STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34423 Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure residents were treated with dignity whole being assisted with a meal. This deficient practice was identified for 1 of 3 units, [NAME] wing and was evidenced by the following: On 01/15/2025 at 12:38 PM, the surveyor observed the Infection Preventionist (IP) assisting a resident with their meal who was seated in his/her Geri chair. The IP was standing over the resident while feeding her/him. During an interview at that time, the IP said yes I attempting to feed resident. When asked how should you be positioned when feeding a resident and he replied I would like to be head level with resident but I don't have a chair. On 01/16/2025 at 08:25 AM, Certified Nursing Assistant (CNA #1) was observed to be standing while assisting a resident to eat who was seated in a Geri chair in the west unit dining room. After CNA #1 completed assisting the 1st resident, CNA #1 proceeded to move to a 2nd resident and stood while feeding him/her. There was a chair observed to be available for CNA #1 to sit in while assisting a resident to eat. On 01/16/2025 at 12:16 PM, during a lunch meal observation on the west wing, the surveyor observed CNA #1 to be assisting a resident to eat their entire meal from a standing position. The resident was seated in a Geri chair. During an interview with the surveyor on 01/22/2025 at 01:41 PM, the Licensed Nursing Home Administrator and Director of Nursing were asked is it appropriate for a staff to stand while assisting a resident with their meal. The LNHA responded no, staff is supposed to be sitting while assisting residents with their meals. A review of a facility policy on 01/22/2025 at 12:16 PM, titled [facility name] Feeding Assistance Guidance undated. The list of the guidance indicated that sit facing the resident at eye level. NJAC8:39-4.1(a)(12)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34423 Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure residents were treated with dignity while being assisted with a meal and creating a homelike environment during dining by removing the food from the tray. This deficient practice was identified for 2 of 3 units, [NAME] wing and South wing and was evidenced by the following: 1. On 01/15/2025 at 12:38 PM, Surveyor #1 observed the Infection Preventionist (IP) assisting a resident with their meal who was seated in his/her Geri chair. The IP was standing over the resident while feeding her/him. During an interview at that time, the IP said yes I attempting to feed resident. When asked how should you be positioned when feeding a resident and he replied I would like to be head level with resident but I don't have a chair. 2. On 01/16/2025 at 08:25 AM, Certified Nursing Assistant (CNA #1) was observed to be standing while assisting a resident to eat who was seated in a Geri chair in the west unit dining room. After CNA #1 completed assisting the 1st resident, CNA #1 proceeded to move to a 2nd resident and stood while feeding him/her. There was a chair observed to be available for CNA #1 to sit in while assisting a resident to eat. On 01/16/2025 at 12:16 PM, during a lunch meal observation on the west wing, Surveyor #1 observed CNA #1 to be assisting a resident to eat their entire meal from a standing position. The resident was seated in a Geri chair. 40039 3. On 01/15/2025 at 12:16 PM, Surveyor #2 observed the South Unit dining room at the lunch meal. Eight (8) residents were observed to be seated in the South unit dining room across from nurse's station. The second meal cart arrived at 12:19 PM and staff were observed to hold the meal trays to ensure all trays were able to be passed at the same time. Trays were passed to the eight residents at 12:23 PM, by 4 unit staff. 8 of 8 residents present in the dining room were served their lunch meal on the tray. The food was not removed from the tray when placed on the table. 4. On 01/16/2025 at 12:26 PM, Surveyor #2 arrived on the South unit and observed the lunch meal on the South Unit dining room. The meal had already been served prior to the surveyor arriving on the unit and the 4 of 4 residents present in the dining room received their lunch meal on a tray. 5. On 01/21/2025 at 12:12 PM, Surveyor #2 observed the South Unit dining room at the lunch meal. 7 residents were observed in the South unit dining room and were served the lunch meal on the tray. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the survey team on 01/22/2025 at 01:38 PM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were notified of the above mentioned meals and the practice of facility staff standing while assisting residents with meals and serving meals on trays. Surveyor #1 asked if it was appropriate for staff to be standing while feeding a resident. The LNHA responded no, staff is supposed to be sitting while assisting resident during meals. Surveyor #2 asked the LNHA if serving meals on trays in the dining room created a home-like environment for the residents. The LNHA responded, To be honest I think that is the way that they have always done it. A review of a facility policy on 01/22/2025 at 12:16 PM, titled [facility name]Feeding Assistance Guidance undated. The list of the guidance indicated that sit facing the resident at eye level. N.J.A.C. 8:39-4.1(a)(12)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 39460 Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to follow hold parameters for the administration of a blood pressure medication in accordance with professional standards of practice. This deficient practice was identified for 1 of 28 residents (Resident #46) reviewed for standards of practice and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 1/15/25 at 11:20 AM, the surveyor observed Resident #46 in their room seated in a high back wheelchair. Resident #46 stated they were a dialysis patient and went to the facility three times a week. The surveyor reviewed the medical record for Resident #46. A review of the Admission Record face sheet reflected the resident was admitted to the facility in July of 2023 with diagnoses which included chronic kidney disease, dependence on renal dialysis, and hypotension (low blood pressure). A review of the most recent comprehensive Minimum Data Set (MDS), and assessment tool dated 11/28/24, reflected a brief interview for mental status (BIMS) score of 9 out 15, which indicated a moderately impaired cognition. A further review reflected the resident received dialysis treatments. A review of the individualized person-centered care plan reflected a focus area initiated 9/6/23, for hemo-dialysis three times a week related to renal failure/disease. Interventions included monitor vital signs. Notify MD (physician) of significant abnormalities. A review of the Order Summary Report (OSR) included a physician's order (PO) dated 10/9/24, Vital signs every shift- if SBP (systolic blood pressure) under 100 [mmHg millimeters of mercury]- See PRN (as needed) order for Midodrine every 8 hours. The corresponding Midodrine order was as follows: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Midodrine oral tablet 5 mg (milligram); give one tablet by mouth every 8 hours as needed for b/p (blood pressure); give if SBP less than 100 [mmHg]. A review of the corresponding November 2024 Medication Administration Record (MAR) revealed the resident's blood pressure (SBP) was less than 100 and the resident did not receive Midodrine on the following days: 10:00 PM; 11/19/24, 11/23/24, 11/26/24, 11/20/24. A review of the corresponding December 2024 Medication Administration Record (MAR) revealed the resident's blood pressure (SBP) was less than 100 and the resident did not receive Midodrine on the following days: 2:00 PM; 12/11/24, 12/12/24, 12/16/24 10:00 PM; 12/9/24, 12/10/24, 12/18/24, 12/19/24, 12/24/24 A review of the corresponding January 2025 Medication Administration Record (MAR) revealed the resident's blood pressure (SBP) was less than 100 and the resident did not receive Midodrine on the following days: 2:00 PM; 1/18/25 10:00 PM; 1/9/25, 1/10/25, 1/18/25, 1/19/25 Further review of the December 2024 and January 2025 MAR revealed the resident had received Midodrine when the SBP was above 100 and should not have been given on the following days: 12/11/24 at 8:11 AM 12/28/24 at 12:49 PM 1/12/25 at 10:17 AM, 1/14/25 at 12:27 PM, and 1/17/25 at 11:17 AM During an interview with the surveyor on 01/22/2025 at 11:14 AM, Licensed Practical Nurse # 4 (LPN #4) stated the resident received dialysis three times a week and took Midodrine for their blood pressure. At that time the surveyor and LPN #4 reviewed the resident's MARs. LPN #4 acknowledged the resident had not received Midodrine when their SBP was less than 100 on multiple occasions and had received Midodrine when the dose should have been held based on the physician's hold parameters. During an interview with the surveyor on 01/22/2025 at 11:28 AM, Licensed Practical Nurse/ Unit Manager #2 (LPN/UM #2) and the surveyor reviewed the resident's MARs and confirmed the nurses were not following the physician's hold order parameters for Midodrine on multiple dates. During a meeting with the survey team on 01/22/2025 at 2:21 PM, with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The DON stated the nurses should follow the parameters of the physician's orders like indicated in the Midodrine order for Resident #46. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Medication Pass policy dated reviewed 2023, included .Hold Parameters: check blood pressure and/or pulse rate immediately prior to pouring . The policy did not include following physician's order regarding medication hold parameters. NJAC 8:39-11.2(b); 27.1(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51337 Based on observation, interview, review of the medical record, and other facility documentation, it was determined that the facility failed to ensure that a resident who was identified as having a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity or rigidity of joints) received services to prevent further decreased Range of Motion (ROM). This deficient practice was identified for 1 of 1 resident reviewed for limited ROM, (Resident #78) and was evidenced by the following: On 01/15/2025 at 10:04 AM during the initial tour of the facility, Resident #78 was observed by the surveyor sleeping with right arm bent at the elbow close to their body. Their right hand was clenched in a fist. There was no observed splint, handroll, rolled towel or napkin on the right hand. During an interview with the surveyor on 01/15/2025 at 12:36 PM, the resident family stated that no splint or hand roll was being applied to resident's right hand. The family said that Resident #78 used to roll a napkin with their left hand to put in their right hand, but someone removed it. The family went on to say they were told that they were going to be replaced with the appropriate device, but no device was provided. On 01/16/2025 at 08:10 AM, the surveyor observed Resident #78 in bed sleeping with right arm bent at the elbow close to their body and their right hand clenched in a fist. There was no splint or handroll noted on their right hand. On 01/16/2025 at 08:11 AM, the surveyor observed resident #78 eating breakfast with their left hand using a fork. Their right arm was bent at the elbow closed to their body. Their right hand had no splint or handroll. A review of Resident #78's Admission Record, in the Electronic Medical Record (EMR) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; Cerebral Infarction (blood vessel blockage in the brain) and Major Depression (a mental health condition that involves a persistent low mood and loss of interest in activities). A review of the most recent Quarterly Minimum Data Set (QMDS), an assessment tool used to manage care, dated 11/01/2024, reflected a Brief Interview of Mental Status (BIMS) score of 6/15 which indicated that the resident's cognition was moderately impaired. Further review of the QMDS under Section O.0500 Restorative Nursing Programs, did not include documentation of wearing splint or brace. A review of the active Physician Orders on 01/16/2025 at 12:21 PM did not reveal order for any care or treatment for the contracture of the right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #78's Care Plan initiated on 06/29/2023, with focus for limited physical mobility related to Stroke included the following goal: To remain free of complications related to immobility, including contractures Interventions included: Monitor/document/report as needed any signs and symptoms of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury; Provide gentle range of motion as tolerated with daily care; Provide supportive care, assistance with mobility as needed; Document assistance as needed; and PT, OT referrals as ordered as needed. The ongoing care plan did not reveal a specific intervention for the resident's right upper extremity impairment or the contracture of the right hand. A review of the Physician's History and Physical progress notes by Advanced Practice Nurses (APN) dated 01/04/2024, 02/02/2024, 02/27/2024, 03/14/2024, 04/08/2024, 05/15/2024, 06/06/2024, 07/01/2024, 07/22/2024, 08/08/2024, 09/13/2024, 10/07/2024, 11/05/2024, 12/12/2024 and 01/06/2025 revealed assessments of the muscular system to have right-sided weakness with contracture of the right upper extremity (RUE). There was no treatment plan addressing the contracture of the RUE in the notes. During an interview with the surveyor on 01/21/2025 at 10:18 AM, the head therapist stated that the most recent date that the resident was on therapy was on 01/09/2024 to 02/07/2024. A review of the Occupational Therapy (OT) notes revealed the reason for therapy was because the resident was at risk for further contracture. Discharge recommendations included: Patient agreed to don and maintain wearing of right handroll for 4 hours per day with daily caregiver skin checks. During an interview with the surveyor on 01/21/2025 at 10:15 AM, Certified Nursing Assistant (CNA #3) stated that they washed the resident, set up their tray and let them stay in bed per resident's preference. During an interview with the surveyor on 01/21/2025 at 10:23 AM, CNA #4 stated that they took care of the resident in coordination with the hospice aide. They also stated that there were no devices being applied to the resident. During an interview with the surveyor on 01/21/2025 at 11:47 AM, Licensed Practical Nurse/ Unit Manager (LPN/UM #1) stated that they had a handroll and a splint for the resident before, but the resident would not wear them. When asked what the staff were doing at present for the contracture, LPN/UM #1 stated that they would ask the APN to examine the resident for any recommendations. LPN/UM #1 further stated that they did not know what happened with the recommendations as she was not working during that time period. During an interview with the surveyor on 01/22/2025 at 10:20 AM, hospice aide (HA #1) was asked what care she provided to the resident. HA#1 stated that they had to put washcloth in the right hand to clean it because the resident was stiff in the hand. HA#1 further stated that it was difficult to clean under because it was bent at the elbow close to the body. During a telephone interview with the surveyor on 01/22/2025 at 11:03 AM, the APN #1 stated that hospice followed up the resident and that the hospice aide placed rolls of towel in the resident's hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the survey team on 01/22/2025 at 11:32 AM, the Director of Nursing (DON) was asked how the facility addressed residents with contractures. The DON stated that the following interventions were being practiced: Residents were encouraged to reposition, staff anticipated their needs all shifts, the residents were encouraged to get out of bed, follow up with psychiatry if the residents were not compliant, pain will be addressed by the Nurse Practitioners, therapy referral if related to mobility. The DON further stated that these interventions are in the care plans and orders of the EMR. A review of an undated facility policy on 01/21/2025 at 12:42 PM titled [facility name] Assistive Device Policy under Covered Indications revealed on the third paragraph: The clinician, (therapy department or clinician designee) will usually initiate the discussion and consideration of [NAME] (mobility assistive equipment) use. Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs (mobility-related activities of daily living) such as toileting, feeding, dressing, grooming, and bathing. N.J.A.C. 8:39-27.1(a), 27.2(m)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40039 Based observation, interview, record review and review of other facility documentation, it was determined that the facility failed to consistently perform quarterly smoking assessments according to facility policy for residents designated as active smokers. This deficient practice occurred for 3 of 3 residents (Resident #30, #58, and #127) reviewed for smoking. This deficient practice was evidenced by the following: 1. On 01/15/2025 at 10:21 AM, Surveyor #1 observed Resident #30 in his/her room getting a haircut. Resident #30 stated that he/she was a smoker, and that the facility staff held their smoking materials. Resident told Surveyor #1 that he/she had designated smoke times, and they could not smoke whenever they wanted to. On 01/16/25 at 12:44 PM, Surveyor #1 reviewed the electronic medical record (EMR) as follows; A review of the Admission Record revealed Resident #30 was admitted to the facility with the following but not limited to diagnoses: Parkinson's disease, dementia, anxiety disorder, and depression. A review of the Minimum Data Set (MDS), an assessment tool, dated October 19, 2024, revealed that Resident #30 had a Brief Interview for Mental Status score of 10, indicating moderate cognitive impairment. According to Section J Resident #30 was an active smoker. A review of Resident #30's comprehensive care plan revealed the following care plan Focus: I [resident name]am a smoker of long duration. The following were listed as Interventions: Smoking supplies are stored in the activity office, instruct resident about smoking risks and hazards and about smoking cessation aids that are available, instruct resident about the facility policy on smoking: locations, times, safety concerns, monitor oral hygiene, notify charge nurse immediately if it is suspected resident has violated facility smoking policy. and observe clothing and skin for signs of cigarette burns, date initiated: 04/22/2024. The care plan did not address quarterly smoking assessments. The EMR revealed that Resident #30's original smoking contract was completed and signed on 10/16/23. Resident #30 had quarterly smoking assessments completed on 01/18/24, 04/22/2024, and 08/22/2024. Review of the Assmt (assessment)tab in the EMR revealed no quarterly smoking assessment had been completed since 08/22/2024 (approximately 5 months) for Resident #30. 2. On 01/16/2025 at 01:22 PM, Resident #127 was observed by Surveyor #1 outside in the designated smoking area without staff supervision. On 01/17/2025 at 08:39 AM, Resident #127 was observed lying in bed and watching television. Resident #127 told Surveyor #1 that he/she does not possess their smoking materials in their room or on their person. Resident #127 explained that they must pay for their own cigarettes and that staff holds them until the designated smoke time which was like 5 times per day. Staff would provide cigarette and lighter to resident at designated smoke times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Admission Record Resident #127 was admitted to the facility with the following but not limited to diagnoses; Traumatic subdural hemorrhage without loss of consciousness (bleeding in the area between the brain and the skull), seizures, type 2 diabetes mellitus, and alcohol abuse. A review of the comprehensive MDS dated [DATE], Resident #127 had a Brief Interview for Mental Status score of 14, which indicated intact cognition. Section J of the MDS revealed that Resident #127 was a current tobacco user. According to Resident #127's comprehensive care plan date initiated: 08/14/2024 revealed the following care plan Focus: I [resident name] am a smoker. Review of the care planned interventions did not address quarterly smoking assessments. A review of the EMR revealed Resident #127 had their initial smoking safety evaluation completed on 08/14/2024. According to the EMR on 01/16/2025 at 01:30 PM under the heading Next Assessment Due Resident #127's Smoking Safety Evaluation V 2.0: was 63 days overdue - with a due date of 11/14/2024. During an interview with Surveyor #1 on 01/17/2025 at 08:44 AM, the corporate activity director (CAD) was asked what the facility process was for residents who were active smokers. The CAD told the surveyor that we purchase the cigarettes for the residents, and we also possess smoking materials which are locked away during non-smoking times. The CAD further stated that we distribute smoking materials to smokers at designated smoke times and the smoke monitor will supervise during the designated times. We have a designated smoke monitor. When asked who was responsible for completing smoking assessments the CAD stated nursing completes the smoking evaluations. During an interview with Surveyor #1 on 01/17/2025 at 08:50 AM, Licensed Practical Nurse/Unit manager (LPN/UM#1) was asked asked who was responsible for the completion of smoking assessments. LPN/UM #1 told the Surveyor #1 that initial and quarterly smoking assessments are completed by activities staff. She further stated that nursing does not complete the smoking evaluations but if I see something wrong, I will give them my input. During an interview with the survey team on 01/17/2025 at 10:41 AM, Surveyor #1 asked the Director of Nursing (DON) who was responsible for the completion of smoking assessments. The DON replied, our activities department completes the smoking evaluations, and the MDS coordinator assists as needed. During an interview with Surveyor #1 on 01/17/25 at 10:45 AM, the Licensed Nursing Home Administrator (LNHA) was made the LNHA aware that resident smoking assessments that were reviewed were noted to not been completed timely. The LNHA told the surveyor that the facility activities director left around a month ago and moved out of state. The LNHA told the surveyor We are actively seeking a new director. 41442 3. On 01/15/2025 at 10:50 AM, during the initial tour, Surveyor #2 observed Resident # 58 in his/her room. Resident #58 stated that he/she smokes during scheduled times and that the activities staff holds his/her cigarettes and lighter. He/she added that staff is always present during smoking times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/15/2025 at 01:51 PM, Surveyor #2 reviewed the Electronic Medical Record (EMR) for Resident #58 as follows; A review of the admission record reflected that Resident #58 was admitted to the facility with a diagnosis that included but not limited to, Metabolic Encephalopathy (a brain condition that occurs when there is an imbalance of chemicals in the blood), Major Depressive Disorder, Polyneuropathy (disease that affects peripheral nerves, causing weakness, numbness, and pain), Opioid Induced Disorder, Personality Disorder, and Anxiety. A review of the most recent MDS dated [DATE], indicated that Resident # 58 had a BIMS score of 13/15 indicating Resident #58 was cognitively intact, and under section J indicated that Resident #58 was a current smoker. A review of Resident #58's Comprehensive Care Plan had a focus area indicating, [residents name] am a smoker of long duration . A review of Resident #58's admission Smoking Safety Evaluation, with an effective date of 08/22/24, indicated that Resident # 58 was an unsafe smoker. A further review of the EMR for Resident #58 did not include any further smoking evaluations. A review of the facility policy titled Smoking Policy - Residents, Staff and Visitors, undated. The following was revealed under the Policy Interpretation and Implementation: 5. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: a. Current level of tobacco consumption. b. Method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.). c. Desire to quit smoking if a current smoker; and d. Ability to smoke safely with or without supervision (per a completed Smoking Evaluation). e. All residents that smoke are required to sign a smoking agreement contract. f. All residents that smoke are required to purchase their own smoking materials. 7. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. N.J.A.C. 8:39-31.6 (e)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 39460 Based on observations, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain an indwelling urinary catheter tubing off the floor to prevent the spread of infection. This deficient practice was identified for 1 of 2 residents (Resident #261) reviewed for catheter care and was evidenced by the following: On 1/15/25 at 11:14 AM, during initial tour the surveyor observed Resident #261 seated in a wheelchair self ambulating using his/her feet down the hallway. The resident was wearing shorts and the tubing of the urinary collection bag was visible hanging out of their shorts and the tubing was dragging on the ground below the chair. The surveyor reviewed the medical record for Resident #261 as follows: A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses which included urinary tract infection, dementia, and neuromuscular dysfunction of the bladder. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/21/24, reflected that the resident had a brief interview for mental status (BIMS) score of 14/15, which indicated a fully intact cognition. It further included that the resident had an indwelling catheter. A review of the resident's individualized person-centered Care Plan (CP) included a focus area initiated on 12/18/24 for utilizing an indwelling catheter related to a diagnosis of neurogenic bladder (bladder dysfunction caused by the nervous system). Interventions included to: monitor, document, notify medical doctor of signs and symptoms of complication; assess for urine characteristics (volume, color, clarity, odor) and document; keep drainage bag off the floor and cover for dignity; and change bag per facility protocol. During an interview with the surveyor on 01/22/2025 at 2:23 PM, the Infection Preventionist (IP) stated nothing should touch the floor, the tubing and bag should fit in the privacy bag, its important because you don't want cross contamination and germs spread and don't want the resident to get an infection. During an interview with the surveyor on 01/22/2025 at 10:29 AM, Licensed Practical Nurse (LPN #5) stated the urinary collection tubing should never touch the ground. If the tubing did touch the floor the nurse should replace it. During an interview with the surveyor on 01/22/2025 at 10:57 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated the urinary collection tubing and bag should be placed beneath the resident's bladder and in a privacy bag. The tubing should never touch the ground, its an infection control issue, the catheter bag should then be changed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the survey team on 01/22/2025 at 2:23 PM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were questioned on if it was appropriate for catheter tubing to touch the floor. The DON stated urinary collection tubing should never be on the floor, its an infection control and dignity concern. The nurse should then change the tubing for the resident. A review of the facility's undated Foley Catheter Care policy included . The drainage bag must not touch the floor at any time . The policy did not include that the tubing must also be maintained off the floor. NJAC 8:39- 19.4 (a)5; 27.1 (a)

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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. 51337 Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed implement infection control measures for the handling and storage of respiratory equipment for 1 of 3 residents reviewed for respiratory care reviewed (Resident #53). This deficient practice was evidenced by the following: During the initial tour on 01/05/2025 at 09:26 AM, the surveyor interviewed Resident #53 who stated that they had COPD (Chronic Obstructive Pulmonary Disease), (a lung disease causing restricted airflow when breathing). During the interview, the surveyor observed a nebulizer mask (a machine and tubing used to deliver an inhaled solution into the lungs) was face down inside the bedside on top of the resident's belongings including a book, mirror, napkins, and bracelet. The mask was exposed and was undated. On 01/16/2025 at 08:09 AM, the surveyor observed Resident #53 eating breakfast in bed. A nebulizer mask connected to the machine was observed inside the side table drawer exposed and undated on top of the side table. On 01/17/2025 at 09:40 AM, the surveyor observed that the resident was out of the room and the nebulizer mask laying inside the half-open bedside drawer exposed. A review of the Admission Record revealed Resident #53 was admitted to the facility with diagnoses including but not limited to; Atrial Fibrillation (condition where the heart's upper chamber beats irregularly and rapidly), and COPD. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/19/2024, reflected a Brief Interview for Mental Status (BIMS) score of 13/15, which indicated that the resident was cognitively intact. A further review of Section O reflected the resident had not received any respiratory therapy during a seven day look back period. A review of the Order Summary Report (OSR) dated as of 07/06/2024 included the following: A Physician Order dated 07/05/2024 for Albuterol Sulfate Inhalation Nebulization Solution (a medication used to treats lung conditions like asthma. It works by opening your airways to make breathing easier.) (2.5 milligram/ 3 milliliter) 0.083% (Albuterol Sulfate) 1 dose orally via nebulizer every 6 hours as needed for wheezing. A further review of the OSR showed the order for the nebulizer was discontinued on 08/05/2025. A review of the August 2024 Medication Administration Record (MAR) indicated the last time the resident had received the albuterol solution nebulization was 08/02/2024. A review of the individualized person-centered care plan included a focus for COPD which included an intervention for administration of aerosol or bronchodilators as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/21/2025 at 10:28 AM, the surveyor and the resident's Licensed Practical Nurse (LPN #1) together observed the exposed nebulizer mask in the resident's side table. LPN #1 stated that the mask should have been bagged and labeled. On 01/22/2025 at 01:55 PM, in the presence of the survey team, the Director of Nursing (DON) stated that the nebulizer mask should be put in a bag when not in use. A review of the undated facility's Oxygen Administration policy did not address the care or storage of nebulizers. NJAC 8:39-27.1 (a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 40039 Based on observation, interview, review of the electronic medical record (EMR) and review of other facility documentation, it was determined that the facility failed to consistently ensure communication with a contracted dialysis facility according to facility policy and procedure. This deficient practice was evidenced for 1 of 2 residents (Resident #88) reviewed for dialysis. This deficient practice was evidenced by the following: 1. On 01/15/2025 at 10:31 AM, during the initial tour of the facility, the surveyor interviewed Resident #88 room and asked if he/she had any concerns with their dialysis treatment. Resident #88 stated that he/she attends dialysis 4 days per week. Resident #88 stated that they had been receiving dialysis treatment for approximately 5 years. A review of Resident #88's Admission Record revealed that he/she had been admitted to the facility with the following but not limited to diagnoses: Type 2 diabetes mellitus with diabetic chronic kidney disease, end stage renal disease, and dependence on renal dialysis (a treatment to remove extra fluid and waste when kidneys fail). According to the quarterly Minimum Data Set (MDS), an assessment tool, dated 12/28/2024, Resident #88 had a Brief Interview for Mental Status score of 15/15 indicating intact cognition. Section O of the MDS revealed that Resident #88 received dialysis. According to the Order Summary Report with active orders as of 01/22/2025, Resident #88 had the following physician order: Dialysis on Mon, Tues, Thurs, Sat at [facility name] 5 AM pickup. Order date: 01/17/2025. A review of Resident #88's comprehensive care plan revealed a care planned Focus of: I [resident name] receive hemo-dialysis 3x/week related to renal disease (long duration) with an initiated ate of 09/28/2023. The following was listed as a care planned Intervention: Monitor VITAL SIGNS (Notify MD (medical doctor) of significant abnormalities. Date initiated: 09/28/2023. The care planned interventions did not reference the use of a communication record. On 01/21/2025 at 10:32 AM the surveyor reviewed the Nursing Facility/Dialysis Center Communication Records for Resident #88 via the EMR, as the forms had been scanned into the EMR by the facility. The surveyor reviewed the past 60 days of communication records up to the present date (11/2/2024-11/30/2024, 12/2/2024 - 12/30/2024 and 01/01/2025 - 01/22/2025). A review of the dialysis communication forms revealed that the facility did not document the following information to the dialysis center on the following dates for Resident #88: Information From Sending Facility; Temperature, Blood Pressure #, Pulse, Access Site Status, and Any Problems/Patient complaints or Other Concerns Since Last Dialysis Treatment on the following dates: 11/21/2024, 11/23/2024, 12/3/2024, 12/5/2024, 12/16/2024, 12/21/2024, and an undated communication record that was scanned into the EMR on 1/20/2025. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with surveyor on 01/21/2025 at 10:44 AM, Licensed Practical Nurse (LPN#3) who was assigned to Resident #88 was asked what the facility process was for residents who received dialysis and the use of the Nursing Facility/Dialysis Center Communication Records. LPN#3 told the surveyor we send a dialysis book with the resident. It's a full sheet that we document vitals before leaving and we can also report pain or details concerning the dialysis port if needed. LPN#3 further explained the dialysis center is to provide information such as pre and post weights, medications provided, vital signs and any other pertinent recommendations. The surveyor then asked LPN#3 if the top portion of the communication form in the information from sending facility section was to be completed by the assigned nurse prior to the resident attending dialysis treatment. LPN#3 stated Yes, the top portion of the form should be filled out by nurses at the facility. LPN#3 also explained that if the dialysis center forgets to document the information from dialysis center section I will call the dialysis center and obtain the necessary information. During an interview with the survey team on 01/22/2025 at 01:51 PM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor asked the DON what facility process was for documenting on dialysis communication forms prior to the resident leaving the facility for dialysis treatment. The DON told the surveyor we utilize a communication book, but urgent communications would be conducted by phone call to the dialysis facility or to the facility by dialysis. The facility is responsible for looking at the book, the weight before, and vitals before dialysis. The surveyor asked the DON if the sending nurse was responsible to fill out the Information from Sending Facility prior to dialysis treatment. The DON responded, They (nursing staff) are to ensure that the form is completed. There shouldn't be blank forms before the resident goes to dialysis. It would be good; it should be filled out. A review of a facility provided policy titled [facility name] Dialysis Policy, undated, revealed under General Statement of Policy: [Facility Name] has established standards of care for the dialysis resident. Designated Licensed Nurse will maintain the established standard of care. Section F of the policy titled Communication revealed the following: 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 information through the communication book. The communication book will be reviewed by the licensed nurse upon return from dialysis. N.J.A.C. 8:39-27.1 (a)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 34423 Based on observation, interview, and review of the Electronic Medical Record (EMR), and review of other facility documentation, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face to face visits and wrote progress notes at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. This deficient practice continued over several months for 8 of 35 sampled residents (Resident #1, Resident #31, Resident #53, Resident #59, Resident #78, Resident # 79, Resident #120, and Resident#139) and was evidenced by the following: 1.) On 01/21/2025 at 09:01 AM, a review of the EMR for Resident # 139 revealed the following: According to the Admission Record, Resident #139 was admitted to the facility with diagnoses including but not limited to: Dementia with other behavioral disturbance, anxiety disorder. A review of the EMR revealed that there was no documentation to indicate Resident #139 was seen by attending physician at any time from 06/10/2024 thru 01/08/2025. Resident #139 was seen by the Advanced Practice Nurse (APN) on 11/20/2024, 12/16/2024, and 01/08/2025. 2.) On 01/16/2025 at 10:22 AM, a review of the EMR for Resident #79 revealed the following: According to the Admission Record, Resident #79 was admitted to facility with diagnoses including but not limited to Bipolar Disorder and Neuropathy. A review of the EMR for Resident #79 did not include documentation that Resident 379 was seen by the attending physician since 07/07/2024. Resident #79 was seen by the APN on 08/29/2024, 09/30/2024, 10/22/2024, 12/23/2024, and 01/14/2025. 3.) On 01/17/2025 at 09:41 AM, a review of the EMR for Resident #59 revealed the following: According to the Admission Record, Resident #59 was admitted to facility with diagnoses including but not limited to Bipolar Disorder (a mental illness that causes extreme shifts in mood) and Non-Alzheimer's Dementia (a variety of Dementia not caused by Alzheimer's Disease). A review of the EMR for Resident #59 did not include documentation that Resident #59 was seen by the attending physician in greater than the past 60 days Resident #59 was seen by the APN on 01/16/2024, 02/15/2024, 03/29/2024, 04/25/2024, 05/03/2024, 06/11/2024, 07/01/2024, 08/01/2024, 09/11/2024, 10/03/2024, 10/31/2024, 11/13/2024, 12/09/2024, and 01/08/2025. 51337 (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) On 01/15/2025 at 01:44 PM, a review of the EMR for Resident #120 revealed the following: According to the Admission Record, Resident #120 was admitted to facility with diagnoses including but not limited to Cauda Equina Syndrome (a serious condition that occurs when the nerves in the lower back are compressed) and Obstructive Uropathy (a condition that occurs when urine flow is blocked, causing urine to build up in the kidney). A review of the EMR for Resident #120 did not include documentation that Resident #120 was seen by the attending physician since 10/17/2024. Resident #120 was seen by the APN on 10/21/2024, 10/28/2024, 10/30/2024, 11/7/2024, 11/25/2024, 12/11/2024, 01/03/2025 and 01/06/2025. 5.) On 01/20/2025 at 09:23 AM, a review of the EMR for Resident #31 revealed the following: According to the Admission Record, Resident #31 was admitted to facility with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease (COPD), a lung disease causing restricted airflow and breathing problems, and Atrial Fibrillation (irregular heartbeat). A review of the EMR for Resident #31 did not include documentation that Resident #31 was seen by the attending physician from 10/23/2024 through 12/04/2024. Resident #31 was seen by the APN on 10/23/2024, 10/31/2024, 11/11/2024, 12/10/2024,12/26/2024, and 01/02/2025. 6.) On 01/20/2025 at 02:09 PM, a review of the EMR for Resident #1 revealed the following: According to the Admission Record, Resident #1 was admitted to facility with diagnoses including but not limited to Depression and Weakness. A review of the EMR for Resident #1 did not include documentation that Resident #1 was seen by the attending physician in greater than 60 days. Resident #31 was seen by the APN on 08/01/2024, 08/15/2024, 08/22/2024, 08/23/2024, 08/26/2024, 08/28/2024, 09/05/2024, 09/30/2024, 10/08/2024, 10/17/2024, 10/24/2024, 11/05/2024, 12/11/2024, 12/18, 2024, and 01/17/2025. 7.) On 01/16/2025 at 12:39 PM, a review of the EMR for Resident #78 revealed the following: According to the Admission Record, Resident #78 was admitted to facility with diagnoses including but not limited to Cerebral Infarction (blood vessel blockage in the brain) and Major Depression (a mental health condition that involves a persistent low mood and loss of interest in activities). A review of the EMR for Resident #78 did not include documentation that Resident #78 was seen by the attending physician in greater than 60 days. Resident #78 was seen by the APN on 08/08/2024, 09/13/2024, 10/07/2024, 11/05/2024, 12/12/2024, and 01/06/2025. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8.) On 01/16/2025 at 11:58 AM, a review of the EMR for Resident #53 revealed the following: According to the Admission Record, Resident #53 was admitted to facility with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease (COPD), a lung disease causing restricted airflow and breathing problems and Atrial Fibrillation (condition where the heart's upper chamber beat irregularly and rapidly). A review of the EMR for Resident #53 did not include documentation that Resident #53 was seen by the attending physician in greater than 60 days. Resident #53 was seen by the APN on 08/05/2024, 08/14/2024, 08/16/2024, 08/22/2024, 09/03/2024, 09/24/2024, 09/30/2024, 10/07/2024, 10/10/2024, 10/19/2024, 11/19/2024, 11/21/2024, 12/10/2024, 12/18/2024, and 01/03/2025. On 01/21/2025 at 09:59 AM, the surveyor interviewed Licensed Practical Nurse (LPN#2) who stated that all physicians document their notes in the EMR since they have access to it. On 01/21/2025 at 10:03 AM, the surveyor interviewed LPN #3 who stated that all doctors' notes are in the EMR. LPN #3 further stated that if some people could not access it, the handwritten notes are scanned to the EMR, and that the facility did not have paper charts. On 01/21/2025 at 11:47 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/ UM #1) who stated that the doctors' notes were in the EMR under progress notes section. On 01/22/2025 at 12:45 PM, Surveyors #1 and #2 interviewed the Medical Director (MD) who stated that he see's their patients every other month or every third month. MD stated that they usually see their patients in the hospital. The MD confirmed that they do not write physician notes and instead the APNs write the physician notes in the EMR. During an interview with the survey team on 01/22/2025 at 01:55 PM, the Director of Nursing (DON) stated that the APNs visit the residents twice a week and that the medical director could be contacted anytime. The DON further stated that the physician notes were in the EMR which included the History and Physical Examination, diagnosis list, medication review, current complaints, and laboratory findings. A review of a facility provided policy titled Physician Services revised in April 2013 under Policy Interpretation and Implementation included 5. Physician visits, frequency of visit, emergency care of residents, etc. are provided in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. Consultative services shall be made available from community-based consultants or from a local or medical center. NJAC 8:39-23.2 (b), 23.2 (d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

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. 40039 Based on observation, interview, and document review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner. This deficient practice was evidenced by the following: On 01/15/2025 at 09:16 AM, the surveyor, accompanied by the Food Service Director (FSD) observed the following in the kitchen: 1. A meat slicer was observed on a metal table in the cook's area. The meat slicer was not covered and was exposed to the air. The surveyor asked the facility cook if she had used the meat slicer at any point this AM for food production. The cook stated that she had not utilized the meat slicer for food production this AM. The surveyor asked the FSD if the meat slicer was cleaned and sanitized and he said yes that it was cleaned and sanitized. The table behind the blade guard/slicer wheel had unidentified food debris and a white slimy substance present when observed. The meat slicer was not covered while not in use and was exposed to contamination. The cook then further clarified to the surveyor that she had not used the meat slicer today. When interviewed the FSD confirmed that the meat slicer was cleaned and sanitized and stated it was not going to be used any time soon. The FSD then told a kitchen staff to re-clean and sanitize the meat slicer and cover it when not in use. 2. On a lower shelf of what the FSD identified as Drying Rack number 2 a stack of approximately 8 deep 1/4 pans were in the inverted position. The surveyor lifted the top quarter pan and observed a wet water-like substance on the pan directly below in the stack, commonly known in the food service industry as wet nesting (the practice of stacking wet dishes or pots and pans together, which prevents them from drying and creates an environment where bacteria and other microorganisms can grow). The FSD told the surveyor there wet when he observed the stack of deep 1/4 pans. The surveyor and FSD touched with their finger the 1/4 pans and agreed that the pans were not completely air dried prior to stacking. The top 4 pans in the stack were all observed to be wet with a clear, water-like liquid. The deep 1/4 pans were removed from the rack and returned to the dish room to be rewashed and sanitized and completely air dried prior to stacking. On 01/21/2025 from 09:21 to 09:34 AM, the surveyor, accompanied by the Licensed Practical Nurse/Unit Manager (LPN/UM #2), observed the following on the North Pantry/Nourishment room: 1. The surveyor observed a thick buildup (about a 1/4 inch) of ice on the bottom of the freezer. Embedded in the ice was a white plastic spoon and what appeared to be several pieces of white napkin, aluminum foil, and what appeared to be Styrofoam pieces. There were also bagged ice packs stored in the freezer with resident food. When interviewed the LPN/UM #2 did not know who was responsible for the maintenance of the pantry/nourishment room freezer. A review of the facility policy titled Foods Brought by Family/Visitors, reviewed 5/2023, failed to identify who was responsible for the maintenance and sanitation of the facility resident nourishment refrigerators. A review of a facility provided policy titled [facility name] Sanitization/Cleanliness, revised November 2024, revealed under Policy Interpretation and Implementation: (continued on next page)

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	315293	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination. 8. When cleaning fixed equipment (e.g., mixers, slicers, and other equipment that cannot readily be immersed in water), the removable parts are: a. washed and sanitized and non-removable parts cleaned with detergent and hot water, rinsed, air-dried, and sprayed with a sanitizing solution (at the effective concentration); and b. the equipment is reassembled and any food contact surfaces that may have been contaminated during the process are re-sanitized (according to the manufacturer's instructions). N.J.A.C. 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
	315293	A. Building B. Wing	01/23/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 41442 Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to maintain a Hospice Communication Record for 1 of 1 resident (Resident #85) reviewed for Hospice Services. This deficient practice was evidenced by the following: During the initial tour of the North Unit on 01/15/2025 at 10:19 AM, the surveyor observed Resident #85 in his/her room with no concerns. At that time, Resident #85 was identified as having Hospice Services. A review of the admission record, revealed Resident # 85 was admitted with diagnoses including but not limited to; Encounter for Palliative Care, Depression, and Sacral Wounds. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 12/14/24 indicated that Resident #85 was on Hospice Care. A review of Resident #85's individual comprehensive care plan (ICCP) on 01/16/2025 at 11:39 AM, included a focus area, dated 12/6/24, that indicated resident #85 was on Hospice. Interventions included to coordinate Care Plan with Hospice, evaluate effectiveness of medications/interventions to address comfort, and to notify hospice of any change in condition or medication changes. During an interview with the surveyor on 01/17/2025 at 9:22 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM #2) was asked to provide Resident #85's Hospice Communication Book. At that time, LPN/UM#2 stated that she would have to get permission from her Director of Nursing. LPN/UM #2 then provided the Hospice Communication Book and upon review of the book, there were only 2 documents found that included a facility billing notification and a symptom management recommendation. When further questioned, LPN/UM #2 was unable to provide any additional documentation or communication from the Hospice providers. A review of the facility's Hospice Program policy, with a review date of 5/2023, included, Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day . NJAC 8:39-27.1(a)