review of the Wound Consult progress notes dated 12/06/24 and located under the Evaluations tab of the EMR, revealed R92 had a stage two pressure injury to the right buttock. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/25 at 2:41 PM with the Regional Nurse verified the admission MDS was inaccurate. The Regional Nurse reviewed the admission MDS dated [DATE] and revealed R92 did not have any pressure concerns coded on the MDS. However, the Regional Nurse reviewed the admission skin assessment done on 11/27/24 which revealed there was redness to the sacrum and on the 12/02/24 skin assessment there was a two-to-three-centimeter pressure area to the sacrum but was not staged. The Regional Nurse reviewed the physician orders dated 12/04/24 and further revealed that R92 had orders for treatment to the right buttock and the sacral area was healed. The Regional Nurse revealed the admission MDS should have reflected the pressure area and the risk for further pressure areas. The Regional Nurse revealed the pressure ulcer area on the MDS which showed treatment was correct, but the pressure ulcer area was not coded correctly. The Regional Nurse revealed the MDS should have been coded as a pressure area existing on the sacral and buttock areas. Review of the facility's policy titled, MDS Guideline for Completion, reviewed October 2024, revealed It is the policy of [facility] to ensure accurate and timely completion of MDS . in accordance with Federal and State Operation Manual. Review of the RAI (Resident Assessment Instrument) Manual, dated 10/01/24 and located at https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual revealed .It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [interdisciplinary team] completing the assessment . NJAC 8:39-33.2(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 42440 Based on record review, interview, and facility policy review, the facility failed to complete a new level one Preadmission Screening and Resident Review (PASARR) when a psychiatric diagnosis was identified for one of three residents (Resident (R) 20) and failed to ensure level II was conducted for one of three residents (R101) reviewed for PASARR out of 32 sample residents. This had the potential for a failure to identify what specialized or rehabilitative services the residents needed and whether placement in the facility was appropriate. Findings include: 1. Review of R20's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] without a psychiatric diagnosis. Review of R20's Pre-Admission Screening and Resident Review (PASARR) Level I Screen, located in the Misc tab of the EMR, revealed the hospital completed the form on 09/01/23 and documented no diagnosis or evidence of a major mental illness. Review of R20's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 09/11/23 revealed R20 had not been evaluated for a Level II PASARR and determined to have a serious mental illness and/or intellectual disabilities or a related condition. R20 had no schizophrenia diagnosis. Review of R20's diagnoses under the Med Diag tab of R20's EMR revealed the facility entered a diagnosis of schizoaffective disorder on 09/13/23, with an onset date of 09/12/23. Review of a Nursing Progress Note, dated 09/25/23 and located in the Prog Note tab of the EMR, revealed Call was placed to [daughter] in ref [reference] to her mother's psych history. [Daughter] stated that her mother was diagnosed with schizophrenia and bipolar disorder years ago. Review of R20's quarterly MDS assessment with an ARD of 12/02/24 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of six out of 15 indicating R20 was severely cognitively impaired. She had a diagnosis of schizophrenia (e.g., schizoaffective, and schizophreniform disorders). Review of R20's EMR revealed there was no evidence of a new PASARR level one screen after the facility added the schizoaffective diagnosis. During an interview on 02/25/25 at 11:16 AM, the Regional Nurse stated the MDS Coordinator (MDSC) who entered the schizoaffective diagnosis into the EMR was out of the country. The Regional Nurse stated she would check to see if a new PASARR level one screen had been completed with the addition of the schizoaffective diagnosis. The Regional Nurse stated the facility normally received the PASARR level one screen from the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/25 at 12:14 PM, the Regional Nurse reported she could not find a new PASARR level one screen when the diagnosis was added. The Regional Nurse stated the facility should have completed one at the time of the diagnosis. During an interview on 02/26/25 at 10:34 PM, the Social Services Director (SSD) stated if the social services department was made aware of a new psychiatric diagnosis, they should complete a new PASARR level one screening with the updated information. During an interview on 02/26/25 at 1:06 PM, the Director of Nursing (DON) stated she expected a new PASARR level one screening to be completed with the addition of a new psychiatric diagnosis. 2. Review of R101's Admission Record located under the Profile tab of the EMR revealed R101 was originally admitted to the facility on [DATE] with diagnoses that included depression, a history of mental and behavioral disorders, end stage renal disease, and general anxiety disorder. Review of the quarterly MDS with an ARD of 01/27/25 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated the resident had intact cognition. Review of R101's PASARR Level I Screening Tool, dated 02/15/24 and located under the Miscellaneous tab of the EMR, indicated a Positive Screen for MI (mental illness) based on responses to questions in Section II. Screening Outcomes, located in Section IV, revealed R101 was found to have a Positive screening under Section II and should have been referred for a level II. During an interview on 02/26/25 at 9:22 AM the SSD confirmed that the facility was aware of R101's positive Level I PASARR screening. She stated that the facility had been working with their psychological services department to get the resident scheduled for a Level II screening. In a subsequent interview, SSD stated that the facility was allowed to admit residents who had a positive screening but reiterated that she was working to get the resident a Level II screening. During an interview on 02/26/25 at 9:30 AM, the Assistance Director of Nursing (ADON) confirmed that the PASARR Level II Screening was requested yesterday, which would have been 02/25/25. Review of the facility's undated policy titled, Screen/ Pre-Admission Screen Resident Review (PASRR) Process, revealed If an issue is identified, it is reported to the Director of Social Services for further evaluation and consultation . Social Services is responsible receiving and confirming all PASSR Level I are completely correctly and if a Level II review is required. NJAC 8:39-40.3(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 42440 Based on record review, interviews, and facility policy review, the facility failed to ensure a comprehensive care plan was developed for three of 32 sample residents (Resident (R) 13, R56, and R121) reviewed for care plans specific to vision, oxygen use, and boots for skin protection. The failures had the potential to affect resident care. Findings include: 1. Review of R13's Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses that included end stage renal disease and heart failure. Review of R13's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/25 and located in the resident's EMR MDS tab, revealed R13 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated intact cognition. The MDS documented R13 had impaired vision. Review of the Care Area Assessment (CAA) revealed, Triggers due to visual deficits. This puts resident at risk for falls and safety issues and decreased socialization and quality of life. Staff to provide support as needed to maximize his independence by informing him of item placement, who they are and providing adequate lighting. Review of the Orders tab of R13's EMR revealed an order, dated 01/25/25, for ophthalmology consult as needed blurry vision. Review of R13's Care Plan, located in the Care Plan tab of the EMR, revealed no documentation of vision impairment or associated interventions. During an interview on 02/23/25 at 10:19 AM, R13 reported he had cataracts which needed surgery. R13 reported he was unable to clearly see the TV in his room. During an interview on 02/26/25 at 12:44 PM, the Licensed Practical Nurse (LPN) Unit Manager (UM) 1 stated the unit managers initiated the care plans upon a resident's admission and updated them with changes. UM1 reported she was unfamiliar with CAAs. During an interview on 02/26/25 at 12:58 PM, the Regional Nurse reported if a CAA was triggered on the MDS, it was expected to be on the care plan. The MDS Coordinator (MDSC) was expected to review and sign off on the care plans. During an interview on 02/26/25 at 1:06 PM, the Director of Nursing (DON) reported a CAA area was expected to be on the care plan. 2. Review of R56's Profile tab of the EMR revealed she was initially admitted to the facility on [DATE] and had a hospital stay from 12/28/24 to 01/06/25. R56 had diagnoses of bronchiectasis, with onset date of 01/07/25, and acute respiratory failure with hypercapnia, dated 01/09/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R56's quarterly MDS with an ARD of 12/16/24 and located in the resident's EMR MDS tab, revealed R56 had a BIMS score of 13 out of 15 which indicated intact cognition. R56 did not utilize oxygen. Review of the Orders tab of R56's EMR revealed an order, dated 01/06/25, for oxygen at 2 LPM [liters per minute] via nasal cannula every shift. Review of R56's five-day MDS with an ARD of 01/13/25 and located in the resident's EMR section titled MDS revealed R56 had a BIMS score of 12 out of 15 which indicated moderately impaired cognition. R56 utilized oxygen. Review of R56's Care Plan located in the Care Plan tab of the EMR, revealed no documentation of the resident's need for supplemental oxygen. During a concurrent observation and interview on 02/23/25 at 11:59 AM, R56 was observed lying in bed with an oxygen concentrator administering oxygen at 5-LPM via a nasal cannula. R56 reported she had used oxygen since returning from the hospital. R56 did not know what her orders were for the oxygen setting. During an interview on 02/24/25 at 2:04 PM, LPN5 reported R56 had orders for oxygen to be delivered at 2-LPM and changed the oxygen concentrator setting from 3.5 LPM to 2-LPM. During an interview on 02/26/25 at 12:28 PM, LPN3 stated he was not involved in the care planning process and was unsure where to look in the EMR to find care plans. During an interview on 02/26/25 at 12:33 PM, Certified Nurse Aide (CNA) 6 stated if she wanted to know how to care for a resident, she referred to their hard chart or asked the nurse. CNA6 was unaware of anywhere she could look for a plan of care in the EMR. During an interview on 02/26/25 at 12:44 PM, UM1 stated the unit managers initiated the care plans upon a resident's admission and updated them with changes. UM1 reported oxygen should have been addressed on R56's Care Plan and verified it was not addressed. During an interview on 02/26/25 at 1:06 PM, the DON reported oxygen use was expected to be on the care plan. 3. Review of R121's admission MDS located in the MDS tab of the EMR with an ARD of 01/13/25, R121 had a BIMS score of 11 out of 15 which indicated moderately impaired cognition. Review further revealed R121 hand upper and lower impaired range of motion (ROM) to one side and was dependent on lower body dressing and putting on footwear. Review of the MDS revealed R121 was at risk for pressure sores. Review of the physician's order, dated 02/02/25, located under the Orders tab of the EMR revealed an order for heel protector boots to both feet while in bed to ensure skin and joint integrity and R121 needed assistance to apply and remove the boots. Review of the physician orders revealed an order, dated 02/02/25, for Multipodus boots to both feet while out of bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review R121's comprehensive care plan located under the Care Plan tab of the EMR with an initiated date of 01/06/25 revealed a problem was addressed for limited ROM but there was no intervention for green boots or black boots. Review of the care plan further revealed a problem was listed for dependence on staff for meeting Activities of Daily Living (ADL) and the interventions did not include the use of green boots or black boots. Review of the care plan further revealed a problem was listed for R121 for being at risk of skin impairment but no interventions for the boots were listed. During an interview on 02/25/25 at 10:12 AM, UM1 revealed it was CNA's responsibility to put the boots on R121. UM1 revealed the CNA point of care screen and verified there were no interventions for the boots to alert the CNA of the need for them. UM1 revealed it was the unit manager's responsibility to put the information into the computer for the CNA's and it had not been added. During an interview on 02/26/25 at 1:23 PM, the DON revealed all residents' care plan should be followed and the care plan was the basis of how staff should care for them. The DON revealed if the care plan was not followed or not accurate then a resident's care may not be what the resident needed. The DON revealed the care plan was like a recipe for how to take care of a resident. During an interview on 02/26/25 at 3:14 PM, the Regional Nurse revealed care plans should be followed. The Regional Nurse revealed the purpose of the care plan was to establish guidelines on how to care for a resident. The Regional Nurse revealed the nurse who admitted the resident would initiate the care plan then each discipline would follow up. The Regional Nurse revealed the MDS coordinator was responsible for verifying the care plan was in place and that it was accurate. Review of the facility's policy titled Care Planning with a revised date of 09/24, revealed an individualized comprehensive care plan would be developed for each resident. The policy revealed the comprehensive care plan was based on a thorough assessment that identified the highest level of functioning the resident may be expected to attain. The policy further revealed it reflected the residents' wishes regarding their care. The policy revealed identified problems would have interventions that were targeted and meaningful Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan .The Care Planning/ Interdisciplinary Team is responsible for the review and updating of care plans . when the resident has been readmitted to the facility from a hospital stay. Review of the facility's policy titled, MDS Guideline for Completion, revised October 2024, revealed that MDS director or MDS assessors will be responsible to ensure that all CAAs are completed and addressed in residents care plan before signing section V0100B. It also stated, The IDT [interdisciplinary team] is responsible for reviewing all resident strengths, problems, needs and plan of care to insure the delivery of appropriate and quality care. NJAC 8:39-11.2(e)thru(i) NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 15879 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure proper incontinence care assistance to avoid double briefing for one of two residents (Resident (R) 92) reviewed for incontinence care of 32 sample residents. This failure put R92 at risk of pressure sore formation and skin breakdown. Findings include: Review of R92's Admission Record face sheet located in the electronic medical record (EMR) under the Admission Record tab revealed he was admitted to the facility on [DATE] after hospitalization with diagnoses of non-traumatic acute subdural hemorrhage, anoxic brain damage, chronic obstructive pulmonary disease (COPD), atrial fibrillation, convulsions, acute embolism and thrombosis of deep veins, quadriplegia, hypertension, and sepsis. Review of R92's admission Minimum Data Set (MDS) assessment located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/04/24 revealed R92 did not have a Brief Interview for Mental Status (BIMS) available. Review of the MDS further revealed R92 was dependent on staff with all Activities of Daily Living (ADL). R92 was totally dependent on staff for toileting hygiene. Review of the MDS further revealed R92 was always incontinent of bowel and bladder and was not a candidate for a bowel and bladder program. Review of R92's comprehensive care plan located in the Care Plan tab of the EMR with an initiated date of 11/27/24 and revised on 12/04/24 revealed a problem for dependence on staff for meeting all R92's daily living needs which included toileting, dressing, personal hygiene, bathing, repositioning, bowel, and bladder elimination. Review of R92's comprehensive care plan located in the Care Plan tab of the EMR and initiated on 12/04/24 further revealed a problem for bowel and bladder incontinence with an intervention for pericare after every incontinent episode. Review of R92's comprehensive care plan located in the Care Plan tab of the EMR and initiated on 12/04/24 further revealed a problem for incontinent of bladder and was at risk for urinary tract infections. The care plan revealed the peri area was to be cleaned after each incontinent episode and the peri area was to be monitored for skin integrity. Review of the physician orders, dated 12/31/24, located under the Orders tab of the EMR, revealed an order for zinc oxide to the bilateral buttocks to be done every shift for protection. During an interview on 02/23/25 at 4:21 PM Family Member (FM) 1 revealed she had a concern with R92 being double briefed and showed this surveyor that he was indeed double briefed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/23/25 at 4:39 PM, Licensed Practical Nurse (LPN) 7 was going to get a Certified Nurse Aide (CNA) to change R92 but came back into the room without the CNA, who was on their lunch break. Observation further revealed LPN7 applied personal protective equipment (PPE) and checked R92's brief and verified he was double briefed, and the blue inner brief was soaked with urine and the yellow brief was slightly wet. During an interview on 02/23/25 at 4:45 PM, LPN7 revealed to her knowledge residents should not be double briefed and it was so wrong because it could cause skin breakdown. During an interview on 02/23/25 at 4:45 PM, CNA3 revealed a resident should not be double briefed and he did not have R92 that day. CNA3 further revealed if a resident was double briefed and not changed when wet, the resident was more at risk for a bedsore to worsen or develop a new pressure sore. During an observation on 02/24/25 at 1:43 PM, CNA4 was giving a bed bath to R92, and he was double briefed again. Observation further revealed the blue inner brief was wet, but the yellow outer brief was dry. During an interview on 02/25/25 at 1:23 PM, the Director of Nursing (DON) revealed no residents should be double briefed unless they have requested to be. The DON revealed there was only one resident in the facility who had requested to be double briefed, and it was not R92. The DON further revealed if a resident was double briefed it could cause skin breakdown and if a resident had a history of pressure sores, then it would put them more at risk of recurrent pressure sores. Review of the facility's undated policy titled, Incontinence Care Plan revealed it was the policy of the facility to provide care to residents who were incontinent of bowel and bladder. The policy further revealed CNA' s would follow a residents incontinence program as instructed in the CNA task. The policy further revealed residents should be checked for incontinence at least every two hours and the residents should be toileted as needed. The policy revealed brief, and pads should be used appropriately with one pad on the residents' bed and one diaper on the residents. The policy further revealed that briefs and pads were to be changed immediately when wet or soiled and pericare was to be completed. NJAC 8:39-4.1(a) NJAC 8:39-21.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure activities were provided according to assessments and care plans for five of six residents (Resident (R) 5, R87, R92, R112, and R121) reviewed for activities out of the 32 sample residents This failure had the potential to affect the residents social and mental status. Findings include: 1. Review of R5's Admission Record face sheet located in the Admission Record tab of the electronic medical record (EMR) revealed R5 was readmitted to the facility on [DATE] with diagnoses of cerebral infarction, hemiplegia and hemiparesis, dysphagia, congestive heart failure (CHF), peripheral vascular disease, diabetes, and hypertension. Review of R5's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 12/16/24 revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated severely impaired cognition. Review of the MDS further revealed it was very important to R5 to do her favorite activities. Review of R5's MDS revealed she was dependent on staff for dressing and transfers. Review of the MDS further revealed chair to bed and back to chair transfers did not occur during the look back period. Review of R5's comprehensive Care Plan located under the Care Plan tab in the EMR, with a target date of 12/15/24 revealed a problem for activities that included R5 being invited to scheduled activities and that were compatible with individual needs and abilities. During an interview on 02/23/25 at 9:30 AM, R5 revealed she did not go to activities in the dining room because she was not invited, and she wanted to go. Review of the January 2025 activity calendar revealed there were approximately 65 activities that were available in the dining room. Review of the February 2025 activity calendar revealed there were approximately 50 activities that were available in the dining room. Reviews of January 2025 and February 2025 log for R5 revealed she had not attended any of those activities. Review of the February 2025 activity calendar revealed on Sunday 02/23/25 at 2:00 PM bingo was being conducted in the dining area. On Monday 02/24/25 at 10:00 AM, the activity calendar revealed communion was being done, at 10:20 AM a blackjack activity was being done in the main dining room. On Tuesday 02/25/25 at 10:30 AM the activity calendar revealed sit, and stretch was going on in the main dining room. During an observation on 02/24/25 at 10:44 AM, R5 was in bed and awake and had not gone to the blackjack activity being done in the main dining room. During an observation on 02/25/25 at 10:44 AM, R5 was sitting up in her bed in her room while the sit and stretch activity was going on down in the dining room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/25/25 at 10:44 AM R5 stated she had not been asked to go to the exercise program downstairs, and she would have gone if she had been asked. The interview further revealed she did not receive communion on Monday and was not asked to attend. R5 revealed she was Methodist and would receive communion if asked and she had never had communion since being at the facility. During an interview on 02/26/25 at 11:29 AM the Activity Director (AD) revealed R5 had not gone to the dining room for activities for the month of January or February because they had not had any music or dancing entertainment which R5 enjoyed. The Activity Director revealed the main activities done with R5 were conversation, coffee cart, chronicle news, and snack and beverage cart. The Activity Director further revealed R5 also liked entertainment and if she did not go to the baking activities downstairs, they brought the food up to her. During an interview on 02/26/25 at 12:58 PM, the Recreation Aid (RA) revealed R5 liked to go to anything that was going on and special events and he assisted her if she was up. The RA revealed he tried to get staff to get her up so R5 could go to the activities she enjoyed. 2. Review of R87's Admission Record face sheet located in the Admission Record tab of the EMR, revealed R87 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of nontraumatic intracerebral hemorrhage, respiratory failure, failure to thrive, tracheostomy complications, gastrostomy status, and anxiety. Review of R87's annual MDS located under the MDS tab in the EMR, with an ARD of 01/06/25 revealed a BIMS was not conducted due to resident was rarely/never understood. Review of R87's comprehensive care plan located under the Care Plan tab in the EMR, with a revision date of 01/15/25, revealed a problem for activities was listed and the interventions included R87 needed one-on-one bedside/in-room activities if unable to attend out-of-room events. Review of the January 2025 activity calendar revealed there were approximately 65 activities that were available in the dining room. Review of the February 2025 activity calendar revealed there were approximately 50 activities that were available in the dining room. Review of the January 2025 and February 2025 log for R87 revealed he had not attended any of those activities. Reviews of the January 2025 and February 2025 log for R87 revealed he had room visits daily, but the log did not specify what activities were done. During an observation on 02/23/25 at 10:50 AM R87 was lying in his room with no television or radio playing. During an observation on 02/24/25 at 10:42 AM R87 was lying in bed in his room and was awake. Observation further revealed R87's brother was at bedside. Observation further revealed Enhanced Barrier Precautions (EBP) was posted on the door. During an interview on 02/24/25 at 10:42 AM Family Member (FM) 2 revealed R87 did not verbally respond. FM2 further revealed the staff did not get him up and he did not go to any activities. FM2 further revealed that R87 liked music. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 11:29 AM the AD revealed the RA was the activity person that provided activities to the residents on the third floor. During an interview on 02/26/25 at 11:55 AM the AD revealed R87's room visits consisted of hand massages, music channels, shut curtains for relaxation, and putting the television on. The AD revealed R87 did not speak English, so the music was in Spanish. During an interview on 02/26/25 at 1:06 PM the RA revealed R87 was on room visits but he had not done them, and another activity assistant might have done R87's activities. 3. Review of R92's Admission Record face sheet located in the Admission Record tab of the EMR, revealed R92 was admitted to the facility on [DATE] with diagnoses of nontraumatic acute subdural hemorrhage, anoxic brain damage, chronic obstructive pulmonary disease, atrial fibrillation, embolism and thrombosis of deep veins in extremities, convulsions, sepsis, quadriplegia, hypertension, and epilepsy. Review of R92's admission MDS under the MDS tab in the EMR with an ARD of 12/04/24 revealed a BIMS was not conducted because R92 was rarely/never understood and his decision-making ability was severely impaired. Review of the MDS further revealed R92 had a tracheostomy. Review of R92's comprehensive care plan located under the Care Plan tab in the EMR, with a target date of 12/17/24 revealed a problem for activities and one of the interventions was for one-on-one bedside/in-room visits if unable to attend out of room events. Review of the physician orders under the Orders tab in the EMR, dated 11/28/24 and revised on 02/13/25, revealed R92 was nothing by mouth (NPO). Review of the January 2025 activity calendar revealed there were approximately 65 activities that were available in the dining room. Review of the February 2025 activity calendar revealed there were approximately 50 activities that were available in the dining room. Review of the log for R92 revealed he had not attended any of those activities. Review of the January 2025 log revealed R92 received room visits every day, however it was not always noted what activity was done. Review of the January log further revealed on 01/12/25 through 01/16/25 and 01/20/25 through 01/22/25, R92 received conversation, snack, and beverage visits, and on 01/21/25, R92 had a food social activity. Review of the February 2025 activity log revealed room visits were done but there was no documentation of what the room visit consisted of. Review further revealed the room visits did not have a signature of who had completed the activity. During an observation on 02/23/25 at 4:02 PM, R92 was lying in bed, and his wife and son were visiting him. Observation further revealed EBP was posted on the door caddie of the resident's room. During an interview on 02/23/25 at 4:21 PM, Family Member (FM) 1 revealed staff never got R92 up and he did not go to any activities. FM1 revealed the Geri-chair that R92 used was broken and they had not yet replaced it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 02/24/25 at 9:47 AM, 10:40 AM, and 1:43 PM, R92 was lying in bed in his room and the television and radio were not on. During an observation on 02/25/25 at 8:48 AM and 9:15 AM, R92 was lying in bed in his room and the radio and television were both on at the same time. During an observation on 02/26/25 at 8:39 AM, R92 was lying in bed in his room and the radio and television were both on at the same time. During an interview on 02/26/25 at 8:54 AM, Therapy Director revealed the Geri-chair was broken, and they had ordered another one, but it had not arrived yet. The Therapy Director revealed therapy had established it was okay to get R92 up in a Geri-chair. During an interview on 02/26/25 at 11:40 AM, the AD revealed R92 preferred to stay in his room, so room visits that consisted of conversation and about life in general were done. The interview further revealed she was not sure if the Geri-chair was broken. The interview further revealed, after she reviewed the January 2025 log, if R92 had a trach then he would not get the snack and beverage activity as documented on the log. The Activity Director revealed she was not sure if he had a trach. During an interview on 02/26/25 at 12:51 PM, the RA revealed R92 did not go downstairs for any activity, and he had not done any activities with him. The RA revealed if they had an extra person, they would do more one on one activities. 4. Review of R112's Admission Record face sheet located in the Admission Record tab of the EMR, revealed R112 was admitted to the facility on [DATE] with diagnoses of nontraumatic intracerebral hemorrhage intraventricular, dysphagia, aphonia, and pneumonia. Review of R112's admission MDS located under the MDS tab in the EMR with an ARD of 11/23/24 revealed a BIMS was not conducted due to R112 being rarely/never understood and had severely impaired decision-making skills. Review of R112's comprehensive care plan located under the Care Plan tab in the EMR, with a target date of 12/26/24, revealed a problem for activities and the interventions included the resident needed one on one bedside/in room visits and activities if unable to attend out of room events. Review of the January 2025 activity calendar revealed there were approximately 65 activities that were available in the dining room. Review of the February 2025 activity calendar revealed there were approximately 50 activities that were available in the dining room. Review of the log for R112 revealed he had not attended any of those activities. Review of January 2025 and February 2025 log for R112 revealed he had room visits but there was no documentation of what those visits consisted of or what activity person had completed the activity. Review revealed the log that was kept in a book where the RA documented what activity was done. During an observation on 02/23/25 at 11:45 AM, R112 was lying in bed, and no activities were being done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/24/25 at 12:44 PM, R112 was lying in bed and was awake with no activities being done. During an observation on 02/25/25 at 8:59 AM, R112 was lying in bed, and no activities were being done. During an interview on 02/26/25 at 11:57 AM, the AD revealed R112 received room visits daily which consisted of television, music on the television, hand massages, sensory things with lights and music. The AD further revealed R112 spoke and understood English. During an interview on 02/26/25 at 1:04 PM, the RA revealed he did not do any in-room visits with R112 but there were other activity assistants who might have. The RA further revealed R112 did not speak English and was nonverbal. 5. Review of R121's Admission Record face sheet located in the EMR under the Admission Record tab revealed R121 was admitted to the facility on [DATE] with diagnoses of diffuse traumatic brain injury, traumatic subarachnoid hemorrhage, fracture of skull and facial bone, zygomatic fracture right side, stable burst facture of fourth thoracic vertebra, stable burst fracture of the first lumbar vertebra, wedge compression fracture of the second lumbar vertebra, epilepsy, depression, and anxiety. Review of R121's admission MDS located in the MDS tab of the EMR with an ARD of 01/13/25, R121 had a BIMS of 11 out of 15 which indicated moderately impaired cognition. Review further revealed R121 hand upper and lower impaired range of motion (ROM) to one side and dependent on staff for transfers. Review of the MDS further revealed it was somewhat important to him to participate in religious services, to do favorite activities, to listen to music, and participate in group activities. Review R121's comprehensive care plan located under the Care Plan tab of the EMR with an initiated date of 01/06/25 revealed a problem was listed for dependence on staff for meeting social needs and one intervention was to ensure R121 attended activities that were compatible with his interests, preferences, and physical condition. Review further revealed R121 should be invited to scheduled activities and one-on-one room visits if unable to attend out-of-room events. During an observation on 02/23/25 at 4:14 PM, R121 was lying in bed in his room and the television was on. During an observation on 02/24/25 at 8:38 AM, R121 was lying in bed in his room and no activities were being provided. During an observation on 02/24/25 at 10:38 AM, R121 was lying in bed in his room and no in-room activities were being done. During an observation on 02/24/25 at 1:04 PM, R121 was lying in bed in his room and no in-room activities were being done. During an interview on 02/25/25 at 10:04 AM, CNA4 revealed she had taken care of R121 on Monday 02/24/25 and was R121's aide today. CNA4 further revealed R121 had not been to any activities on those days. CNA4 revealed she was not even sure if he was supposed to go to any activity since he had just gotten to the unit Friday from another floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 9:43 AM, the AD revealed residents that were on EBP were not allowed to go to the dining room for activities such as entertainment, but the staff could do activities with them in their rooms. During an interview on 02/26/25 at 11:45 AM, the AD revealed RA did the activities for the third floor. The interview further revealed, after she reviewed the activity logbook twice, she could not find the January 2025 or February 2025 logs for R121. The AD revealed the pages may have fallen out and would look for the pages. During an interview on 02/26/25 at 12:26 PM, the Infection Preventionist (IP) revealed there was no reason why a resident that was on EBP could not go to any of the activity's downstairs. IP further revealed residents that had a trach did not have to stay in their rooms all the time. During an interview on 02/26/25 at 12:30 PM, the AD revealed she had overlooked the pages in the book and found his record of activities. The interview further revealed R121 had room visits for the months of January 2025 and February 2025 but there was no documentation of what activities had been done. During an interview on 02/26/25 at 1:23 PM, the Director of Nursing (DON) revealed residents that were on EBP could go to the dining room downstairs for any activity. The DON further revealed residents' activities should be established around their likes and dislikes, Review of the facility's policy titled, Activities, with a revised date of 02/19/25, revealed it was the policy of the facility to provide an ongoing activity program to support residents in their choices of activities. The policy further revealed activities referred to any endeavor, other than routine Activities of Daily Living (ADL) that enhance the resident's sense of well-being and emotional health. The Activity policy further revealed activities would be designed to reflect the residents' interests and religious preferences. Review of the facility's policy titled, Enhanced Barrier Precautions (EBP) with a revised date of 02/25, revealed residents that were on EBP were permitted to leave their room to participate in activities. The policy further revealed EBP should not prevent a resident from participating in a group activity or restrict a resident to their room. NJAC 8:39-7.3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure physician orders were followed for two of 32 sample residents (Resident (R) 121 and R89) reviewed for orders regarding boots to prevent skin breakdown for R121 and dressing change for R89. This failure put residents at risk for skin breakdown, infection, and worsening contractures. Findings include: 1. Review of R121's Admission Record face sheet located in the electronic medical record (EMR) under the Admission Record tab, revealed R121 was admitted to the facility on [DATE] with diagnoses of zygomatic fracture right side, stable burst facture of fourth thoracic vertebra, stable burst fracture of the first lumbar vertebra, and wedge compression fracture of the second lumbar vertebra. Review of R121's admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/13/25 revealed R121 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated moderately impaired cognition. Review further revealed R121 had hand upper and lower impaired range of motion (ROM) to one side and was dependent on lower body dressing and putting on footwear. Review of the MDS revealed R121 was at risk for pressure sores. Review of R121's comprehensive care plan located under the Care Plan tab of the EMR with an initiated date of 01/06/25 revealed a problem was addressed for limited ROM but there was no intervention for green boots or black boots. Review of the care plan further revealed a problem was listed for dependence on staff for meeting Activities of Daily Living (ADL) and the interventions did not include the use of green boots or black boots. Review of the care plan further revealed a problem was listed for R121 for being at risk of skin impairment but no interventions for the boots were listed. Review of the physician's order, dated 02/02/25, located under the Orders tab of the EMR revealed an order for heel protector boots to both feet while in bed to ensure skin and joint integrity and R121 needed assistance to apply and remove the boots. Review of the physician orders, dated 02/02/25, revealed an order for Multipodus boots to both feet while out of bed. During an observation on 02/23/25 at 4:14 PM, R121 was lying in bed and did not have any boots on his feet. During an observation on 02/24/25 at 8:38 AM, R121 was lying in bed and did not have any boots on his feet. During an observation on 02/24/25 at 10:38 AM, R121 was lying in bed and did not have any boots on his feet. Observation further revealed there were green boots lying on the chair in the room. During an observation on 02/24/25 at 1:04 PM, R121 was lying in bed and did not have any boots on his feet. Observation further revealed there were green boots lying in the chair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/25/25 at 10:05 AM, R121 was lying in bed and did not have any boots on his feet. Observation further revealed green and black boots were on the chair in the room. During an interview on 02/25/25 at 10:06 AM Certified Nursing Assistant (CNA) 4 revealed that the green boots were to be used when a resident was in bed and the black boots were to be used when the resident was up in a wheelchair. CNA4 revealed R121 had come to the unit on Friday, and she had not taken care of him before. CNA4 revealed she had seen the boots lying on the chair but did not know his schedule. CNA4 revealed she did not get any report from the nurses yesterday or today about his care. CNA4 revealed, after she reviewed the tablet that had the care needs of R121, there was not any indication that R121 needed to have the boots on his feet. CNA4 tried to look at the care plan on the tablet but she did not know how to get to the care plan to advance to the next page. The CNA4 confirmed the boots were not on the resident. During an interview on 02/25/25 at 10:12 AM with the Licensed Practical Nurse (LPN) Unit Manager (UM) 1 revealed it was CNA's responsibility to put the boots on R121. UM1 revealed the nurse told the CNA what the care needs were for R121, and it should be on the tablet. UM1 revealed R121 received green boots to his feet when in bed to prevent skin breakdown. UM1 further revealed R121 was to wear the black [NAME] boots on his feet when he was up in the wheelchair. UM1 reviewed the CNA point of care screen and verified there were no interventions for the boots to alert the CNA of the need for them. UM1 revealed it was the unit manager's responsibility to put the information into the computer for the CNA's and it had not been added. During an interview on 02/26/25 at 9:29 AM, the Therapy Director revealed R121 had been admitted to the facility from the hospital and the boots were already established from there and the therapy department did not have to address them. The Therapy Director further revealed the heel protectors should have been worn in bed for offloading to prevent skin breakdown. The Therapy director further revealed R121 was at risk of skin breakdown if boots were not being utilized. During an interview on 02/26/25 at 1:23 PM, the Director of Nursing (DON) revealed after an order was obtained it should be documented in the task section so the CNA's can see what the residents' needs were. The DON revealed if the order was not transferred over to the task, then the CNA might not be able to see the care needs. During an interview on 02/26/25 at 3:14 PM, the Regional Nurse revealed R121 had an order for the green boots to be worn when he was in bed. The Regional Nurse further revealed the green boots, and the black boots were not on the comprehensive care plan and should be an intervention for the resident. The Regional Nurse revealed R121 was at risk for skin breakdown and the boots should be utilized on the feet. 2. Review of R89's Admission Record located under the Profile tab of the electronic medical record revealed R89 was originally admitted to the facility on [DATE] with diagnoses that included diabetes mellitus due to underlying condition with diabetic chronic kidney disease, end stage renal disease, sepsis due to methicillin resistant staphylococcus Aurea (MRSA), and MRSA infection as the cause of diseases. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/23/25 at 11:20 AM, R89 was ambulating, unassisted, throughout the 4th floor. The resident was not wearing a top and a large bandage could be seen on the resident's left pectoral. Hanging from the bandage was a peripherally inserted central catheter (PICC) line along with a clamp. Upon closer assessment at 11:27 AM, the bandage revealed a date of 02/14/25. Review of the admission MDS with an ARD of 01/31/25 located under the MDS tab of the EMR revealed a BIMS score of 15 out of 15 which indicated R89 was cognitively intact. During an interview on 02/23/25 at 3:03 PM, R89 stated he did not recall the last time his bandage was changed but advised that he has had no complications related to his PICC line. Review of R89's orders located under the Orders tab of the EMR revealed the following dressing change orders: 1) Change PICC/Midline dressing once weekly, every night shift every Fri with a start date of 01/31/25; 2) R [right] chest PICC dressing change weekly on Wed 7-3 shift, every day shift every Wed starting on 01/12/24. Review of the Medication Administration Record (MAR) for the month of February 2025 revealed that the dressing change was performed on 02/07/25, 02/12/25, 02/14/25, 02/19/25, 02/21/25, 02/26/25. During an observation and interview on 02/24/25 at 3:45 PM, UM2 was shown the bandage dated 02/14/25 and confirmed that bandages are typically changed weekly. UM2 confirmed that per the order and administration record, the bandage had not been changed. During an interview on 02/25/24 at 10:26 AM, LPN9 stated that she entered the order for the bandage to be conducted weekly on Fridays. She was asked about the duplicate order to change bandages on Wednesdays, and she stated she was not aware of another order. LPN9 was also asked why the MAR had been documented as if the wound change occurred and she confirmed that she did not know. Review of the facility's policy titled, Dressings, Dry/Clean, dated June 2024, revealed its purpose was to provide guidelines for the application of dry, clean dressings. Per the policy, to prepare for a dressing change staff must verify there's a physician's order; review care, orders, and diagnoses to determine if there are special resident needs; check the treatment record; and lastly assemble the equipment and supplies as needed. 1. Adjust bedside stand to waist level. Clean bedside stand. Establish a clean field. 2. Place the clean equipment on the bedside stand. Arrange the supplies so they can be easily reached. 3. Tape a biohazard or plastic bag on the bedside stand or open on the bed. 4. Pull strips of tape adequate for securing dressing at the end of the procedure and add date, time, and initials. Place on edge of bedside table to enable easy access when needed. Review of the facility's policy titled, Adaptive Devices with a revised date of 10/24 revealed adaptive devices were utilized to maximize positioning comfort and function. Review further revealed the LPN would document adaptive device on the CNA accountability record and on the interdisciplinary care plan. NJAC 8:39-27.1(a) 37590

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, interview, record review, and policy review, the facility failed to administer oxygen at the physician prescribed dose for one of six residents (Residents (R) 56) reviewed for respiratory care out of 32 sample residents. This had the potential to cause residents' respiratory distress. Findings include: Review of R56's Profile tab of the electronic medical record (EMR) revealed she was initially admitted to the facility on [DATE] and had a hospital stay from 12/28/24 to 01/06/25. R56 had diagnoses of bronchiectasis, with onset date of 01/07/25, and acute respiratory failure with hypercapnia, dated 01/09/25. Review of the Orders tab of R56's EMR revealed an order, dated 01/06/25, for oxygen at 2 LPM [liters per minute] via nasal cannula every shift. Review of R56's five-day Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/13/25 and located in the MDS tab of the EMR, revealed a BIMS score of 12 out of 15 which indicated R56 had moderately impaired cognition. R56 utilized oxygen. Review of R56's Medication Administration Record (MAR), dated February 2025 and located in the EMR under the Orders tab, revealed nurses signed off the order for oxygen at 2 LPM every shift and documented an oxygen saturation level. During a concurrent observation and interview on 02/23/25 at 11:59 AM, R56 was observed lying in bed with an oxygen concentrator administering oxygen at five LPM via a nasal cannula. R56 reported she had used oxygen since returning from the hospital. R56 did not know what her orders were for the oxygen setting. During an observation on 02/24/25 at 12:51 PM, R56 was in bed with her oxygen concentrator set at 3.5 LPM delivering oxygen via nasal cannula. During an observation and interview on 02/24/25 at 2:04 PM, Licensed Practical Nurse (LPN) 5 reported R56 had orders for oxygen to be delivered at two LPM, verified the concentrator was set incorrectly, and changed the oxygen concentrator setting from 3.5 LPM to two LPM. During an interview on 02/26/25 at 1:06 PM, the Director of Nursing (DON) stated she expected oxygen orders to be followed. The DON stated high settings of oxygen delivery could be problematic for residents with chronic obstructive pulmonary disease (COPD) or when trying to wean a resident off of oxygen. Review of the facility's policy titled, Oxygen Administration, reviewed October 2024, revealed staff were to, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on record review, interview, and facility policy review, the facility failed to ensure a meal or snack was provided and that there was ongoing pre- and post-dialysis communication for a resident receiving dialysis three times a week for one of one resident (Resident (R) 13) reviewed for dialysis out of 32 sample residents. This had the potential to affect the nutritional status and health of residents receiving dialysis. Findings include: Review of R13's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed he was admitted to the facility on [DATE] with diagnoses that included end stage renal disease and heart failure. Review of R13's Care Plan section of the EMR revealed a focus area, dated 07/20/23, [Resident] needs hemodialysis three times a week with interventions including: Vital signs are taken before and after dialysis. The Care Plan also included a focus for R13 being at risk for altered weight status [related to] edema . [hemodialysis]/fluid fluctuations. Review of R13's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/25 and located in the resident's EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated intact cognition. R13 received dialysis. Review of the Orders tab of R13's EMR, revealed an order, dated 02/20/25, dialysis pick up - 5:30 am one time a day every Tue, Thu, Sat. Review of a Dialysis binder, located at the nurse's station for R13, revealed it contained Dialysis and Nursing Home Hand-Off Communication Tool papers in it for each dialysis day. The papers were pre-filled with R13's name, code status, allergies, diet, current type of precautions, contact person, and nursing home name and number. There were areas above the prefilled line containing the facility's name and number to fill in vital signs, what the last meal or snack was, and the time it was consumed. The middle section, below the nursing facility's name and number, and above To be completed by dialysis facility addressed dialysis access concerns, medications taken, and changes since last dialysis treatment. The areas had yes/no boxes to check. Further review of the Dialysis binder for R13 revealed that, of the 19 papers filled out for dialysis days between 01/11/25 and 02/25/25, fifteen contained no documentation of vital signs taken before dialysis. None of the papers documented any meal or snack. Seventeen of the papers had no boxes checked regarding whether the resident had taken any medications or had any changes since the last dialysis treatment. During an interview on 02/23/25 at 10:26 AM, R13 reported receiving dialysis for eleven years. R13 stated he went out to dialysis at 5:30 AM on Tuesdays, Thursdays, and Saturdays without receiving a snack. I'm very hungry when I return around 11:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/25 at 4:15 PM, Licensed Practical Nurse (LPN) 4 stated dialysis communication forms were in a binder, which went with the resident to dialysis. LPN4 was unsure who filled out the top portion of the forms, above the to be completed by dialysis facility area since she did not send residents to dialysis. She stated when R13 returned from dialysis, LPN4 reviewed the bottom part of the communication form, which dialysis filled out, wrote a progress note, and checked his vital signs. During an interview on 02/25/25 at 4:20 PM, LPN3 stated the facility should fill out the top of the form above the to be completed by dialysis facility. LPN3 stated when LPN3 worked the evening shift, dietary staff did not send food in the evening for the residents to eat the morning of dialysis. During an interview on 02/25/25 at 4:24 PM, Unit Manager (UM) 1 stated that dialysis filled out the communication form under the nursing home name but above to be completed by dialysis facility. UM1 stated this section included medications taken, new medical problems or falls, hospitalization s or emergency department visits, labs drawn since last dialysis, and new medications or vaccinations. During an interview on 02/25/25 at 4:43 PM, the Director of Nursing (DON) stated the nurse sending the resident to dialysis was expected to fill out the top of the dialysis communication form all the way to the area to be completed by dialysis for ongoing communication with dialysis. During an interview on 02/26/25 at 9:39 AM, LPN8 reported the nursing staff made R13 tea each morning before dialysis. LPN8 stated that sometimes R13 took crackers in the morning before dialysis, but sometimes he refused. LPN8 stated dietary staff did not send up an early breakfast tray or snack. She stated the dialysis binder, with the communication forms, went with R13 to dialysis. She stated the top of the communication forms had prefilled information. LPN8 stated nursing documented vital signs prior to dialysis. She stated the rest of the form was only filled out with changes, and there were no recent changes. During an interview on 02/26/25 at 11:00 AM, the Dietary Manager (DM) stated if a resident went out to dialysis before 6:00 AM, dietary sent a bagged breakfast up to the unit the evening before, which nursing kept in the refrigerator until the next morning. DM stated if a resident went out at 6:00 AM or later, dietary was onsite and sent up an early breakfast tray. Review of the facility's policy titled, Meals for Dialysis Residents, created 03/24, revealed Nursing Services will notify the Food Services Department when a resident will be at dialysis during meal times. Such information will include, but is not necessarily limited to: need for an early meal tray; which meal(s) the resident will miss; how long the resident will be absent; and which meal the resident will be served upon returning to the facility. Review of the facility's Dialysis Procedure, reviewed 01/25, revealed Communication with the Dialysis Center will be maintained through the use of a communication book. The book is located at the nurse's station and is clearly labeled with the resident's name. The communication book is sent with the resident each time they are transported to dialysis. The nursing staff and the Dialysis Center will communicate any pertinent resident information through the communication book. In addition, the Dietician will be made aware to provide snacks/meals as needed. NJAC 8:39-2.9 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on record review and interviews, the facility failed to ensure PRN (as needed) psychotropics were not prescribed beyond 14 days without documented rational, for one of five residents (Resident (R) 101) reviewed for unnecessary medications of 32 sample residents. This failure had the potential to contribute to excessive medication administration. Findings include: Review of the Admission Record located under the Profile tab of the electronic medical record (EMR), revealed R101 was originally admitted to the facility on [DATE] with diagnoses that included depression, a history of mental and behavioral disorders, end stage renal disease, and general anxiety disorder. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/27/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition. Review of R101's Order tab of the EMR, revealed an order for Clonazepam 2MG [milligram] once every 24 hours as needed (PRN) for anxiety, with a start dated 02/13/24. There was no end date indicated. Review of the most recent psychiatric evaluation follow-up, located under the Evaluations tab of the EMR, on 02/19/25, revealed the resident was reviewed related to a history of depression, anxiety, and insomnia. The resident was noted to have no acute behavioral issues or concerns and was pleasant and cooperative during the assessment. According to the evaluation, R101 also denied audio or visual hallucinations along with no presence of delusional ideation or paranoia. Review of the Medication Administration Record (MAR) dated February 2025 and located under the Orders tab of the EMR, revealed that the medication was administered on 02/29/25, 02/20/25, 02/23/25, and 02/25/25. During an interview on 02/16/25 at 4:12 PM, the Director of Nursing (DON) confirmed that the antipsychotic, Clonazepam, was PRN and did not have an end date. She added that the facility was aware of the regulation and that an end date was required for that medication protocol. NJAC 8:39-29.3(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, record review, interview, and facility policy review, the facility failed to ensure medication administration was less than 5% error rate which included gabapentin, scheduled for every eight hours was administered one hour and 39 minutes after the scheduled time; calcium acetate, which had been discontinued, was administered; and one tablet of estradiol was administered instead of two for one of four residents (Resident (R) 101) observed during medication administration of 32 sample residents. Medication errors have the potential to result in adverse health outcomes. Findings include: Review of R101's Admission Record under the electronic medical record (EMR) Profile tab, revealed she was admitted to the facility on [DATE]. R101 had diagnoses which included hypothyroidism and failure to thrive. Review of R101's Orders tab of the EMR, revealed orders which included: -Estradiol 2 milligrams (mg). Give two tablets daily and one tablet every evening, both ordered 12/31/24, for hormone replacement. -Gabapentin 100mg. Give one capsule by mouth every eight hours for neuropathic pain, ordered 12/31/24, and -Calcium acetate 667mg. Give two capsules with meals for high phosphate levels, ordered 12/31/24 and discontinued on 02/22/25. Review of R101's Medication Administration Record (MAR) dated February 2025 and located under the EMR Orders tab, revealed the gabapentin, ordered to be given every eight hours, was scheduled at 8:00 AM. The two tablets of estradiol were scheduled for 9:00 AM, and the calcium acetate had been scheduled for 9:00 AM until it was discontinued on 02/22/25. During an observation on 02/25/25 at 9:25 AM, Licensed Practical Nurse (LPN) 2 reviewed the medication orders in the EMR and removed one estradiol 2mg tablet from a box labeled with R101's name and placed it in the medication cup. LPN2 then removed R101's packaged strip/roll of medications from the medication cart and reviewed the medication orders on the EMR while looking at the medication names and doses listed on the packaged medications. Although the gabapentin and calcium acetate were not on the 9:00 AM medication list LPN2 reviewed, LPN2 placed R101's gabapentin 100mg capsule and two tabs of the calcium acetate 667mg in the medication cup with R101's other medications. At 9:37 AM, LPN2 administered all the medications in the medication cup to R101. During an interview on 02/25/25 at 10:12 AM, LPN2 confirmed she had given the gabapentin late; she had one hour before until one hour after the scheduled time to administer the medication. LPN2 reviewed the estradiol order and reported R101 should receive two tablets in the morning. LPN2 was unable to locate the calcium acetate order and asked another nurse if R101 had recently had medications discontinued. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/25 at 12:05 PM, the Assistant Director of Nursing (ADON) stated medications were to be given from one hour before to one hour after the scheduled time. The ADON stated medications should be given as ordered. During an interview on 02/26/25 at 1:06 PM, the Director of Nursing (DON) stated she expected nurses to administer medications as ordered. DON stated nurses should perform the five rights with their medication administration to prevent medication errors. The DON expected medications to be administered within one hour before to one hour after their scheduled times. Review of the facility's policy titled, Medication Administration, reviewed December 2024, revealed the procedure the licensed nurse was to follow: 3. Reads medication order on electronic Medication Administration Record (e-MAR) 4. Removes medication from resident's drawer in the medication cart, checks name of resident, checks name of drug, checks strength/dose of drug, frequency given 5. Checks medication order again. Compares e-MAR to med rolls to ensure it reads the same . 7. Stock Medications: Carefully read label, compare medication and correct dosage on the e-MAR. Pour medication . The policy further stated, It is a Standard of Practice that medications be administered as ordered by the physician. Medication be [sic] administered to the resident within a one-hour time frame before/after the indicated administration time, unless otherwise specified by drug information. NJAC 8:39-29.2(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, staff interview, and review of facility policy, the facility failed to ensure that three of six medication carts, located on all three floors of the facility, were secure when staff were not present. This had the potential to affect the health of all residents with medications on those carts and the safety of any resident who might open the cart and remove medications. Findings include: Observations of one of two medication carts on the third floor on 02/23/25 revealed: -From 11:25 AM until 11:34 AM, Registered Nurse (RN) 1 walked away and went into a resident's room leaving the medication cart unlocked. Five residents were seated in wheelchairs in the hall within twenty feet of the cart, located across the hall from the Dayroom. -At 11:34 AM, RN1 returned to the medication cart. RN1 removed medication and walked into another resident's room at 11:35 AM, leaving the cart unlocked and unattended. -From 12:20 PM until 12:24 PM, the medication cart was observed in the same location as previous observations and was unlocked. Two residents were seated in wheelchairs nearby. RN1 returned to the cart at 12:24 PM to obtain requested pain medication. At 12:26 PM, RN1 walked away leaving the cart unlocked until locking it at 12:37 PM. -From 12:55 PM to 1:00 PM, the medication cart was unlocked, and RN1 handed out lunch trays. No one was in the vicinity of the cart. During an interview on 02/23/25 at 3:00 PM, RN1 stated the medication cart was to be locked if unattended. RN1 stated there were times he left the cart unlocked during his shift. I'll do better next time. It's my first survey. It's a learning experience. When asked what could occur when the cart was left unlocked, RN1 stated, Some residents might take meds off it. During an observation on 02/23/25 at 3:52 PM, an unlocked medication cart was observed in front of the fourth-floor nursing station, directly across from the elevator. An attempt to pull on each door revealed they were unsecure. There were no nursing staff visible from the elevator and down each corridor, running left to right. There was a resident seated in her wheelchair approximately 10 to 12 feet from the unsecure medication cart, and other residents were traversing the halls passing the cart. During an observation on 02/23/25 at 3:55 PM, Unit Manager (UM) 2 was observed on an adjacent corridor standing at another medication cart. She was asked who was responsible for the unlocked medication cart, and she stated Licensed Practical Nurse (LPN) 12. UM2 was asked if the cart was secure, and she confirmed that it was not. She added that it was expected that if you walk away from your cart, you are to ensure that it was secure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/25 at 12:05 PM, the Assistant Director of Nursing (ADON) stated medication carts should be locked when unattended. During an observation with the ADON on 02/26/25 at 12:08 PM, one medication cart on the second floor was unattended and unlocked in the hallway near room [ROOM NUMBER] with no staff or residents in the hall. The ADON locked the cart. During an interview on 02/26/25 at 12:10 PM, LPN11 stated she should keep the medication cart locked. LPN11 reported she had been in a hurry and had not realized the cart wasn't locked when she pushed the lock button before walking into a resident's room. During an interview on 02/26/25 at 1:06 PM, the Director of Nursing (DON) stated she expected medication carts to be locked when nurses walked away from them. Review of the facility's policy titled, Medication Storage, revised May 2024, revealed Medication room, carts, and medication supplies are locked or attended by persons with authorized access. NJAC 8:39-29.2 NJAC 8:39-29.4(h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03115 Based on observation, interviews, and facility policy review, the facility failed to ensure staff changed gloves and washed hands after touching face and contaminated items while touching food and plates with the same contaminated gloves in one of one kitchen. This failure had the potential to result in the spread of infection and food borne illness for 132 of 141 residents consuming food in the facility. Findings include: On 02/25/25 at 11:25 AM, Cook1 was observed touching his face and nose with his gloved hands. At 11:35 AM, he began serving food off the steam table without first changing his gloves. While serving he was observed picking the fried fish filets up with his gloved hands not using utensils, removing sandwiches and chicken strips out of the oven with his gloved hands. At 11:47 AM, he picked up visibly soiled cooking mitts and placed one on each of his gloved hands, opened the oven door, removed a pan of fish, and placed it in the steam table. He took the oven mitts off and continued to serve the food touching the serving utensils, the top side of the plates and taking fish out of the pan with his gloved hands without first changing his gloves. At 11:54 AM, he again put the oven mitts over his gloved hands and removed a pan of fish out of the oven and again preceded to continue serving without first changing his gloves and washing his hands. He removed chicken strips out of the oven using his gloved hands. The Dietary Manger (DM) was alerted to the staff not changing his gloves and he also observed Cook1 put the contaminated gloves on and then remove them and continue touching the food without first changing his gloves. The DM confirmed the observation and obtained serving utensils for the fish and the chicken strips and handed them to Cook1 telling him the inside of the cooking mitts were soiled. Cook1 continued to use his hands with the same gloves on and was observed touching the side of his pants and his face again. Review of the facility's policy titled, Red Bank Center for Rehabilitation and Healing .Policy and Procedure . Title: Dietary - Handwashing with a created date of 03/24, revealed hands shall be washed in accordance with established procedures; before working, after eating, after touching any part of the body, after using the restroom, after working with any dirty equipment, and between working with foods. NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on record review, interview, and facility policy review, the facility failed to ensure complete records for two of four residents (Resident (R) 127 and R129) related to the death in facility for R127 and related to being discharged to the community for R129; reviewed for medical records of 32 sample residents. Failure to completely document the circumstances around resident discharge had the potential to result in staff not knowing why the resident was no longer in the facility; not knowing if the physician and family were notified; and potential legal ramifications. Findings include: 1. Review of R127's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed the resident was discharged on [DATE] at 7:20 AM and the resident was discharged to the funeral home. Review of the resident's discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/24 and located under the MDS tab of the EMR, revealed she had a death in facility. Review of the EMR in its entirety revealed it was absent of further documentation related to the death of the resident. There was no documentation related to how the resident's death was discovered; who was notified of the death; and the circumstances surrounding the death. Review of the Prog Note tab in the EMR revealed the last three progress notes in the resident's record was a Social Services evaluation, dated 12/26/24 and timed 9:09 AM; a nutrition/dietary note, dated 12/20/24 and timed 12:24 PM; and a therapy note, dated 12/18/24 timed 4:32 PM which revealed skilled speech therapy was not recommended. There were no notes addressing the resident's death and the circumstances around her death or notification of the physician and responsible party about the death. During an interview on 02/24/25 at 3:51 PM, the Director of Nursing (DON) was asked about the resident's death and medical record. After reviewing the EMR, she verified the record was absent of any documentation related to the death of the resident. Review of the Medication Administration Record (MAR), dated December 2024 and located under the Order tab of the EMR, revealed the resident did not receive medication on 12/29/24 based on review of the initials of the nurses administering the medications and revealed Licensed Practical Nurse (LPN) 2 was the last nurse to administer her medication. During an interview on 02/25/25 at 1:47 PM, LPN2 verified she forgot to document on the resident's death. She stated she had worked a double shift from 11:00 PM to 3:00 PM that day and it just slipped her mind, and she forgot to document on the death. She stated the resident passed away on the 11:00 PM to 7:00 AM shift stating it was maybe around 6:00 AM. She stated the Certified Nursing Assistant (CNA) told her the resident did not look good and when she went to check on the resident she did not have any vital signs and had already passed away, so she notified Registered Nurse (RN) 1 and he pronounced her dead. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/25 at 2:39 PM, RN1 stated he was working on the third floor, and the fourth-floor nurse called him to come to the fourth floor. He stated when he arrived at the resident's room she was not breathing, her pupils were fixed and dilated, she was cold to touch, and he pronounced her dead. When asked, he stated he did not do any documentation because the nurse working on the floor was going to do the documentation and notify the family and responsible party. During an interview on 02/25/25 at 2:46 PM, LPN2 stated the resident had a court appointed power of attorney and she called the number and left a message, and she called the physician and informed him of the death however she did not document it because she forgot. Review of the orders tab of the EMR revealed there was no order from the physician to release the resident's body to the funeral home. 2. Review of R129's EMR Admission Record located in the Profile tab revealed she was admitted to the facility on [DATE] with diagnosis of multiple fractures of pelvis with stable with stable disruption of pelvic ring, fusion of spine, encounter screening of human immunodeficiency virus, mononeuropathy, retention of urine, pain, laceration of the liver, and laceration of the right kidney. Review of the EMR Miscellaneous information tab of the Admission Record, revealed the resident was discharged on [DATE] to a private home/apartment with home health services. Review of the discharge MDS with an ARD of 12/19/24 and located under the MDS tab of the EMR revealed the resident's last MDS was a Discharge Return Not Anticipated. Review of her progress notes in the Progress note tab of the EMR, revealed there were no progress notes for the date she was discharged . The last progress note was a Medical Professional Note, dated 12/18/24 and timed 3:34 PM. The note was absent to the resident's discharge. The next note was dated 12/18/24 timed 12:00 AM (prior to the discharge date) which revealed it was a discharge note completed by a Nurse Practitioner (NP). The note revealed the NP completed a final examination of the resident, completed medication reconciliation, prescribing discharge medications and discussion of continuing care instructions with the resident, family, and relevant care givers. During an interview on 02/25/25 at 12:55 PM, LPN4 stated she was R129's nurse at the time of discharge, however she forgot to document on the discharge. She stated she remembered her grandmother picking her up, but she could not remember if she was going to her grandmother's house or to her mother's house and she could not remember if she sent any discharge instructions or medications with the resident, however she thought she did send in two subscriptions with the resident. Review of the facility's policy titled, [Facility Name] for Rehabilitation and Healing . Title: Documentation of Transfers/Discharges, with a reviewed date of 10/24, revealed When a resident is transferred or discharged , his or her medical records shall be documented as to the reasons why such action was taken. The policy stated when a resident is transferred or discharged the reason for the discharge, the appropriate notice was provided to the physician and responsible party; the time and date of the transfer; the new location of the resident; the mode of transportation; disposition of the resident's personal effects; disposition of medications; and a summary of the resident's overall medical, physical, and mental condition must be documented along with the signature of the person recording the data in the medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 4.1(a)18 NJAC 8:39-35.2(d)(k)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure infection control Enhanced Barrier Precautions (EBP) were followed for two of four residents (Resident (R) 92 and R107) reviewed for EBP and failed to ensure medications were handled properly for one of four residents (R101) reviewed for medication administration of 32 sample residents. In addition, isolation supplies were not readily available on one out of four floors of the facility. These failures put all residents at risk of infection. Findings include: 1. During observations on [DATE] from 9:50 AM- 2:41 PM for rooms 316, 317, 319, 325, 326, and 328, EBP signage was located. Review of the signage for EBP located on the door caddie or wall of the rooms revealed everyone must clean their hands including before entering the room and when leaving the room. The signage further revealed providers, and staff must also put on gloves and a gown when doing high contact care which included changing a brief, device care for tracheostomy and wound care. During an observation on [DATE] at 12:56 PM, a lunch tray was passed to room [ROOM NUMBER] which had EBP posted on the door caddie by Certified Nurse Aide (CNA) 2 and CNA2 did not sanitize her hands before or after entering the room. CNA2 went down the hall and passed another tray to room [ROOM NUMBER] which had EBP signage on the door caddie and did not sanitize her hands going into the room or when leaving. CNA2 continued down the hall to the small dining room and helped residents without washing or sanitizing her hands. During an interview on [DATE] at 2:46 PM, CNA2 revealed she had been employed at the facility for eleven months and been in-serviced on EBP. CNA2 revealed if a resident was on EBP they had to gown up and put gloves on anytime they touched the resident. CNA2 revealed when they passed trays in a room with EBP they did not have to sanitize their hands when they entered or left the room. Review of the in-service training completed on [DATE] revealed CNA2 had education on infection control in healthcare setting and it contained information about EBP. During an observation on [DATE] at 8:55 AM, Licensed Practical Nurse (LPN) 5 went into R92's room, who had EBP posted on the door caddie, and did not sanitize her hands or apply a gown but she did put a mask on and gloves. LPN5 proceeded to clean the mucus from around the covering of the tracheostomy tube, did not remove her gloves, opened the drawer beside the bed, and reached down and unplugged the suction machine and plugged in the breathing treatment machine, fixed the blanket, removed her gloves, and sanitized her hands. LPN5 applied gloves but did not put on a gown and the nebulizer had a piece missing. LPN5 removed the gloves and did not sanitize or wash her hands. Observation of R92 revealed he was coughing and mucous sounding. Observation further revealed LPN5 did not have any gloves on and reached down beside the table and unplugged the nebulizer and plugged in the suction machine. LPN5 sanitized her hands and applied sterile gloves but no gown to suction R92. LPN5 suctioned R92 and after suctioning him she cleaned around the outer covering of the tube and wiped around the stoma area without changing gloves. LPN5 removed the gloves, sanitized her hands, and put a gauze around the tracheostomy with no gloves or gown on. LPN5 sanitized her hands and applied the nebulizer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 12:53 PM, LPN5 applied gloves, mask, and no gown to clean mucus from the neck of R92. LPN5 removed her gloves and washed her hands. During an interview on [DATE] at 12:53 PM, LPN5 stated R92 was not on any precautions and when she suctioned him, she did not need to wear a gown. LPN5 revealed she had worn a gown previously that morning when she suctioned him but this time it was just a little suctioning, so she did not need a gown. LPN5 further revealed they did not have to sanitize their hands if they just went into the room and did not touch the resident even though the signage reflected you needed to sanitize your hands when going in and out of the room. LPN5 further revealed she had been in-service on EBP. During an observation on [DATE] at 9:15 AM, LPN6 went into R92's room and did not sanitize or wash her hands but had regular gloves on her hands. LPN6 did not have a gown or any type of face covering on her. Observation further revealed LPN6 removed the trach tie, neck gauze and cleaned the trach area with normal saline and gauze. Observation further revealed copious amount of light-yellow thick mucus was coughed out and LPN6 unplugged the nebulizer machine and plugged in the suction machine and did not remove her gloves to suction R92. Observation further revealed the cannula was changed but LPN6 did not use sterile gloves. LPN6 did not wash hands or sanitize her hands and did not change gloves to attach the nebulizer. Observation further revealed LPN6 had to unplug the suction machine and plug the nebulizer machine in. During an interview on [DATE] at 9:30 AM, LPN6 revealed she did not wash or sanitize her hands before doing R92's care because she had just come out of the room. LPN6 revealed she did not change gloves and was not aware that sterile gloves needed to be used for suctioning. LPN6 revealed she should have changed gloves when she had suctioned R92 and cleaned the area. LPN6 verified she had not worn a gown even though R92 had been coughing. LPN6 revealed she was not sure what type of precautions R92 was on and had not read the signage for EBP and was not even sure there had been a sign up there before. LPN6 revealed she thought she had an in-service on universal precautions but the agency she worked for did not offer in-services. LPN6 further revealed the room only had four electrical outlets and they were all being used and that was why she had to unplug the suction and nebulizer cords. During an interview on [DATE] at 10:30 AM, the Nurse Practitioner (NP) revealed sterile gloves should be worn to suction a resident and should be removed after suctioning. NP further revealed using dirty gloves that had touched a power cord should not be used to suction a resident and that was a no no. The NP further revealed sterile protocol was broken by not utilizing sterile gloves to suction. The NP revealed you do not know what you have on dirty gloves. During an interview on [DATE] at 1:47 PM, the Infection Preventionist (IP) revealed if a resident was on EBP staff should sanitize their hands before and after they went into a room and that included passing meal trays. The IP further revealed if staff were going to suction a resident that had a trach and was on EBP they should wear a gown, gloves, eye protection, and mask. The IP further revealed the eye shields or goggles should be on the door caddies for immediate use. The IP revealed suctioning was a port of entry for germs and if on EBP they must wear eye protection and a gown to keep from transmitting germs to the rest of the facility and staff. During an observation on [DATE] at 2:41 PM, there were no face shields or goggles on the isolation bins on Hall A, B, and C on the 300 unit. Observation further revealed the door caddies on Rooms 310, 318, 321, 325, and 329 did not have any goggles or face shields available for immediate use even though the residents were on EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:41 PM, IP verified there were no goggles or face shields readily available on the third floor even though there were several trach residents on the unit. The IP stated face shields should be available for immediate use to help prevent the spread of germs, especially if a resident was on a tracheostomy and was coughing with sputum production. The interview with the IP further revealed the staff did not restock supplies as readily as they should. The IP revealed nursing staff, usually the night shift supervisor were the ones who were supposed to restock. During an observation and interview on [DATE] at 3:00 PM, the IP revealed there were supposed to be stock face shields in central supply but when he looked at the two boxes they expired on ,d+[DATE]. Observation further revealed there were no face shields available in the stockroom. Observations with the IP further revealed there were goggles available on the other floors but no face shields. During an interview on [DATE] at 1:23 PM, the Director of Nursing (DON) revealed she expected the staff to follow policy on EBP, transmission-based precautions, and isolation. The DON further revealed when a resident was on EBP staff should sanitize their hands before and after they go into the room and that included passing meal trays. The DON stated if staff provided hands on care, then they should sanitize their hands before going into the room, put a gown on, and gloves before doing care, and face shields if suctioning. The DON further revealed once the care was completed staff should remove PPE and hands should be sanitized or washed. The DON revealed if proper PPE was not utilized then it proposed a high risk of spreading an infection to other residents, families, and staff. During an interview on [DATE] at 1:23 PM, the DON further revealed agency staff had to have documented in-services on infection control before they could work at the facility. The interview with the DON further revealed central supply brought the supplies to the units and the nurse stocked the door caddies and hall bins. 2. Review of R107's Admission Record located in the resident's electronic medical record (EMR) Profile tab, revealed the resident was initially admitted to the facility on [DATE] and had diagnoses that included osteomyelitis and personal history of transient ischemic attack (TIA) and cerebral infarction. R107 returned from the hospital on [DATE]. Review of the R107's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located in the resident's EMR MDS tab, documented R107 had a feeding tube and received 50 percent or more of her total calories through tube feeding. The resident was rarely/never understood, and the Staff Assessment for Mental Status documented memory impairment. Review of R107's Orders tab of the EMR, revealed an order, dated [DATE], for Jevity 1.5 (liquid nutrition for tube feeding) at 50mL (milliliters) per hour. Hang each morning and give a four-hour break when finished. R107 also had orders for enhanced barrier precautions, dated [DATE]. Review of R107's Care Plan located in the Care Plan section of the EMR revealed a focus area dated [DATE], To prevent cross contamination utilize Enhanced Barrier Precautions r/t [related to] risk of infection: indwelling medical devices: foley cath [catheter]/trach/feeding tube. Another focus area, dated [DATE], revealed The resident requires tube feeding via Gtube [gastric feeding tube] r/t Dysphagia [impaired swallowing]. During an observation on [DATE] at 11:45 AM, an enhanced barrier precautions sign hung on R107's door with a door caddy holding gowns and gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 2:45 PM, LPN5 flushed R107's feeding tube with water poured in a syringe attached to the tube. LPN5 then ran the tubing from the new feeding container she hung on a pole, through the pump, and attached the end of the tubing to R107's feeding tube. LPN5 pushed a button on the pump to start the flow of the feeding. During the observation, LPN5 wore gloves but no gown. During an interview on [DATE] at 3:10 PM, LPN5 stated EBP for R107 meant staff wore gowns and gloves when providing wound treatment or perineal care. LPN5 stated a gown was not needed for the tube feeding. During an interview on [DATE] at 1:47 PM, the IP stated staff should wear a gown if passing meds by a g-tube or feeding through a g-tube, as that was considered high contact. During an interview on [DATE] at 1:06 PM, the DON reported the expectation that nurses would use EBP and wore a gown and gloves when flushing a feeding tube and starting a feeding. 3. Review of R101's Admission Record located in Profile tab of the EMR revealed R101 was admitted on [DATE] and had diagnoses which included end stage renal disease. During an observation of a medication administration pass on [DATE] at 9:25 AM, LPN2 was tearing open medication packaging which held multiple pills when one pill landed on the medication cart instead of in a medication cup. LPN2 picked up the pill with an ungloved hand and placed it in the medication cup with the other pills. At 9:37 AM, LPN2 administered all the medications in the medication cup to R101. During an interview on [DATE] at 10:12 AM, LPN2 stated, My error. I would not normally do that, when asked about picking up the pill with an ungloved hand and placing it in the medication cup. During an interview on [DATE] at 1:47 PM, the IP stated when passing medication, staff should not touch pills. They should use touchless method, open the pack, and drop the medication into a cup. If staff needed to touch a pill, the IP recommended using gloves and perform hand hygiene before putting on the glove to pick up the pill. The IP stated by administering medication touched with bare hands, staff risked transmitting germs and putting the residents in jeopardy. During an interview on [DATE] at 1:06 PM, the DON stated nurses were expected to wear gloves if they were touching medications. Review of the facility's policy titled, Medication Administration, revised [DATE], revealed staff were to remove medications from med rolls and administer them using a no touch technique. Review of the facility's policy titled, Enhanced Barrier Precautions with a revised date of ,d+[DATE], revealed the policy was to reduce the risk of transmission of multidrug-resistant organisms in the facility while allowing those most likely to become colonized or those known to be colonized or infected to participate in group activities that night otherwise be limited if they were required to be maintained on contact precautions. The policy further revealed EBP was implemented based on an evaluation of the resident's risk of acquiring multidrug-resistant organisms. The policy revealed EBP would be implemented with residents who have risk factors that included wounds, indwelling medical devices, and colonization. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redbank Center for Rehabilitation and Healing	100 Chapin Avenue Red Bank, NJ 07701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:,d+[DATE].4 42440