STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Fountains of Atco	114 Hayes Mill Road Atco, NJ 08004

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 0689 Level of Harm - 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** Complaint #: 2704937; 414412 Based on observation, interview, and record review, it was determined that the facility failed to ensure a) adequate supervision was provided to a cognitively impaired resident (Resident #7) identified as being at high risk for falls, impulsive, and required supervision. Resident #7 sustained 13 falls including three falls with injury that required transfer to the emergency room on 8/10/25, for a contusion and laceration to the left supraorbital and frontal scalp; on 10/28/25, for a large intramuscular hematoma to the right thigh, and on 11/14/25, for a closed head injury and laceration to the forehead which required sutures; b) ensure each fall was thoroughly investigated to prevent additional falls; and c.) consistently initiate and implement new fall prevention interventions in response to falls to prevent further falls. This deficient practice identified for 3 of 3 residents reviewed for falls (Resident #7, #27, and #70) and was evidenced by the following: A review of the facility's policy titled Managing Falls and Fall Risk, dated/revised 3/2018, included the staff would identify interventions related to the resident's specific risks and causes to prevent the resident from falling and minimize complications from falling.Under Resident-Centered Approaches to Managing Falls and Fall Risk included; that the staff with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls.the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather many at once). When a fall reoccurred despite initial interventions, the staff would implement additional or different interventions or indicate why the current approach remained relevant. If underlying causes could not be readily identified or corrected, staff would try various interventions, based on assessment of the nature or category of falling, until reduced or stopped, or until the reason for the continuation was identified as unavoidable. Under Monitoring of Subsequent Falls and Fall Risk included that the staff would monitor and document each resident's fall response to interventions intended to reduce falling or the risks of falling. For continued falls the staff would re-evaluate the situation and the appropriateness to continue or change current interventions and the attending physician would help the staff reconsider possible causes that may not have been identified. A review of the facility's Falls- Clinical Protocol Policy, revised September 2012, and the Falls Risk Assessment Policy, revised March 2018, were also reviewed. All three policies did not include supervision related to falls. 1. On 1/05/26 at 10:00 AM, the surveyor toured the nursing unit and observed Resident #7 seated in a wheelchair in the dayroom (room [ROOM NUMBER]). The resident had a peg board on the table and was trying to play with the board. The resident could not communicate with the surveyor. The resident appeared restless and confused and there was no staff in attendance. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Some	On 1/05/26 at 11:00 AM, the surveyor observed Resident #7 in the dayroom (room [ROOM NUMBER]) seated at a table alone, along with seven other residents. There was no staff observed in attendance. At 11:20 AM, the surveyor observed a staff member coming from the other room (staff identified it as the Purple Room), and the staff member identified herself as the Activity Aid (AA). The AA informed the surveyor she had to provide activities and monitor both rooms by herself, and she stated she didn't have any help. The AA informed the surveyor that the facility used two dayrooms where the Certified Nurse Aides (CNAs) brought the residents to after providing morning care, and the residents could attend activities in either room [ROOM NUMBER] or the Purple Room. According to the AA, the facility assigned only one staff member to cover both activity rooms. There was no staff observed in the first room to supervise the residents, while the AA had to monitor the residents in the Purple Room. On 1/06/26 at 11:15 AM, the surveyor observed Resident #7 seated alone at a table in room [ROOM NUMBER]. The resident appeared restless and was observed attempting to stand, moving back and forth in the wheelchair. The AA was in the Purple Room and there was no clear, unobstructed path to visualize what was happening in room [ROOM NUMBER]. The surveyor interviewed the AA and inquired who was responsible to supervise and provide activities to room [ROOM NUMBER] while she was attending to the residents in the Purple Room. The AA stated that currently she had no help, and at times she had to transport some of the residents to the hairdresser, so she had to ask the nursing staff to keep an eye on both rooms. The AA stated there were no staff physically assigned to monitor the activity area if she had to step out. The AA asked the surveyor what the ratio should be for activities as she was aware that she could not provide activities and supervise both rooms. The surveyor referred her to the Licensed Nursing Home Administrator (LNHA). The surveyor then asked the AA if she discussed her concerns with the Activity Director, and she stated, yes. On 1/06/26 at 11:35 AM, the surveyor interviewed the CNA who cared for Resident #7. The CNA stated that Resident #7 required extensive assistance with care, was very confused, and required supervision to prevent falls. The CNA further stated that the resident was usually transferred to the dayroom after care for activities. On 1/06/26 at 11:45 AM, the surveyor interviewed Resident #7's Charge Nurse regarding resident falls. The Charge Nurse stated that all the falls were reviewed during morning meetings and the Director of Nursing (DON) updated the care plan. On 1/06/26 at 11:55 AM, the surveyor requested all of Resident #7's fall investigations, their fall risk assessments, and a timeline of their falls from the DON. On 1/07/26 at 10:11 AM, the surveyor observed Resident #7 in room [ROOM NUMBER] with six other residents and there was no staff in attendance. Resident #7 was observed attempting to stand from the wheelchair and another resident (unsampled) asked the resident to sit down. There was no staff in attendance. The surveyor walked to the next room, the Purple Room, and observed the AA in the back of the Purple Room with her back facing the entrance door to the room, looking through papers. The AA was unable to visualize the residents in room [ROOM NUMBER] that was divided by a wall. At that time, the residents in room [ROOM NUMBER] were left unattended. At 10:18 AM, the surveyor was about to exit the door, when the AA came into the room and stated to the surveyor that she had to get something from the Purple Room. On 1/07/26 at 11:30 AM, the surveyor reviewed Resident #7's medical record which revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A review of the admission Face Sheet (an admission summary), reflected that Resident #7 was admitted to the facility with diagnoses which included but were not limited to; aphasia following cerebral infarction (loss or impairment of language ability due to brain injury following a stroke), muscle weakness, bipolar disorder, current episode hypomanic (elevated mood), repeated falls, traumatic subdural hemorrhage with loss of consciousness (blood collects under the brain's outer layer due to head injury), adult failure to thrive. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 11/12/25, reflected that Resident #7 had a Brief Interview for Mental Status (BIMS) score of 3 out 15, which indicated a severely impaired cognition. A review of Resident #7's Comprehensive Care Plan provided by the facility on 1/07/26, included a focus area initiated 4/11/25, that Resident #7 was at risk for falls. The goal was that Resident #7 will be free from falls related injuries through the next review date: 10/15/25, with a target date of 3/24/26. The interventions included:Keep items of importance within reach, initiated 4/14/25. The resident had a special scoop mattress to the bed to facilitate proper positioning and to deter them from rolling off the bed, initiated 4/14/25.The resident was impulsive and has poor safety awareness and requires prompt response to all requests for assistance, initiated 4/14/25.Maintain the bed in the lowest position, initiated 4/18/25.Evaluate the environment at the time of the resident's fall and identify any factors that may have contributed to the fall, initiated 4/22/25. Therapy to screen/evaluate and/or treat as indicated, initiated 4/22/25. The resident was to be in the common area when out of bed, and do not leave the resident alone in the room in the wheelchair, initiated 4/28/25. Staff to bring resident out of the room after morning care to participate in activities of their choice, initiated 4/28/25. The resident needs supervised activities that minimize the potential for falls while providing diversion and distraction, initiated 10/29/25. On 1/07/26 at 11:40 AM, the following Fall Risk Evaluations were provided by the DON: -Fall Risk Evaluation dated 1/16/25, reflected Resident #7 scored a 20, which indicated a high fall risk. (10 or above = high risk for falls).-Fall Risk Evaluation dated 4/16/25, reflected that the facility identified Resident #7 as a high fall risk. Resident #7 received a score of 24. -Fall Risk Evaluation dated 4/24/25, reflected that the facility identified Resident #7 as a high fall risk. Resident #7 received a score of 24. -Fall Risk Evaluation dated 7/23/25, reflected that the facility identified Resident #7 as a high fall risk. Resident #7 received a score of 21.-Fall Risk Evaluation dated 10/24/25, reflected that the facility identified Resident #7 as a high fall risk. Resident #7 scored a 22. The following incidents and Fall Evaluations were documented in the electronic Medical Record, and/or provided by the DON, and revealed the following:-On 11/11/24 at 1:03 PM, a Nursing Progress Note revealed Resident #7 was found on the floor by the housekeeping staff between the bathroom and the bed. There was no fall investigation provided by the facility. -On 11/27/24 at 12:30 PM, a Nursing Progress Note revealed that the writer was called to room by the CNA, and they observed the resident laying on the floor in the room, next to the wheelchair on their right side. The resident was incontinent, and Resident #7 was provided with incontinence care and taken to the common area. There was no fall investigation provided by the facility. -On 11/29/24 at 7:40 PM, a Nursing Progress Note revealed the resident fell in the room and sustained a skin tear. There was no fall investigation provided by the facility. -On 12/09/24 at 2:20 PM, a Nursing Progress Note revealed the resident found on the floor in the activity room. No investigation was provided for this fall. The facility did not identify who was responsible to monitor the resident in the dayroom. -On 12/14/24 at 8:06 PM, a Nursing Progress Note revealed that the resident was found on the floor in the doorway of the room (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	and sustained a skin tear to the right elbow. There was no fall investigation provided by the facility. -On 3/31/25 at 7:00 PM, a Nursing Progress Note revealed that the resident was found on the floor in the room, and upon assessment, Resident #7 was noted with redness to the left arm. A review of the corresponding Unwitnessed Fall report dated 3/31/25, did not include a causal factor for the fall. The Interdisciplinary Care (IDC) team indicated that, The resident has been identified as high risk for falls. All current interventions remain appropriate and in place. Additional interventions are not appropriate at this time. The goal for the resident is to prevent injury from falls.- On 4/09/25 at 9:06 AM, a Nursing Progress Note revealed that the resident was found on the floor in the room, and that the CNA found the resident on the floor in the room, on their back leaning against the bed. The resident was assisted to bed with no injury noted. Neurological checks were initiated. The corresponding Unwitnessed Fall investigation dated 4/09/25, revealed the aide reported the resident on floor. 4/10/25, the IDC team reviewed the fall. The resident fell from bed, the resident was impulsive and does not recognize limits.No revised interventions added to the Care Plan.-On 4/17/25 at 10:15 PM, an Incident report dated 4/17/25, reflected that Resident #7 was found in the room between the bed and the bathroom's door. The recommendation was to maintain their bed in the lowest position. According to the staff, the resident was attempting to go the bathroom. The IDC team notes dated 4/18/25, documented the resident remains impulsive and with poor safety awareness. Bed in lowest position. -On 8/10/25 at 9:11 PM, an Incident Report revealed Resident #7 sustained a fall in the hallway during transfer. The progress notes revealed that the resident was observed lying on the floor in the hallway with swelling and blood dripping from left side of their head. The resident stated, I fell and hit my head. The CNA assisted the resident into the wheelchair and the resident fell forward. The resident was transferred to the Emergency Department (ED) and was diagnosed with soft tissue injury to left supraorbital and frontal scalp, contusion and laceration (skin tear and bruising in the area above the eye). The IDC team's recommendations were to educate staff on safely repositioning in the wheelchair. During the transfer to the room, there was no leg rest in use. According to the CNA's statement, the resident's legs got caught underneath, the resident fell and hit their head. -On 10/06/25 at 2:00 AM, an Incident Report revealed during rounds, a CNA found the resident on the floor. The bed was low, and the IDC team met on the same day to discuss the fall and there was no causal factor indicated for the fall per the resident's care plan intervention, and the care plan interventions were not reviewed or revised.-On 10/28/25 at 11:30 AM, an Incident Report revealed that a CNA alerted the nurse that Resident #7 was found on the floor in the activity room with the wheelchair behind them. On 10/29/25, the IDC team reviewed the fall, and it was determined that Resident #7 would stand and sit repetitively even when there would be a puzzle or activity in front of them. During the fall, Resident #7 stood up and went to sit down and missed the chair and sat on the floor. The resident needs supervised activities that minimize the potential for falls while providing diversion and distraction. - On 11/4/25 at 7:42 AM, following the fall of 10/28/25, the CNA reported to the nurse that Resident #7 had right leg bruising and was swollen and was warm to the touch. The resident was transferred to the ED for evaluation and treatment. A review of the hospital records revealed a history of fall and trauma. A computed tomography (CT) scan (diagnostic imaging that uses a combination of X-rays and computer technology to produce images of any part of the body) of the right lower extremity was performed on 11/04/25, which revealed a large intramuscular hematoma (bruise) to the right leg, measuring 28 centimeters (cm) by (x) 6.5 cm x 4.3 cm. Resident #7 remained at the hospital from [DATE] to 11/08/25. The resident was also diagnosed with bandemia (large amount of immature white blood cells (band cells) released by bone marrow to fight infection or inflammation. Common causes are severe pain or stress, tissue damage.) There was no acute fracture. -On 11/14/25 at 4:03 PM, a late entry Incident Note revealed that Activity Saff reported that the resident was found on the floor in the activity room. The resident was actively bleeding from the right side of their forehead with injury above their eyebrow with a 3-centimeter cut noted and discoloration on their nose bridge noted. The resident was transferred to the emergency room for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	facial/head injury. The resident sustained a laceration above the right eye, bruises to the bridge of nose, open area to the right side of the head. The resident was diagnosed with closed head injury and facial laceration (skin tear) that required sutures (stitches). The Incident Report dated 11/14/25, revealed that on 11/17/25, the IDC team reviewed the fall and determined that Resident #7 attempted to ambulate and fell and All current interventions remain appropriate and in place. Additional interventions are not appropriate at this time. The goal for the resident is to prevent injury from falls. The IDC team did not address the failure to supervise the resident after it was documented post fall on 10/28/25, that the resident required supervision while in activities. A review of the therapy Screen/Referral Form dated 9/30/25, revealed the following: After speaking with nursing staff and CNA, as well as observation of [the resident], [the resident] may at times demonstrate unsafe behavior (stands up with I to participate in [activities of daily living (ADLs)], however this is [the resident's] typical behavior. There has been no decline in ADLs or transfer. No [occupational therapy] indicated. The facility did not indicate what measures were put in place to address the unsafe behavior. On 1/08/26 at 9:53 AM, the surveyor interviewed the DON regarding Resident #7's multiple falls at the facility including the falls with injuries. The DON stated that the staff should have followed the care plan. When asked if Resident #7 had behaviors, the DON stated, No. The DON added that Resident #7 was easily redirected, and Resident #7 attempted to stand up all the time as this is their ritual, someone has to remind them to sit. On 1/09/26 at 11:39 AM, the surveyor interviewed and shared the above concerns with the Activity Director (AD) regarding staffing. The AD stated, the activity needs to be re-evaluated, currently staffing is lacking, and stated her expectations were to re-evaluate and provide a safe environment to all residents. When asked if her expectations were being met/considered, she stated that she was aware of the staffing issue, that the activity staff had to oversee residents in both rooms, and she did not have a plan yet to resolve the staffing issues and ensure the residents' needs were met. A review of the Activity Director Position Description revealed the following: The activity director is responsible for the development, implementation, and supervision of the full scope of the facility's recreation services. This includes providing an ongoing inclusive program that uses purposeful activities to improve and maintain the quality of life for residents. The Activity Director was to uphold and safeguard resident's rights, advocates for and on behalf of residents. 2. The surveyor reviewed the electronic medical record (EMR) which revealed a comprehensive Minimum Data Set (MDS), an assessment tool dated 8/05/24, which indicated Resident #70 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated an intact cognitive function. a further review of the MDS revealed Resident #70 required maximum assistance for transfers and had diagnoses that included but were not limited to; Alzheimer's disease, anxiety, and diabetes. A review of the individual comprehensive care plan (ICCP) included a focus area dated 7/29/24, for high risk for falls. The focus area was updated to include a fall with no injury on 8/03/24, a fall with no injury on 8/06/24, a fall with no injury on 8/11/24, a fall with no injury on 8/14/24, a fall with no injury on 8/30/24, and an actual fall with skin tear to their left hand and elbow on 10/18/24. Interventions dated 7/29/24, included to review information on past falls and attempt to determine cause of falls; record possible root causes; after remove any potential causes if possible; anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; the resident needs prompt response to all requests for assistance; educate the resident/family/caregivers about safety reminders and what to do if a fall (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	occurs; ensure that the resident is wearing appropriate footwear; follow facility fall protocol; maintain bed in lowest position while in bed; offer and provide toileting assistance before and after meals, at bedtime and as needed. An intervention dated 8/06/24, was physical therapy (PT) and occupational therapy (OT) evaluate and treat as ordered or as needed (PRN). An Intervention dated 8/11/24, was to encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Interventions dated 8/14/24, were to continue as risk plan and offer activities that minimize the potential for falls while providing diversion and distraction. An intervention dated 10/21/24, was the resident currently needs new glasses and will be seen by the optometrist on 10/23/24. Monitor closely at this time until new glasses are received. According to documentation reviewed, there were no new interventions for the falls that occurred on 8/30/24. A review of the facility provided Accident/Incident reports did not indicate when the resident was last seen or toileted, footwear at time of the incident, position of bed (if applicable), or if resident had participated in activities as per ICCP interventions. Effectiveness of interventions were not evaluated and a root cause of falls not identified. A review of the facility provided Fall Risk Evaluation dated 7/29/24, indicated that Resident #70 scored a 22 (above 10 indicates high risk for falls). No additional fall risk evaluations provided. On 1/09/26 at 10:55 AM, the survey team interviewed the Director of Nursing (DON), who stated that when there was a fall, the nurse on duty did the incident report. The DON continued that the Interdisciplinary care team (IDCT) met the next morning to look for the root cause of the fall, and interventions were put into place immediately, before investigation was complete. The DON stated as a team, the fall was reviewed to look at what happened, and the care plan was updated with intervention(s) to prevent further falls. The DON stated they contacted whoever was needed for the intervention (i.e. therapy if PT or OT was indicated). The DON stated when the investigation was complete, we changed the interventions if needed. A review of the facility provided policy Falls - Clinical Protocol, dated revised March 2018, which included:Assessment and Recognition .2. In addition, the nurse shall assess and document/report the following .h. Precipitating factors, details on how the fall occurred .5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations, etc .Cause Identification: 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall .2. If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes .Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation . 3. On 1/05/25 at 10:44 AM, the surveyor observed Resident #27 in the activities room, seated in a high back wheelchair, well dressed, groomed, asleep and was not awakened by the surveyor's voice. The surveyor reviewed the medical record for Resident #27. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	According to the resident's admission Record, Resident #27 was admitted to the facility with diagnoses that included but not limited to; hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs and facial muscles) following cerebral infarction (stroke due to disrupted blood flow to the brain) affecting left non-dominant side and epilepsy. A review of the most recent quarterly MDS dated [DATE], reflected the resident had a BIMS score of 2 out of 15, which indicated the resident had a severely impaired cognition. Section E -Behavior reflected the Resident #27 did not exhibit behaviors related to the rejection of care. Section GG, Functional Abilities, reflected Resident #27 was dependent (helper does all the effort) for upper and lower body dressing and toileting (adjust clothes before and after voiding or bowel movements). A further review of the MDS under Section J1800 Falls revealed the resident had a fall that resulted in an injury (skin tears, abrasion, laceration, superficial bruises, hematomas and sprain; or any fall -related injury that caused the resident to complain of pain). A review of the facility Risk Management Report (RMR) dated 8/12/25 at 6:45 PM, revealed Resident #27 had fallen while being turned on their right side, by the Certified Nursing Assistant (CNA). The report was prepared by the Licensed Practical Nurse (LPN) who was alerted by the CNA. The LPN also documented that the Resident #27's leg hit the floor while their body remained on the bed. The RMR did not include Resident #27's signed statement but was described as aware of who they were and the situation. Further review of the RMR reflected that on 8/13/25, the interdisciplinary (IDCP) team met to discuss Resident #27's fall and resulted in staff education of positioning the resident in the center of the bed before turning to one side or the other. A review if the individualized comprehensive care plan (CP) for Resident #27 under falls did not include the incident that occurred on 8/13/25, and the CP was not updated after that fall, including that the fall occurred and the intervention discussed of proper positioning Resident #27 required prior to being turned to one side or the other. On 1/09/26 at 10:15 AM, during an interview with the surveyor, the Licensed Practical Nurse/Charge Nurse stated that the Director of Nursing (DON) was responsible for updating the resident's CP. On 1/09/26 at 10:49 AM, during an interview with the surveyor, the DON stated that the Assistant Director of Nursing (ADON) was responsible for collecting the data for all incidents and accidents reported and that she as the DON reviewed the information the ADON collected. The DON stated that after a fall, the interdisciplinary team (included the DON, ADON, social services, rehabilitation services and activities) met as a team to review and placed interventions prior to the completion of investigation to prevent further falls. On 1/09/26 at 12:02 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the DON, the surveyor discussed the concerns regarding Resident #27's CP was not updated to include the intervention discussed during the IDCP meeting on 8/13/25, to prevent falls. A review of the provided policy titled; Managing Falls and Fall Risk included that the staff would monitor and document each resident's response to interventions intended to reduce falling or risk of falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	No further information was provided. N.J.A.C. 8:39-27.1(a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and document review, it was determined that the facility failed to have a system in place to ensure a) prior to hire, all employees were pre-screened to ensure that they had not been found guilty in a court of law of abuse, neglect, or misappropriation, or had findings entered into the state nurse aide registry or against a professional license, and b) a process was in place to maintain documentation to confirm an appropriate pre-screening had occurred for all contracted facility employees which including dietary and housekeeping. The deficient practice was identified for 28 of 55 (50%) employee files reviewed that were provided by the facility (99 out of 154 employee files were not able to be provided by the facility).The evidence was as follows: A review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021 included:Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: . 4.Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: ^a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; b. had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment or residents or misappropriation of resident property. On 1/5/26 at 9:40 AM, the surveyor requested a list of all employees, including contracted employees, that had been hired since 6/28/24 (last recertification survey date) and included employee name, date of hire, title, and date of separation (if applicable) from the Human Resources Director (HRD). On 1/6/26 at 7:55 AM, the HRD provided the list of 154 employee names with their status, title, department, date of hire and termination date (if applicable). The surveyor requested the HRD to provide all of the corresponding new hire documentation, including medical information, for the 154 employee names on the list. Thirty-five of the employees were listed as working for the Dietary and Housekeeping Department which was contracted with the facility. On 1/07/26 at 9:00 AM, the HRD provided the surveyor with 55 out of a total of 154 employee files requested. A review for employee files revealed the following:Employee # 2 was hired on 8/14/25, and a criminal background search was completed and dated 11/5/25 (22 days after employee #2 began working).Employee # 3 was hired on 9/4/25, and a criminal background search was completed and dated 11/4/25 (61 days after employee #3 began working).Employee # 7 was hired on 7/10/25, and there was no criminal background report report in the file. Employee # 8 was hired on 7/30/25, and a criminal background search was completed and dated 11/5/25 (98 days after employee #8 began working).Employee # 11 was hired on 5/29/25, and there was no criminal background report in the file. Employee # 12 was hired on 8/1/24, and a criminal background search was completed and dated 10/29/25 (89 days after employee #12 began working).Employee # 13 was hired on 6/5/25, and a criminal background search was completed and dated 10/30/25 (146 days after employee #13 began working).Employee # 14 was hired on 12/3/24, and a criminal background search was completed and dated 3/25/25 (112 days after employee #14 began working).Employee # 15 was hired on 9/5/25, and a criminal background search was completed and dated 10/29/25 (54 days after employee #15 began working).Employee # 17 was hired on 9/4/25, and a criminal background search was completed and dated 10/29/25 (55 days after employee #17 began working).Employee # 18 was hired on 7/17/25, and there was no criminal background report in the file. Employee # 19 was hired on 3/13/25, and a criminal background search was completed and dated 10/29/25 (230 days after employee #19 began working).Employee # 20 was hired on 8/28/25, and there was no criminal background report in the file. Employee # 22 was hired on 3/27/25, and a criminal background search was completed and dated 10/29/25 (216 days after employee #22 began (continued on next page)

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The Fountains of Atco	114 Hayes Mill Road Atco, NJ 08004

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	working).Employee # 25 was hired on 1/7/25, and a criminal background search was completed and dated 10/29/25 (295 days after employee #25 began working).Employee # 28 was hired on 8/14/25, and a criminal background search was completed dated 10/30/25 (76 days after employee #28 began working).Employee # 31 was hired on 5/19/25, there was no criminal background report in the file. Employee # 32 was hired on 7/29/24, and a criminal background search was completed dated 10/30/25 (93 days after employee #32 began working).Employee # 37 was hired on 6/26/25, a criminal background search was completed and dated 11/4/25 (131 days after employee #37 began working).Employee # 38 was hired on 9/4/25 a criminal background search was completed and dated 11/4/25 (61 days after employee #38 began working).Employee # 39 was hired on 7/10/25, and there was no criminal background report in the file. Employee # 42 was hired on 8/21/25, a criminal background search was completed and dated 11/4/25 (76 days after employee #42 began working).Employee # 44 was hired on 2/7/25, a criminal background search was completed and dated 2/13/25 (Five days after employee #44 began working).Employee # 45 was hired on 7/31/25, a criminal background search was completed and dated 11/5/25 (36 days after employee #45 began working).Employee # 46 was hired on 7/24/25, a criminal background search was completed and dated 11/4/25 (88 days after employee #46 began working).Employee # 47 was hired on 9/1/25, a criminal background search was completed and dated 10/20/25 (50 days after employee #47 began working).Employee # 49 was hired on 9/6/24, a criminal background search was completed and dated 11/4/25 (59 days after employee #49 began working). Employee # 52 was hired on 5/22/25, a criminal background search was completed and dated 11/5/25 (162 days after employee #52 began working).Employee # 55 was hired on 9/11/24, a criminal background search was completed and dated 11/4/25 (54 days after employee #55 began working). On 1/07/26 at 12:27, PM, the HRD in the presence of the Licensed Nursing Home Administrator (LNHA), confirmed that they were unable to provide all requested employee files. The HRD stated we cannot find them. When asked how do you know that all the employees were not excluded to work based on a criminal back search, they were unable to answer.On 1/9/26 at 8:19 AM, the LNHA provided a copy of the Master Dining Service Agreement (Contractor) executed on 12/20/23 and commencing on January 1, 2024, the Contractor would provide the services identified on Exhibit B. Exhibit B which revealed: Management and Labor Responsibilities: Background checks for employees, at its cost, as required by, and in compliance with applicable federal and stated law. The Client Responsibilities section revealed: Vaccines, other physical and medical exams and tests, and drug screenings not required by the applicable state and federal authorities. On 1/9/26 at 9:30 AM, the Food Service Director provided a copy of an unsigned Dining Services Director/Account Manager Job Description which revealed under Job Function . Maintains personnel files in a locked cabinet. On 01/09/26 at 10:02 AM, the HRD confirmed that the background checks that were provided were what was available and confirmed that all background checks and references were not completed for all employees prior to date of hire. The HRD stated, I can't do references and background checks for employees that have been terminated. On 01/09/26 at 11:38 AM, the HRD confirmed that she had never received any of the 35 employee files requested from the Contractor and was unable to confirm if the required background checks were completed prior to hire. On 01/09/26 at12:01 PM, during and exit conference held with the LNHA and Director of Nursing, no further information was provided.NJAC 8:39-9.3(b)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure a) sufficient and competent staff were available to provide timely and appropriate incontinence care, showers, and feeding assistance for residents who were dependent on staff for Activities of Daily Living (ADL's) care, b) ensure staff were available to supervise residents identified as high fall risks, c) competent to reposition a resident in bed so the resident did not sustain a fall, and d) ensure minimum Certified Nurse Aide staffing requirements were consistently met. The deficient practice was evidenced for 5 of 5 residents who attended a resident council meeting, 4 of 4 residents reviewed for ADLs (Resident #9, Resident #22, Resident #73, Resident #74) and 2 of 2 residents reviewed for accidents (Resident #7 and Resident #27) and affected all residents who resident at the facility.The evidence was as follows: The deficient practice was as follows:Refer to F610, F677 & F689a) On 1/5/26 at 10:12 AM, during the initial tour of the facility, a strong odor of urine was permeated in the hallway. The surveyor continued the tour and entered Resident #22's room. A strong urine odor was noted in the room. The surveyor asked a Certified Nurse Aide (CNA) to assist with an incontinence tour. Resident #22 had 2 incontinence briefs on and was soiled with urine and feces. The CNA exited the room and returned 10 minutes later. The surveyor asked CNA #1 to check if the resident was incontinent. The surveyor observed Resident #22 wearing two incontinence briefs, the 1st brief was saturated with urine and soiled with feces. CNA #1 informed the surveyor that the 11:00 PM to 7:00 AM, staff provided care and left the two briefs on the resident. The surveyor then asked CNA #1 to ask the charge nurse to come to the room.On 1/5/26 at 10:30 AM, the surveyor summoned the Licensed Practical Nurse (LPN) Charge Nurse to the room and we both observed that the incontinent briefs were soiled with urine and feces. The LPN stated in the presence of CNA #1, that the resident should not have been wearing two incontinence briefs.On 1/6/26 at 8:30 AM, the surveyor observed the resident in the bathroom, CNA #2 was in the room making the bed. During an interview with CNA#2, she stated that the resident was aware of their incontinence needs, the resident required assistance with transfer from the bed to the bathroom.On 1/6/26 at 9:20 AM, the surveyor conducted an interview with Resident #22. The resident informed the surveyor that they did not request to wear two incontinence briefs. The resident stated that they were aware when they had to use the bathroom.On 01/07/2026 10:10 AM, the surveyor interviewed the Director of Nursing regarding incontinence care protocol. The DON stated incontinence care was to be provided every 2 hours and as needed. The DON also stated that no resident should have 2 incontinence briefs on, as the skin could be affected. The DON stated that she was made aware of the issue with the above resident, in-service education was done, she will provide the in-service education regarding incontinence care. On 01/07/2026 at 12:16 PM, the surveyor interviewed again CNA #1 who cared for Resident #22 on 1/5/26. The CNA admitted and contradicted the earlier statement provided to the surveyor and admitted that she placed the two briefs on the resident. CNA #1 stated again that the resident was a heavy wetter it is much easier for the resident and staff. The surveyor then asked CNA #1 what should be done for a resident that was frequently incontinent, CNA #1 stated, change them, or assist them to the bathroom.b. On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility Resident #74 stated it's bad here and the resident stated, I am paralyzed. Resident #74 stated they wanted to be transferred to [another facility name] and the Social Worker (SSD) had been made aware. Resident #74 also reported that a couple weeks ago they called 911 because the staff did not feed me breakfast. Resident #74 stated they were worried because it was after 10:00 AM and the staff did not feed me, and Resident #74 stated that they were a diabetic and they started feeling unwell. Resident #74 also reported that they had not received a shower since they were admitted to the facility. The resident stated that every time the resident asked for a shower the staff stated the water was (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cold.On 1/06/26 at 9:22 AM the surveyor requested the Unit Manger (UM) provide documentation of the showers that were given to the residents. The surveyor reviewed the facilities shower binder for Skin Monitoring: Comprehensive CNA Shower Review Sheets (SRS) for December 2025 and January 2026. There were none found for resident #74. In addition, there were no skin assessments found in the medical record for resident #74. On 1/06/26 at 9:30 AM, the surveyor interviewed the Unit Manger (UM) regarding the Skin Monitoring: Comprehensive CNA SRS for Resident #74. In the presence of the surveyor, the UM reviewed the shower binder and was unable to find any shower sheets for Resident #74. The UM stated she would look for them. No further information was provided. On 1/06/26 at 12:15 PM Resident #74 stated I used to get a shower at the other facility. I would get out of bed for a shower oh yes! On 1/06/26 at 12:43 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that she had taken care of Resident #74. She stated that their shower days were Wednesday and Sunday 7 AM- 3 PM. The resident's CNA stated that she always offered Resident #74 a bed bath not a shower. CNA stated, they can't stand and don't like the shower bench and if they refused, I would document refused in the CNA documentation system. The surveyor then reviewed the CNA documentation system for December 2025 and January 2026 CNA task Bathing: Self Performance revealed Resident Refused column was left blank every day since Resident #74's admission date which was approximately one month prior. On 01/08/26 at 10:44 AM, the DON confirmed there were no SRS available for Resident #74. She stated I will look through the progress notes to see if they received the care. She further stated that the staff informed her that the Resident #74 refused a shower. c. On 1/5/26 at 10:28 AM, during the initial tour, the surveyor observed Resident #9 in bed, and the surveyor inquired about the care provided at the facility. Resident #9 stated there had been multiple times that they had been left unattended in wet incontinence briefs and linens for hours. Resident #9 also stated that one time they called 911 due to not being provided with incontinence care and the police responded to the facility. d. On 1/6/26 at 10:13 AM, two (2) surveyors interviewed Resident #27 regarding the care that they received. Resident #27 stated their name and was aware that they resided in a long-term care facility. Resident #27 also stated that they had anticipated a medical appointment related to follow-up brain surgery that was scheduled for 12/29/25, and Resident #27 shared that they were eager to see their physician because of the persistent deep pain they felt in their head. Resident #27 added that nobody from the facility came to get them dressed and ready for their appointment on the morning of 12/29/25. Upon request for incident reports the facility provided a Risk Management Report (RMR) dated 8/12/25 at 6:45 PM which revealed Resident #27 had fallen while being turned on their right side, by the Certified Nursing Assistant (CNA). The report was prepared by the Licensed Practical Nurse (LPN) who was alerted by the CNA. The LPN also documented that the Resident #27's leg hit the floor while their body remained on the bed. Further review of the RMR reflected that on 8/13/25, the interdisciplinary (IDCP) team met to discuss Resident #27's fall and resulted in staff education of positioning the resident in the center of the bed before turning to one side or the other.e. On 1/7/26 at 9:00 AM, during morning care, Resident #7 informed the Certified Nurse Aide (CNA) they would like to have a shower instead of being washed in the bed. The CNA did not provide a shower. The CNA informed the resident that their shower was scheduled for the 3:00 PM to 11:00 PM shift on Thursday. During an interview with the CNA she confirmed that Resident #73 had asked for a shower that morning, and she did not provide the shower as Resident #73 was scheduled to receive a shower on the 3:00 PM-11:00 PM shift. The CNA did not relay the request for a shower with the nurse. According to a review of the electronic medical record, Resident #73 had been hospitalized since 12/30/25. On 1/7/26 at 9:30 AM, Resident #73 asked the surveyor if they could arrange for them to have a shower. The resident reported that they had not had a shower since last week. The surveyor exited the room and went to the nursing station to inquire regarding Resident #73's shower day. During an interview with the Charge Nurse (CN), she stated that Resident #73 was scheduled to have a shower on Monday during the 3:00 PM-11:00 PM shift. The CN reviewed the shower log and the progress notes in the presence of the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	surveyor and was unable to locate any documentation regarding whether Resident #73 was offered or had refused a shower on 1/5/26 (scheduled shower day) during the 3:00 PM-11:00 PM shift.On 1/7/26 at 9:45 AM, the CNA confirmed that Resident #73 asked for a shower on 1/7/26 but did not provide the shower due to the resident shower being scheduled for the 3:00 PM-11:00 PM shift. f. On 1/6/6 at 10:30 AM, the surveyor conducted a resident council meeting with six alert residents and 6 of 6 residents reported the following concerns:A delay in answering the call lights during the 3:00 PM-11:00 PM and the 11:00 PM-7:00 AM shift. The residents reported concerns with care and staffing on the weekends, which were the worst regarding short staffing. One resident reported they had not had a shower since November 2025 and were only offered a bed bath, and 5 of 6 residents stated they would not be offered a shower on their scheduled shower day. The residents stated that staff would answer the lights and stated they would come back, and they never returned. Another resident stated they witnessed their roommate use the call bell and it took close to an hour for someone to respond. The surveyor discussed the above concerns with the Director of Nursing (DON) and no additional information was provided.g. On 1/5/26 at 12:30 PM, the facility provided a copy of the facility assessment (FA) which completed by the prior Licensed Nursing Home Administrator on 2/10/25 and revealed under Staff training/education and competencies 3.6 Describe the staff training/education and competencies that are necessary to provide the level and tapes of support and care needed for your resident population . It may be helpful to review specific references in the regulation regarding the facility assessment .Consider the following training topics (this is not an inclusive list) . A review of the Matrix for Provided (a required document that lists diagnoses for the resident population) that was provided by the Director of Nursing (DON) revealed facility residents had pressure ulcers, required nutritional support by a feeding tube, had falls, indwelling urinary catheters and one resident had a colostomy. On 01/09/26 at 8:43 AM, the surveyor asked the LNHA to review the FA and show the surveyor the competencies and training requirements identified for the staff based on the resident population. The LNHA stated, I can't say I see it. On 01/09/26 at 11:20 AM, the surveyor interviewed the Infection Preventionist (IP) /Staff Educator. The surveyor asked if the IP had a schedule on training that she completed for the staff. The IP stated that she did not have a schedule of training for the staff and confirmed that competencies were not completed. The IP provided a binder of education that was completed, and stated education was completed in relation to specific incidents that had occurred with residents. h. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:One Certified Nurse Aide (CNA) to every eight residents for the day shift.One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.Staffing had been calculated for the following time frames and revealed the following: 1. For the 2 weeks of staffing prior to survey from 12/21/2025 to 01/03/2026, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:-12/21/25 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -12/28/25 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs. -01/02/26 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. On 1/9/26 at 12:02 PM, the above concerns regarding incontinence care and showers were presented to the Licensed Nursing Home Administrator and the Director of Nursing at the pre-exit conference and additional information was requested.01/09/26 at 8:43 AM, the surveyor asked the Licensed Nursing Home Administrator (LHNA) how the facility ensured that the staffing met the needs of the residents. The LNHA stated the staffing coordinator or nursing filled the positions when nursing staff had called out. When asked if (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the nursing department reported to the LNHA if staffing was adequate, he stated typically yes, but not all the time. The surveyor asked if the facility met the staffing requirements and he stated, we try to. On 1/9/26 at 1:30 PM, during the exit conference, no additional information was provided. no additional information was provided.A review of the facility's policy titled, Activities of Daily Living (ADLs) Supporting last revised 3/2018 revealed the following:Policy StatementResidents will be provided with care and services as appropriate to maintain or improve their ability carry out activities of daily living (ADLs).Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate.A review of Resident Rights as documented in the facility admission Agreement revealed: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Self Determination: The resident has a right to be treated with respect and dignity, including, the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences . Self-Determination: The resident has the right to and the facility must promote and facilitate resident self-determination through support of the resident choice. The resident has a right to choose activities, schedules (including sleeping and waking times) NJAC 8:39-27.1 (a)2(g)(h); 8:39-4.1

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and document review it was determined that the facility failed to ensure that annual performance reviews were completed for Certified Nurse Aides (CNAs) and ensure that education was provided based on the outcome of the review. The deficient practice was evidenced for 5 of 5 CNA records reviewed and was evidenced by the following: requested CNA files. A performance review had not been completed for all five of five CNAs: CNA #1, Date of Hire (DOH) 7/29/24CNA #2, DOH 7/30/2024CNA #3, DOH 8/08/2024CNA #4, DOH 9/06/2024CNA #5, DOH 11/07/2024On 01/07/26 at 12:30 PM, the Human Resources Director (HRD) confirmed that she did not have the performance reviews. On 01/09/26 at 10:02 AM, the HRD stated that performance evaluations were the responsibility of the department heads where the employee worked. The HRD stated sometimes the department heads provided copies and sometimes they did not. Performance evaluations are completed by the manager of the department where the employee works. Admin is responsible for department heads are responsible. Sometimes they give them to me and sometimes the manager keeps themOn 01/09/26 at 11:48 AM, the DON confirmed no competencies were completed for any CNAs and there was no training based on performance evaluations. NJAC 8:39-43.17(b)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and document review it was determined that the facility failed to have a system in place to ensure menus were prepared using standard meal planning guides, and recipes were utilized with portion sizes to ensure menus were nutritionally adequate. This deficient practice was evidenced by the following: On 1/5/26 at 10:00 AM, the Food Service Director provided a copy of the for week menu cycle and the surveyor requested the extensions/portion sized for all diets. On 01/06/26 at 12:03 PM, during the lunch preparation observation in the remote dining pantry, the surveyor observed staff utilize a 2- ounce scoop and prepared portions of cucumber salad that were placed in a plastic cup with a lid. When asked the staff how much the portion of the salad should be, she stated 4 ounces, and then showed the surveyor the blue handled ice cream type scoop which was a 2-ounce scoop. On 01/06/26 at 12:12 PM, the surveyor asked the Food Service Director (FSD) where the portion sizes were listed for staff to ensure that the proper portions were served? The FSD stated it should be on the meal ticket, and reviewed a meal ticket and confirmed there were no portion sized listed. The FSD confirmed the portion sizes were not listed on the menu either. Portion sizes or meal extensions/ portion sizes were not provided for the menus. On 01/06/26 at 12:36 PM, the surveyor interviewed the Executive Chef (EC) about the menus and asked to show the surveyor the recipes used for the menu items. The EC stated, we don't have them. When asked who reviewed the menus for nutritional adequacy? The EC stated that he and the FSD made the menus. When asked if the Registered Dietitian (RD)reviewed the menus also, he stated he hasn't seen her as the RD didn't work for the company. When asked about a nutritional analysis of the menus or a process used to develop the menus. He stated, I don't have that. When asked if that would be important to have, he responded, yes, for maintaining nutritional value of the menu. When asked how much cucumber salad was supposed to be served to the residents, he stated it should be at least a 4 ounce portion. The surveyor shared the observations of 2 ounce portion of the cucumber salad.On 01/06/26 at 1:18 PM, the surveyor interviewed the Registered Dietitian (RD) and asked if she worked with the kitchen on the menus? The RD stated she did not work with the kitchen and when asked if portion sizes, recipes and a nutritional analysis were important to have regarding the menus? The RD stated it was important to to ensure the residents were adequately served and the menus met the dietary guidelines. NJAC 8:39-17.2(b); 17.4(3)

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	315297	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Fountains of Atco	114 Hayes Mill Road Atco, NJ 08004

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, it was determined that the facility failed to ensure a) food was stored in a manner to ensure it was utilized by a safe use- by date, and b) the kitchen and remote service kitchen environment and equipment was maintained in a sanitary manner to prevent potential contamination from foreign substances and limit the potential for the development a food borne illness. This deficient practice was evidenced by the following:On 01/05/26 at 9:48 AM, the surveyor conducted an initial tour of the kitchen with the Executive Chef (EC) and Food Service Director (FSD) and observed the following:-The EC utilized a hair net on his face which did not cover all of his facial hair above lip and on sides. -Staff was observed using the dish-machine to clean dishware/food preparation equipment and while the dish machine was functioning the surveyor observed that the wash gauge did not register a temperature. The surveyor observed a hot water booster directly under the dish machine. The surveyor alerted the FSD to the observation and the FSD stated, we were not aware. When asked if the facility had a hot water booster, the FSD responded to the surveyor that he, didn't know. The surveyor observed the temperature log for the dish machine that was affixed to the wall which listed a wash temperature and 5 out of 13 entries, did not have staff initials documented next to the temperatures. The surveyor then interviewed the staff (FSW) that was observed doing the dishes and asked how was a temperature documented if the gauge did not function? The FSW stated that he just found out this morning and I did what I was told to do.Continued with EC and observed:-The fan in the walk in refrigerator unit was soiled with embedded dust like debris which was also affixed to the celling.-A partially sealed bag of scallions located on a shelf, had no use by date and the ends were shriveled.-A bin of celery, a box of carrots and a box of onions had no use by date. When asked the EC if there should be a use -by date, he stated yes.-An opened box of 4 ounce yogurts had no use by date, and the yogurts and box was stamped best by January 3rd, 2026 and the EC stated they expired on Saturday and removed the box. At 10:06 AM, a District Manager (DM) for the Management Company joined the tour.-The Dry storage area had food stored on metal racks which had visible debris affixed to the racks throughout the store room. The surveyor used a piece of paper to remove the debris and showed the EC. The surveyor asked when the racks were last cleaned and he stated he did not know and confirmed the surveyor's observations. -Visible dark and crumb like debris were observed behind the cooking area including the stoves and ovens. - English muffins were located in a reach in freezer without a use by date.- The large and small blender were both stored upright and were wet inside. The FSD stated nothing should be holding water.-The ceiling in the kitchen had visible splatters. -Underneath the metal shelf pass through by the food preparation area was heavily soiled with debris. On 1/5/26 at 10:29 AM, the surveyor observed the skilled nursing remote food service pantry with the FSD present, and observed the following:-One person was utilizing an under the counter dish machine to clean up the breakfast dishes. The same staff was removing clean dishes and placing dirty dishes into the machine without washing hands. When asked the FSD if one person was allowed to go from clean to dirty without washing hands, he stated, no.-The staff was observed with a rack of insulated bowls that were visibly wet and piled on top of one another, and the staff took each bowl and proceeded to wipe them with a rag on the inside. The surveyor asked if it was okay to use a rag to wipe the bowls and showed him the wet bowls piled up. The FSD stated the bowls should be air dried and stated only one staff was scheduled for dishes in the pantry.-The refrigerator in the pantry had an internal thermometer that did not register temperature and the FSD stated it was not working and needed to be removed.-The gaskets on the refrigerator were ripped in several areas and there was visible splatter and debris inside of the refrigerator. -The refrigerator contained 8 of the same 4-ounce expired yogurts that were observed in the main kitchen. The staff stated they brought the yogurts to the pantry from the main kitchen.On 1/5/26 at 2:14 PM, the surveyor received the requested report from (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the dish machine service company which detailed that all three temperature gauges for the dish machine and two fuses in the hot water booster were replaced due to broken temperature gauges. On 01/06/26 at 12:03 PM, the surveyor observed the meal service preparation in the pantry and observed a stack of 11 meal trays that staff confirmed were used to deliver meals to the rooms. The Food Preparation Policy, Revised 9/2017 revealed: 1. All staff will practice proper hand washing techniques and glove use. 2. Dining Services Staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological and chemical contamination. The Cold Foods Storage Policy, Revised 4/2018 revealed: 4. An accurate thermometer will be kept in each refrigerator . NJAC 8:39-17.2(g)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in the facility's name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program:(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76 (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (2) All other changes in enrollment must be reported within 90 days. Prior to the survey, the surveyor accessed the facility website which listed the facility name as The Fountains at Atco at the address listed for the registered name Allegria at the Fountains. On [DATE] at 9:00 AM, upon arrival to the facility, the surveyors observed signage on the building which read The Fountains at Atco. That name did not correspond with the CMS licensed, approved name and provider registered name Allegria at the Fountains.On [DATE] at 9:05 AM, upon entering the facility, the surveyors observed signage on the wall which documented the License for 60 Long Term Care beds and was issued [DATE] from the New Jersey Department of Health, and Expired [DATE] which listed the facility name The Fountains of Atco, which differed from the exterior signage. The Centers for Medicare and Medicaid Services (CMS), Clinical Laboratory Improvement Amendments certificate, identified the facility name as Allegria at the Fountains. On [DATE] the surveyor requested from the Licensed Nursing Home Administrator (LNHA) any communication from CMS that confirms they have accepted the name change for the facility. The LNHA provided a copy of an approval from the New Jersey Department of Health, Certificate of Need and Licensing dated [DATE], that approved the transfer of ownership and name change to the Fountains of Atco. The LNHA did not provide information from CMS. No additional information regarding the facility's name change was provided to the survey team. NJAC 8:39-5.1 (a)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview, record review and document review it was determined that the facility failed to ensure the facility assessment addressed the skill sets, and competencies required by staff to provide care to the resident population. The deficient practice affected all residents and was evidenced by the following: On 1/5/26 at 12:30 PM, the facility provided a copy of the facility assessment (FA) which completed by the prior Licensed Nursing Home Administrator on 2/10/25 and revealed under Staff training/education and competencies 3.6 Describe the staff training/education and competencies that are necessary to provide the level and tapes of support and care needed for your resident population . It may be helpful to review specific references in the regulation regarding the facility assessment .Consider the following training topics (this is not an inclusive list) . A review of the Matrix for Provided (a required document that lists diagnoses for the resident population) that was provided by the Director of Nursing (DON) revealed facility residents had pressure ulcers, required nutritional support by a feeding tube, had falls, indwelling urinary catheters and one resident had a colostomy. On 01/09/26 at 8:39 AM, the surveyor interviewed the LNHA regarding what was the purpose of the FA. The LNHA stated it identified the care and services the facility offered and he stated it was completed prior to his arrival. When asked if he had reviewed it, he stated I did not. On 01/09/26 at 8:43 AM, the surveyor asked the LNHA to review the FA and show the surveyor the competencies and training requirements identified for the staff based on the resident population. The LNHA stated, I can't say I see it. NJAC 8:39-5.1(a)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review it was determined that the facility Quality Assurance and Performance Improvement (QAPI) committee failed to self-identify systems and processes that may negatively affect resident quality of care, quality of life and review significant events implement data driven QAPI program. The deficient practice affected all residents who resided at the facility and was evidenced by the following: Refer to 607F, 610E, 677E, 684E, 689H, 742DOn 1/5/26 at 10:12 AM, the surveyor observed Resident #22 lying in bed in their room. There was a strong urine odor in the room. The resident was alert and informed the surveyor that he/she was soiled. The surveyor left the room and informed the Certified Nursing Aide (CNA) if he could assist with an incontinence tour observation. The CNA exited the room and returned 10 minutes later. The surveyor asked CNA #1 to check if the resident was incontinent. The surveyor observed Resident #22 wearing two incontinent briefs which were saturated with urine and soiled with feces.On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility Resident #74 stated it's bad here and the resident stated, I am a veteran. Resident #74 stated they wanted to be transferred to [another facility name]and the Social Worker (SW) had been made aware. Resident #74 also reported that a couple weeks ago they called 911 because the staff did not feed me breakfast. A review of Resident #74's electronic medical record revealed the resident had a history of Post Traumatic Stress Disorder (PTSD) that the facility had not identified.On 1/05/2026 at 10:28 AM, the surveyor observed Resident #9 lying in bed. Resident stated there have been multiple times that they have been left in wet brief and linens were also wet for hours. Resident #9 also stated that one time they called 911 was and the Police responded due to the staff not helping them.On 1/5/26 at 11:00 AM, the surveyor observed Resident #7 in the dayroom seated at a table alone, and seven other residents were in the room, and no staff observed in attendance. At 11:20 AM the surveyor observed a staff coming from the other room, the staff who identified herself as the activity aid, informed the surveyor she had to provide activity and monitor both rooms as she does not have any help. The facility had 2 dayrooms where the CNA placed the residents after care for activity, (room [ROOM NUMBER] and room [ROOM NUMBER]). According to the activity aid, the facility had one staff assigned to both activity rooms. There was no staff observed in the first room to supervise the residents while the activity aid had to monitor the residents in Room # 2 (the purple room).On 1/5/26 at 12:30 PM, the facility provided a copy of the facility assessment (FA) which completed by the prior Licensed Nursing Home Administrator on 2/10/25 and revealed under Staff training/education and competencies 3.6 Describe the staff training/education and competencies that are necessary to provide the level and tapes of support and care needed for your resident population . It may be helpful to review specific references in the regulation regarding the facility assessment .Consider the following training topics (this is not an inclusive list) . A review of the Matrix for Provided (a required document that lists diagnoses for the resident population) that was provided by the Director of Nursing (DON) revealed facility residents had pressure ulcers, required nutritional support by a feeding tube, had falls, indwelling urinary catheters and one resident had a colostomy. On 1/6/26 at 10:13 AM, during an interview with two (2) surveyors, Resident #27 stated their name and was aware that they resided in a long-term care facility. Resident #27 also stated that they had anticipated their appointment the night before 12/29/25 and was eager to see their physician because of the persistent deep pain they felt in their head. Resident #27 added that nobody came to get them dressed and ready for their appointment on the morning of 12/29/25 and did not refuse the appointment. The resident stated that they felt dizzy, had cramping pain and headache, the resident used their finger to indicate the pain was from the back base of their neck, radiated to the back of their head and removed their head scarf to show the pain radiated from their right hemi craniotomy (temporarily removing part of the skull to create space for a swollen brain). On 1/6/26 at 11:15 AM, the surveyor observed (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #7 seated alone at a table. The resident attempted to stand and was moving back and forth in the wheelchair. Resident #7 appeared restless. The activity aid was in the next room and could not visualize what was going on in the first room. On 1/7/26 at 10:11 AM, the surveyor observed the resident in activity with 6 other residents, there was no staff in attendance. The resident attempted to stand; another resident had to ask the resident to sit down. The surveyor walked to the next room and observed the Activity staff in the back of the purple room, with her back facing the entrance door to the room, looking through some papers. She could not visualize the residents. At 10:18 AM, the surveyor was about to exit the door to get a staff at the nursing station to assist Resident #7, when the Activity staff came to the room and stated she had to get something in the next room. She was not aware that the surveyor had been in the first room, as the room is divided by a wall, and she was in the back of the purple room. A review of the electronic medical records for Resident #7, along with facility provided documents identified the resident as being at high risk for falls, was impulsive, required supervision, and sustained 13 falls including three falls with injury that required transfer to the emergency room on 8/10/25 for a contusion and laceration to the left supraorbital and frontal scalp; on 10/28/25 for a large intramuscular hematoma to the right thigh, and on 11/14/25 for a closed head injury and laceration to the forehead which required sutures.On 1/07/26 at 12:27, PM the Human Resources Director (HRD) with the LNHA present, confirmed that they were unable to provide all requested employee files, HRD stated we cannot find them.On 01/09/26 at 8:39 AM, the surveyor interviewed the LNHA regarding what was the purpose of the FA. The LNHA stated it identified the care and services the facility offered and he stated it was completed prior to his arrival. When asked if he had reviewed it, he stated I did not. On 01/09/26 at 8:43 AM, the surveyor asked the LNHA to review the Tacitly Assessment and show the surveyor the competencies and training requirements identified for the staff based on the resident population. The LNHA stated, I can't say I see it. The surveyor asked about the QAPI process and how would a QAPI plan be initiated? The LNHA stated when department heads identified and issue in the department, they would complete audits. The LNHA stated that the department head would bring the concern to the QAPI meeting they would discuss it at the QAPI meeting and develop audits to rectify the problem and the goal would be set at 100%. The LNHA stated the problem must be identified, the measures in place for review, data must be collected for each QAPI. The surveyor asked the LNHA what the current QAPI plans were and he stated per the most recent QAPI meeting, held on 10/9/25, the current QAPI plans were: 1. Residents with weight loss completed by the Registered Dietitian.2. Pharmacy consultant report. 3. Antibiotic Stewardship. 4. Rehabilitation from the former rehabilitation company.5. Number of grievances.6. Dietary (not related to sanitation).7. Radiology and Cardiology.8. Wheelchair cleaning.When asked if there was a review of significant events, including when 911 was called by two residents, the employee files that were not available, and there was no QAPI plans related to staffing, related to failure to identify residents with Post Traumatic Stress Disorder and for not having a system in place to ensure resident were sent to appropriate appointments, or appointment outside of the facility were rescheduled as needed. The LNHA stated he was unaware of how bad the employee files were and moving forward he would do more QAPI plans. NJAC 8:39-27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of facility policies and review of pertinent facility documentation, it was determined that the facility failed to develop a system to prevent the spread of potential influenza (flu) by ensuring a process was in place to monitor employee flu vaccination to prevent potential transmission of influenza to residents. This deficient practice had the potential to affect all resident who resided at the facility and was evidenced by the following:Reference: Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings; Health Care Providers (HCP); April 28, 2025.On January 13, 2020, Governor [NAME] signed P.L. 2019 c. 330 (codified at N.J.S.A. 26:2H-18.79 and referred to hereafter as the Statute). The Statute requires certain healthcare facilities to establish and implement an annual influenza vaccination program. The New Jersey Department of Health (Department) is required by the Statute to promulgate rules and designate a medical exemption form to be distributed to the covered healthcare facilities. This memo and the attached form are intended to assist general or special hospitals, nursing homes (long-term care facilities licensed pursuant to N.J.A.C. 8:39), and home health care agencies, collectively referred to as facility or facilities, in understanding and meeting their obligations under the Statute, until the rules and the medical exemption form can be adopted through rulemaking.All facility employees are required to be vaccinated, including employees who are not responsible for direct patient care. Per diem and contract employees are to be considered facility employees and are required to be vaccinated.Facilities are required to review and confirm each medical exemption to ensure the exemption is consistent with standards enumerated by the Advisory Committee on Immunization Practices, which can be found at: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html.Facilities must maintain a record or attestation, as applicable, of influenza vaccinations and medical exemptions for each employee. The Department will address through rulemaking proper procedures for submitting data to the Department.The facility must require any employee who does not receive an influenza vaccination to wear a surgical or procedural mask when in direct contact with patients and in common areas, as specified in facility policy, or to be removed from direct patient care responsibilities during influenza season. On 1/7/26 at 11:22 AM, the surveyor interviewed the Infection Preventionist (IP) regarding the staff flu vaccine process, and she stated that there were many exemptions for the flu vaccine and those staff members must wear a mask during flu season.On 1/7/26 at 11:55 AM, the surveyor reviewed the facility provided documentation for staff flu vaccinations provided by the IP. The surveyor noted that 24 out of 75 employees (32%) were documented to have refused the flu vaccine for the current flu season. No medical documentation was found for these refusals. Many of the declination forms had no reason for refusal noted, other had various reasons including but not limited to will make me sick, I am satisfied that I possess sufficient/substantial antibodies, personal beliefs, I just do not want the vaccination at this time, religious reasons, I do not feel that it is effective in preventing the flu - there are many different strains and I am willing to take a chance, and my family never gets it. When I was 12 we stopped because I ended up getting it even though I got the shot.On 1/7/26 at 12:09 PM, the surveyor interviewed the Director of Nursing (DON), who stated she was unaware of employee flu vaccine refusals and would provide more information.On 1/08/2026 at 9:28 AM, the surveyor interviewed the IP who stated she was not aware of the current guidance for the flu vaccine including the New Jersey statute of 2020. She stated that she reminded managers to ensure their employees are wearing masks and wearing them properly. When asked if she does any audits regarding wearing masks and wearing them correctly, she stated she has no audits, and if I see a problem, I tell them. On 1/08/2026 at 9:53 AM, the surveyor interviewed the DON, who stated she was unaware any current guidance for the flu vaccine including the NJ state statute of 2020.No further information was provided by the facility.A review of facility provided policy Influenza Vaccine, not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dated included:Policy StatementAll residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or resident' legal representatives); for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy. Policy Interpretation and Implementation1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless vaccine is medically contraindicated, or the resident or employee has already been immunized.2. Employees hired or residents admitted between October 1st, and March 31st shall be offered the vaccine within 5 working days of the employee's job assignment or the resident's admission to the facility.3. Employees will be offered the influenza vaccine at no charge, at a location onsite.4. Prior to the vaccination, the resident or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record.5. For those who receive the vaccine, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record.7. If an employee refuses the vaccine for reasons other than medical contraindication, this shall be documented on the employee informed consent for influenza vaccine.10. Residents and staff may obtain their influenza vaccines from their personal physicians. Documentation of pervious vaccination should be provided to the facility.11. Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.N.J.A.C. 8:39-19.4(a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Fountains of Atco	114 Hayes Mill Road Atco, NJ 08004

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and document review, it was determined that the facility failed to develop and implement a staff training program and ensure staff were competent to provide care and services for the resident population as identified on the facility assessment. The deficient practice was evidenced by the following: On 1/5/26 at 12:30 PM, the facility provided a copy of the facility assessment (FA) which completed by the prior Licensed Nursing Home Administrator on 2/10/25 and revealed under Staff training/education and competencies 3.6 Describe the staff training/education and competencies that are necessary to provide the level and tapes of support and care needed for your resident population . It may be helpful to review specific references in the regulation regarding the facility assessment .Consider the following training topics (this is not an inclusive list) . A review of the Matrix for Provided (a required document that lists diagnoses for the resident population) that was provided by the Director of Nursing (DON) revealed facility residents had pressure ulcers, required nutritional support by a feeding tube, had falls, indwelling urinary catheters and one resident had a colostomy. On 01/09/26 at 8:43 AM, the surveyor asked the LNHA to review the FA and show the surveyor the competencies and training requirements identified for the staff based on the resident population. The LNHA stated, I can't say I see it. On 01/09/26 at 11:20 AM, the surveyor interviewed the Infection Preventionist (IP) /Staff Educator. The surveyor asked if the IP had a schedule on training that she completed for the staff. The IP stated that she did not have a schedule of training for the staff and confirmed that competencies were not completed. The IP provided a binder of education that was completed, and stated education was completed in relation to specific incidents that had occurred with residents. On 01/09/26 at 11:48 AM, the surveyor interviewed the Director of Nursing (DON) regarding any education or staff competencies that were completed for staff. The DON stated she was aware that the 12 hours of Certified Nurse Aide (CNA) education had been completed, and there was no additional staff education or competencies based on the CNAs performance evaluation.NJAC-8:39-33.4

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure investigations were initiated to determine if potential abuse and neglect had occurred when residents who were dependent on staff to provide care, contacted 911 due to the facility not providing incontinence care or assistance with meals. This deficient practice was identified for 2 of 2 residents (Resident #9 and Resident #74) reviewed for abuse and neglect and was evidenced by the following:a. On 1/5/2026 at 10:28 AM, during the initial tour, the surveyor observed Resident #9 in bed, and the surveyor inquired about the care provided at the facility. Resident #9 stated there had been multiple times that they had been left unattended in wet incontinence briefs and linens for hours. Resident #9 also stated that one time they called 911 due to not being provided incontinence care and the police responded to the facility. On 1/6/2026 at 8:58 AM, the surveyor interviewed Resident #9 again regarding the date the 911 call was made, and the resident was unable to recall.On 1/6/26 AT 11:10 am, the surveyor reviewed the electronic medical record (EMR) which revealed the following: A review of the admission Face Sheet (an admission summary) reflected that Resident #9 was admitted to the facility with a diagnosis which included but was not limited to, fracture of the left fibula (a bone in the lower leg).admission Minimum Data Set (MDS), an assessment tool, dated 12/4/25, which indicated Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognitive function and that the resident was occasionally incontinent of bowel and bladder.A review of the individual comprehensive care plan (ICCP) included a focus area dated 12/1/25, that the resident was continent of bowel and bladder with goals that the resident would remain continent of bowel and bladder. A focus area dated 12/1/25 for toileting was also noted with an intervention that the resident needs total assistance of one with toileting. There was no information related to calling 911 documented on the care plan. A review of the EMR from 11/30/25 through 1/6/26 did not reveal any progress notes or ICCP related to the resident making a call to 911.On 1/06/2026 at 1:17 PM, the surveyor interviewed the Director of Nursing (DON) who stated Resident #9 called 911 about ten days ago. When asked if she would complete an investigation of any 911 calls made by residents? The DON stated, yes, they should be investigated.On 1/07/2026 at 2:37 PM, the survey team interviewed the DON who stated that a resident complaining of not receiving care that was so bad that resident called 911, could be allegation of neglect. She also stated that this should be investigated and that she would absolutely investigate what happened and if it was neglect she would definitely report it (to the Department of Health).b. On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility Resident #74 stated it's bad here and the resident stated, I am paralyzed. Resident #74 stated they wanted to be transferred to a [another facility name] and the Social Worker (SSD) had been made aware. Resident #74 also reported that a couple weeks ago they called 911 because the staff did not feed me breakfast. Resident #74 stated they were worried because it was after 10:00 AM and the staff did not feed me, and Resident #74 stated that they were a diabetic and they started feeling unwell. On 1/06/2026, at 10:00 AM the surveyor reviewed the medical record for Resident #74 which revealed the following:According to the facility admission Record, an admission summary, reflected that Resident #74 was admitted to the facility with diagnoses that included, Quadriplegia (paralysis affecting all four limbs), C1-C4 complete (level of injury in the cervical (neck) spinal cord, Depression (mental health disorder), Type 1 Diabetes Mellitus (chronic autoimmune disease), Hypothyroidism (thyroid gland dysfunction), Gastro-Esophageal Reflux Disease (GERD) (digestive disorder) and Anemia (low red blood cells). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/08/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Section GG was left blank.A review of the individual comprehensive care plan (ICCP) included a Focus area dated 12/8/25, Eating; Goals included that the Dining needs will be met (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through the next review date. A Intervention revealed the resident needs total assistance of 1 with dining.A review of the Physician History and Physical note dated 12/21/25 revealed that Resident #74 was seen in bed talking to 911 and reporting not being fed breakfast.On 1/06/26 at 11:34 AM, the surveyor interviewed the DON regarding Resident #74's telephone call to 911. The DON stated if a resident had called 911 the incident should have been documented in the medical record and investigation should have been completed. The DON confirmed she was not aware that Resident #74 called 911 and had no investigation to provide. On 1/07/2026 at 12:46 PM, the survey team interviewed the Licensed Nursing Home Administrator (LNHA), who stated he has been employed at this facility since October (2025).He stated that he was the Abuse coordinator and he has received training with in-services and videos during orientation. He stated that he tried to go to morning meeting and he did not keep any notes from meetings. He stated that he was notified if law enforcement entered the facility. The LNHA stated he is notified of 911 being called and if the police asked to speak with LNHA. On certain days the DON would be the next person responsible, and he stated, there was a list that include the Assistant Director of Nursing and other staff would be contacted to ensure someone was made aware that the law enforcement were in the facility. When asked, If resident was not being changed, or assisted with meals to the point that the resident contacted 911, could that be potential neglect per the facility abuse policy? The LNHA stated I would have to investigate and that he was not sure if it was potential neglect. He further stated that he was not aware of 911 being called and that law enforcement were contacted for either Resident #9 or Resident #74. When asked if he had been aware that resident complaints of not being assisted with meals, or not being changed, severe enough that the resident called 911, would that be investigated. The LNHA stated, yes. On 1/08/26, after surveyor inquiry, the DON provided the surveyor with a Grievance Report dated 1/07/26. A review of the Grievance Report revealed that Resident #74 reported that they became increasingly anxious when they had not received their breakfast on 12/21/25. Resident #74 stated that they had a panic attack and called 911. No further information was provided by the facility. A review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021 included:Policy StatementResidents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy Interpretation and ImplementationThe resident abuse, neglect and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives:1. Protect residents from abuse, neglect, exploitation or misappropriating of property by anyone including, but not necessarily limited to:ˆ2. Develop and implement policies and protocols to prevent and identify a. abuse or mistreatment of residents; b. neglect of residents; and/or c. theft, exploitation or misappropriation of resident property.ˆ8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.9. Investigate and report any allegations within timeframes required by federal requirements.Review of facility provided policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, included:Policy StatementAll reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.Policy Interpretation and ImplementationReporting Allegations to the Administrator and Authorities 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating Allegations:1. All allegations are thoroughly investigated. The administrator initiates investigations.7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	person(s)reporting the incident. e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resdient during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to who the accuse employee provides care or services; k. reviews all events leading up to the alleged incident; and l documents the investigation completely and thoroughly 11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator. NJAC 8:39-9.4(f)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT #2704937 Based on observation, interview, and record review, it was determined that the facility failed to provide a communication device for a resident identified as having language barrier. This deficient practice was identified for one (1) of one (1) resident (Resident #27) reviewed for language and communication deficits and was evidenced by the following: Refer to 684EA review of the Complaint #2704937 reflected an alleged event date on 12/29/25 at 8:15 AM showed the family representative arrived at the hospital on that day at 8:00 AM that day, to meet the resident and was told that the facility cancelled the appointment. The family representative then arrived at the facility at 8:15 AM and spoke with Resident # 27 who spoke minimal English. On 1/5/26 at 10:44 AM, the Certified Nursing Assistant (CNA #1) assigned to the resident that day entered Resident #27's room with the surveyor. At that time, the CNA #1 could not locate a communication device and confirmed that a communication board was no communication board inside the resident's room. The surveyor reviewed the medical record for Resident #27. According to the resident's admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to; hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs and facial muscles) following cerebral infarction (stroke due to disrupted blood flow to the brain) affecting left non-dominant side and epilepsy. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/11/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated the resident had a severely impaired cognition. Section A1100. Language reflected Resident #27's preferred language was [dialect redacted] and needed an interpreter. A review of the individualized comprehensive care plan included a focus on communication that was initiated/revised on 8/22/25. The interventions were dated/ revised on 8/22/25, included that there were staff that spoke the same dialect and were able to translate. The family of Resident #27 was also available via phone to translate, and the resident had a communication board in their room. On 1/6/26 at 1:42 PM, during an interview with the surveyor, CNA #2 stated that the family arrived on 12/29/25 to go with the resident in the transport to help with translation, the resident doesn't speak English, you know. On 1/6/26 at 2:45 PM, during an interview with the surveyor, the Medical Doctor/ Director (MD) stated he could not speak the same language as Resident #27 and communicated with the resident by speaking slowly and by looking at the resident. The MD confirmed that he did not use a translation device or service, nor did the facility provide those services. On 1/7/26 at 11:03 AM, during an interview with the surveyor, the Licensed Practical Nurse/ Charge Nurse (LPN/CN) stated that they did not have a translation or ancillary communication device in the facility. On 1/7/26 at 11:07 AM, in the presence of the DON and the surveyor, the LPN/CN provided binders to the surveyor that had words with corresponding images. The LPN/CN informed the surveyor that she found the binders for translation was found underneath the bedside table. At that time, the surveyor discussed the concern with the communication device that the staff was not aware of and could not be located prior to surveyor inquiry. On 1/9/26 at 12:02 PM, during a meeting with the survey team the Licensed Nursing [NAME] Administrator and the Director of Nursing, the surveyor discussed the concern with the communication device that the staff was not aware of. A review of the provided facility policy titled; Translation Services dated/revised on 1/2020 included that the facility maintained a contracted relationship with a translation service for language and sign language. Family members and friends shall not be relied upon to provide interpretation services fir the resident unless explicitly requested by the resident. Family and friends used to interpret must have a written consent for disclosure of protected health information. No further information was provided. NJAC 8:39-27.1 (a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure residents who were dependent on staff for Activities of Daily Living (ADLs) were provided with timely and appropriate incontinence care, showers, and feeding assistance The deficient practice was evidenced for 4 of 4 residents reviewed for ADLs (Resident #9, Resident #22, Resident #73, Resident #74) and was evidenced by the following:a) On 1/5/26 at 10:12 AM, during the initial tour of the facility, a strong odor of urine was permeated in the hallway. The surveyor continued the tour and entered Resident #22's room. A strong urine odor was noted in the room. The surveyor asked a Certified Nurse Aide (CNA) to assist with an incontinence tour. Resident #22 had 2 incontinence briefs on and was soiled with urine and feces. The CNA exited the room and returned 10 minutes later. The surveyor asked CNA #1 to check if the resident was incontinent. The surveyor observed Resident #22 wearing two incontinence briefs, the 1st brief was saturated with urine and soiled with feces. CNA #1 informed the surveyor that the 11:00 PM to 7:00 AM, staff provided care and left the two briefs on the resident. The surveyor then asked CNA #1 to ask the charge nurse to come to the room. On 1/5/26 at 10:30 AM, the surveyor summoned the Licensed Practical Nurse (LPN) Charge Nurse to the room and we both observed that the incontinent briefs were soiled with urine and feces. The LPN stated in the presence of CAN #1, that the resident should not have been wearing two incomitance briefs. On 1/6/26 at 8:30 AM, the surveyor observed the resident in the bathroom, CNA #2 was in the room making the bed. During an interview with CNA#2, she stated that the resident was aware of their incontinence needs, the resident required assistance with transfer from the bed to the bathroom. On 1/6/26 at 9:20 AM, the surveyor conducted an interview with Resident #22. The resident informed the surveyor that they did not request to wear two incontinence briefs. The resident stated that they were aware when they had to use the bathroom. On 01/07/2026 10:10 AM, the surveyor interviewed the Director of Nursing regarding incontinence care protocol. The DON stated incontinence care was to be provided every 2 hours and as needed. The DON also stated that no resident should have 2 incontinence briefs on, as the skin could be affected. The DON stated that she was made aware of the issue with the above resident, in-service education was done, she will provide the in-service education regarding incontinence care. On 01/07/2026 at 12:16 PM, the surveyor interviewed again CNA #1 who cared for Resident #22 on 1/5/26. The CNA admitted and contradicted the earlier statement provided to the surveyor and admitted that she placed the two briefs on the resident. CNA #1 stated again that the resident was a heavy wetter it is much easier for the resident and staff. The surveyor then asked CNA #1 what should be done for a resident that was frequently incontinent, CNA #1 stated, change them, or assist them to the bathroom. b. On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility Resident #74 stated it's bad here and the resident stated, I am paralyzed. Resident #74 stated they wanted to be transferred to [another facility name] and the Social Worker (SSD) had been made aware. Resident #74 also reported that a couple weeks ago they called 911 because the staff did not feed me breakfast. Resident #74 stated they were worried because it was after 10:00 AM and the staff did not feed me, and Resident #74 stated that they were a diabetic and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they started feeling unwell. Resident #74 also reported that they had not received a shower since they were admitted to the facility. The resident stated that every time the resident asked for a shower the staff stated the water was cold. On 1/06/26 at 9:22 AM the surveyor requested the Unit Manger (UM) provide documentation of the showers that were given to the residents. The surveyor reviewed the facilities shower binder for Skin Monitoring: Comprehensive CNA Shower Review Sheets (SRS) for December 2025 and January 2026. There were none found for resident #74. In addition, there were no skin assessments found in the medical record for resident #74. On 1/06/26 at 9:30 AM, the surveyor interviewed the Unit Manger (UM) regarding the Skin Monitoring: Comprehensive CNA SRS for Resident #74. In the presence of the surveyor, the UM reviewed the shower binder and was unable to find any shower sheets for Resident #74. The UM stated she would look for them. No further information was provided. On 1/06/26 at 12:15 PM Resident #74 stated I used to get a shower at the other facility. I would get out of bed for a shower oh yes! On 1/06/26 at 12:43 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that she had taken care of Resident #74. She stated that their shower days were Wednesday and Sunday 7 AM- 3 PM. The resident's CNA stated that she always offered Resident #74 a bed bath not a shower. CNA stated, they can't stand and don't like the shower bench and if they refused, I would document refused in the CNA documentation system. The surveyor then reviewed the CNA documentation system for December 2025 and January 2026 CNA task Bathing: Self Performance revealed Resident Refused column was left blank every day since Resident #74's admission date which was approximately one month prior. On 01/08/26 at 10:44 AM, the DON confirmed there were no SRS available for Resident #74. She stated I will look through the progress notes to see if they received the care. She further stated that the staff informed her that the Resident #74 refused a shower. c. On 1/5/26 at 10:28 AM, during the initial tour, the surveyor observed Resident #9 in bed, and the surveyor inquired about the care provided at the facility. Resident #9 stated there had been multiple times that they had been left unattended in wet incontinence briefs and linens for hours. Resident #9 also stated that one time they called 911 due to not being provided with incontinence care and the police responded to the facility. On 1/9/26 at 12:02 PM, the above concerns regarding incontinence care and showers were presented to the Licensed Nursing Home Administrator and the Director of Nursing at the pre-exit conference and additional information were requested. On 1/9/26 at 1:30 PM, during the exit conference, no additional information was provided. no additional information was provided. A review of the facility's policy titled, Activities of Daily Living (ADLs) Supporting last revised 3/2018 revealed the following: Policy Statement (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents will be provided with care and services as appropriate to maintain or improve their ability carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate NJAC 8:39-27.1 (a) 2 (g) (h)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Complaint # NJ 2704937Based on observation, interviews, and record review, it was determined that the facility failed to ensure that a system was developed and implemented that enabled residents to attend outside physician appointments in accordance with resident needs, goals for care, and professional stands of practice. This deficient practice was identified for one (1) of one (1) resident (Resident# 27) reviewed for Activities of Daily Living (ADL) and was evidenced by the following: On 1/5/26 at 10:51 AM, Resident #27 was observed asleep in the activities room and appeared well dressed and groomed. The surveyor reviewed the medical record for Resident #27. According to the resident's admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to; hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs and facial muscles) following cerebral infarction (stroke due to disrupted blood flow to the brain) affecting left non-dominant side and epilepsy. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/11/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated the resident had a severely impaired cognition. Section A1100. Language reflected Resident #27's preferred language was [dialect redacted] and needed an interpreter. Further review of the MDS under, Section E -Behavior reflected the Resident #27 did not exhibit behaviors such as rejection of care. Section GG Functional Abilities reflected Resident #27 was dependent (helper does all the effort) for upper and lower body dressing. A review of the physician's progress notes (PN) revealed two entries made by the provider in the resident's electronic medical record (eMR) which were on 9/8/24 and 11/25/24 and reflected the following:The Physician PN dated 9/24/24 was the comprehensive overview of Resident #27's heath status and indicated the resident underwent a right hemi craniotomy (temporarily removing part of the skull to create space for a swollen brain) after a stroke that caused swelling in one side of the brain.The Physician PN dated 11/25/24, included that the resident had left sided weakness and to follow-up with Neurology.No Physician PN were found for 2025 and 2026.On 1/6/26 at 10:13 AM, during an interview with two (2) surveyors, Resident #27 stated their name and was aware that they resided in a long-term care facility. Resident #27 also stated that they had anticipated their appointment the night before 12/29/25 and was eager to see their physician because of the persistent deep pain they felt in their head. Resident #27 added that nobody came to get them dressed and ready for their appointment on the morning of 12/29/25 and did not refuse the appointment. The resident stated that they felt dizzy, had cramping pain and headache, the resident used their finger to indicate the pain was from the back base of their neck, radiated to the back of their head and removed their head scarf to show the pain radiated from their right hemi craniotomy (temporarily removing part of the skull to create space for a swollen brain).On 1/6/26 at 2:45 PM, during a meeting with three surveyors, the Medical Director (MD) stated that he had his own eMR where he documented the resident's PN and transferred into the facility's eMR. The MD also stated that his office copied then pasted the information into the facility's eMR and that there must have been something that went wrong that occurred with transcribing the 2025 PNs. The MD stated he would look into the matter. At that time, the physician could not recall if he was informed by the facility of the missed appointment on 12/29/25. The MD also stated that the resident's headache could be related to the hemi craniotomy and could be related to the reason why he referred the resident to the Neurologist. The MD stated he would upload and forward the information to the surveyor. A review of the provided Physician PN that was uploaded into the facility's eMR reflected the following: On 4/15/25 at 3:39 PM, (late entry) the Physician PN included the resident had left sided weakness, recommended continuation of fall safety precautions, experienced headache, received Fioricet as needed (headache pain reliever) and recommended a follow-up with Neurosurgery/Neurology; On 8/12/25 at 3:25 PM, (late entry) the Physician PN included the resident had left sided weakness, recommended continuation of fall safety precautions, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Fountains of Atco	114 Hayes Mill Road Atco, NJ 08004

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	experienced headache, received Fioricet as needed (headache pain reliever) and recommended a follow-up with Neurosurgery/Neurology; On 1/6/25 at 4:01PM, (late entry) the Physician PN included that the resident was seen as a follow-up of the missed appointment [after surveyor inquiry]. Resident #27 complained of dizziness and the physician recommended a follow-up with Neurology. On 1/7/26 at 11:07 AM, during a meeting with the Director of Nursing (DON), the surveyor inquired if the DON was aware that there were no Physician PN on record prior to surveyor inquiry and discussed the concern that ancillary health care staff were not able to view the physician notes.On 1/7/26 at 2:07 PM, a follow up interview was held at the DON in which she confirmed that Resident #27 did not refuse to the physician appointment on 12/29/25.On 1/6/26 at 10:27 AM, during an interview with the surveyor, the Assistant Director of Nursing stated that appointments were scheduled and then documented in the resident's progress note.On 1/6/26 at 11:01 AM, during an interview with the surveyor, the Licensed Practical Nurse/Charge Nurse (LPN/CN) stated the unit clerk (UC) handled the scheduling and was not at work that day. The LPN/CN stated she also scheduled appointments for the residents and then it was written on the white bulletin board and in progress notes. According to the LPN/CN the December 2025 scheduled appointments were not kept for the record and had no additional information to provide. The LPN/CN stated that any appointments missed for any reason such as transportation, refusals or family member cancellation would be documented under the resident's progress notes. On 1/6/26 at 1:42 PM, during an interview with the surveyor, the Certified Nursing Assistant (CNA) stated she learned from the Charge Nurse, or the Assistant Director of Nursing (ADON), or the Director of Nursing (DON) when a resident had an appointment so that she could get the resident ready for an appointment. The CNA recalled Resident #27 had missed an appointment last week and stated that she was not informed by anybody to get the resident ready for that appointment. The CNA also did not recall the resident's name being listed on the appointment/white board. On 1/6/26 at 1:56 PM, the surveyor and the ADON reviewed the Resident #27's PN together. At that time, the ADON confirmed that there were no documented notes made by facility staff that the resident refused to attend their appointment. The ADON also confirmed that the PN did not reflect the physician was made aware of the missed appointment, a rescheduled follow-up appointment with the Neurologist was not found prior to surveyor inquiry. On 1/9/26 at 12:02 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), and the DON, the surveyor discussed the concern regarding with Resident #27 who had communication deficits, was dependent on staff for upper and lower body dressing, was not assisted, and prepared by staff to attend their Neurosurgeon/Neurologist appointment that was recommended by the Medical Director since November 2024. Additionally, the surveyor discussed the concern that the facility failed to reschedule the appointment prior to surveyor inquiry and failed to inform the physician that the appointment he recommended was missed. A review of the facility provided policy titled; Charting and Documentation included the following information to be documented in the resident medical record: objective observation, treatment and services performed, events, incidents or accidents involving the resident.whether the resident refused the procedure/treatment, notification of family, physician, or other staff.The facility was unable to provide any policy regarding scheduling of resident appointments.NJAC 8:39-11.2(b); 27.1 (a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, it was determined the facility failed to dispose of medications for one (1) of one (1) medication refrigerator and for one (1) of one (1) medication room inspected. The deficient practice was evidenced by the following:On 1/7/26 at 10:33 AM, in the presence of the Licensed Practical Nurse/Charge Nurse (LPN/CN), the surveyor inspected the medication refrigerator and observed the following: -Spikevax (Moderna COVID-19 Vaccine) the pharmacy label reflected, thawed on 10/10/25 and an expiration date of 12/10/25.-discharged Resident #78's one (1) box of Brovana (used for Chronic Obstructive Pulmonary Disease; COPD). Resident #78 was discharged on 11/29/25.-discharged Resident #79's one (1) box Cosentyx (biological medication used for chronic inflammatory condition. Resident #79 was discharged on 9/2/25.-discharged Resident #52's one box (1) of Wegovy (biological used to reduce excess body weight). Resident #52 was discharged on 12/31/25. At that time, the LPN/UM stated that the nurses on the 11:00 PM to 7:00 AM shift and the consultant pharmacist checked for expired medications, and both should have removed the discharged resident's medications from active inventory. On 1/7/26 at 10:59 AM, the surveyor observed 8 boxed of Santyl that belonged to Expired/Unsampled Resident #81 who expired on 7/24/25. At that time, the LPN/UM stated she would remove the items from active inventory A review of the most recent Consultant Pharmacist unit inspection dated 12/11/25 reflected that there was no expired medication in the storage area. The facility's compliance rate for December 2025 was 95.12%. On 1/7/26 at 11:03 AM, the surveyor discussed the concerns found during the inspection of the medication refrigerator and medication room. A review of the undated, provided facility policy titled; Medication Labeling and Storage included that the dispensing pharmacy is contacted for instruction regarding returning or destroying discontinued, outdated or deteriorated medications or biologicals. No further information was provided. NJAC 8:39- 29.4(a) (g)(h), 29.7(a)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to provided rehabilitation services per physician order to ensure a resident reached their highest physical and practical level. The deficient practice was evidenced for 1 of 1 resident reviewed for rehabilitation services (Resident #74) and was evidenced by the following:On 01/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed and when asked how things were going at the facility, Resident #74 stated, it's bad here, I am paralyzed. Resident #74 stated they wanted to be transferred to [another facility name]. Resident #74 also reported that a couple weeks ago they called 911 because the staff was not assisting them with eating breakfast and was worried because they were Diabetic (a condition where your body doesn't make enough insulin and may require insulin to utilize food as energy). The resident also reported that they had not received physical therapy since they were admitted because the facility was waiting for an authorization. On 1/6/25 at 11:00, the surveyor reviewed the medical record for Resident #74 which revealed the following:A hospital Discharge summary, dated [DATE], detailed Resident #74 was treated for acute tetraplegia secondary to spinal epidural abscess due to ESBL (extended spectrum beta-lactamase) E-coli (Escherichia) bacteremia (a sudden onset of paralysis affecting all four limbs due to a severe infection). Treatment prior to transfer and recommendations included: Upper extremity swelling stable, spinal cord injury, occupational therapy addressing upper extremity with splints and positioning; History of sacral wound resolved, continue with turning every two hours, [manufacture name pressure relieving] boots while in bed, specialty mattress .; Description of Further Services Needed: Aspiration Precautions: upright positioning during meals and for at least 30 minutes after. Slow rate, small bites, small/single sips, repeat swallows. Monitor for signs/symptoms aspiration. Discontinue food by mouth if any difficulty noted. Hand Splints: Please DON (put on bilateral resting hand splint on hands after dinner and remove in the AM before breakfast. The Physician Orders, active as of 12/1/26, were reviewed and an Occupational and Physical Therapy Evaluation and Treat as indicated was ordered on 12/8/25. There was no speech therapy evaluation although the resident had a percutaneous endoscopic gastrostomy tube (feeding tube) and aspiration precautions were identified as further services. There were no orders related to the hand splints. There was no therapy documentation or assessment completed per the physician orders on 12/8/25. On 01/06/26 at 11:34 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The surveyor asked about the therapy for Resident #74. The DON stated that she spoke with Resident #74 the previous day regarding the need for the facility to get an authorization prior to providing therapy services. The DON stated she asked for occupational therapy to show her how to stretch Resident #74's arms and legs so she could do it when she was there. The DON stated the resident doesn't want to get out of bed due to being uncomfortable. The DON confirmed Resident #74 has not received any therapy since they were admitted on [DATE] and the Social Worker needed to follow- up to obtain authorization.On 01/06/26 at 12:15 PM, the surveyor asked Resident #74 about receiving therapy services and they stated, I've been waiting for the therapy authorization and stated they used a motorized wheelchair at the prior facility but was unable to take it with them. Resident #74 stated that they got up two weeks ago via a mechanical lift. On 01/06/26 at 1:17 PM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) if the facility accepted an admission would the facility wait until they received payment authorization prior to providing therapy services, despite having an order for therapy? The LNHA stated that therapy should be performed and an evaluation and treatment for Resident #74 should have occurred regardless of payment source. The LNHA stated he was unaware that Resident #74 was not provided with therapy services. NJAC 8:39-27.1(a)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on observation, interview and record review, it was determined that the facility failed to provide the required Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) for 1 of 2 residents (Resident #1) reviewed for change in insurance coverage status and who remained in the facility. The deficient practice was evidenced by the following: On 1/7/26 at 10:06 AM, the surveyor observed Resident #1 in bed, awake, alert and conversant. Resident #1 stated they received rehabilitative services in the past that had stopped without explanation.On 1/8/26 at 9:00 AM, the surveyor reviewed the facility provided Beneficiary Protection Notification Review (BPNR) forms for two residents, Resident #1 and #30, who had a change in insurance coverage status and remained in the facility.A review of Resident #1's BPNR included the last covered day for Medicare Part A Services was on 11/9/25 and the explanation as to why the resident was not provided the SNF ABN was, not applicable.On 1/8/26 at 9:51 AM, during an interview with the surveyor, the Social Services Director (SSD) stated that Resident #1 should have received the SNF ABN since they had benefit days remaining and chose to remain in the facility. The SSD also stated that the notification was important for continuity of care and to ensure the resident and resident's family involvement with their choice to continue to receive care. At that time, the SSD stated the facility did not have a policy for SNF ABN but would double check with leadership.On 1/8/26 at 10:05 AM, during a meeting with the Licensed Nursing Home Administrator (LNHA), the surveyor requested for the SNF ABN policy and informed the LNHA of the identified concern for Resident #1 who had not received the SNF ABN notification prior to discontinuation of service.A review of the provided policy titled; Notice Advance Beneficiary Notifications (ABN) dated 7/2019, included that an ABN is issued to transfer potential financial liability to the Medicare beneficiary in certain instances. Under timing, included that prior to the delivery of the item or service, provision of enough time for the beneficiary to make an informed decision on whether to receive the service or item in question and accept potential liability. No further information was provided. NJAC 8:39-4.1(a)(8)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. COMPLAINT # NJ 2704937 Based on observation, interview, and review of pertinent documents, the facility failed to ensure that the method for filing a grievance was consistent with the facility's practice and policy. This deficient practice was identified for one 1 of four 1 residents (Resident #27) reviewed for grievances and was evidenced by the following: Refer to 684E and 676EOn 1/6/26 at 10:13 AM, two (2) surveyors interviewed Resident #27 regarding the care that they received. Resident #27 stated their name and was aware that they resided in a long-term care facility. Resident #27 also stated that they had anticipated a medical appointment related to follow-up brain surgery that was scheduled on 12/29/25, and Resident #27 shared that they were eager to see their physician because of the persistent deep pain they felt in their head. Resident #27 added that nobody from the facility came to get them dressed and ready for their appointment on the morning of 12/29/25. Resident #27 confirmed that they did not refuse the appointment. The resident stated that they felt dizzy, had cramping pain and a headache, and then the resident used their finger to indicate the pain went from the back base of their neck, radiated to the back of their head and then removed their head scarf to show the pain radiated from their right hemi craniotomy (an area where part of the skull was removed to create space for a swollen brain). On 1/6/26 at 10:35 AM, during an interview with the surveyor, the Social Services Director (SSD) stated she was the grievance officer and tracked the grievances referred to her by the residents and staff. At that time the SSD provided the grievance log for October 2025, November 2025 and December 2025. Further review of the Grievance Log (GL) and Grievance Report (GR) revealed there were no grievances logged and a grievance report was not initiated for Resident #27. On 1/6/26 at 11:01 AM, during an interview with the surveyor, the Licensed Practical Nurse/Charge Nurse (LPN/CN) stated the unit clerk (UC) handled the scheduling and was not at work that day. The LPN/CN stated she also scheduled appointments for the residents and was written on the white board and progress notes. According to the LPN/CN the December 2025 scheduled appointments were not kept on record. The LPN/CN stated that any appointments missed for any reason such as transportation, refusals or family member cancellation would be documented in the resident's progress notes. On 1/6/26 at 11:21 AM, the surveyor reviewed the medical record for Resident #27 which revealed the following: According to the resident's admission Record (AR; or face sheet; admission summary) reflected the resident was admitted to the facility with diagnoses that included but not limited to; hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs and facial muscles) following cerebral infarction (stroke due to disrupted blood flow to the brain) affecting left non-dominant side and epilepsy. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/11/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated the resident had a severely impaired cognition. Section E -Behavior reflected the Resident #27 did not exhibit behaviors such as rejection of care. Section GG Functional Abilities reflected Resident #27 was dependent (helper does all the effort) for upper and lower body dressing. On 1/6/26 at 1:42 PM, during an interview with the surveyor, the Certified Nurse Aide (CNA) stated she would learn from the Charge Nurse, or the Assistant Director of Nursing (ADON), or the Director of Nursing (DON) when a resident had an appointment so that she could get the resident ready for an appointment. The CNA stated she recalled Resident #27 had a missed an appointment last week and stated that she was not informed by anyone to get the resident ready for that appointment. The CNA also stated she did not recall the resident's name on the appointment list which was written on the white board. The CNA stated that the Resident Representative (RR) came into the facility visibly upset about the appointment that was missed and that the ADON and the DON had both been aware. On 1/6/26 at 1:50 PM, during an interview with the surveyor, the ADON stated she recalled Resident #27 missed their appointment last week, was in the hallway with the DON passing trays when the RR arrived visibly (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upset and was yelling in the hallway. The ADON recalled the resident refused to go to the appointment and confirmed she did not speak with the resident, or their family regarding the incident. At that time the ADON stated I don't think a grievance was made. On 1/6/26 at 1:56 PM, the surveyor and the ADON reviewed the progress notes (PN) for Resident #27 together. The ADON acknowledged and confirmed that the PN did not reflect that the resident refused to go to their appointment, a follow-up appointment was also not made, and that the physician was not made aware that Resident #27 had missed their appointment. On 1/6/26 at 2:01 PM, the DON confirmed that she was not made aware that the resident had an appointment on 12/29/25, and only learned of the missed appointment when the RR arrived. The DON stated the RR made her aware of the missed appointment and they were very angry. The DON informed the RR that she would investigate the matter and stated she did not start a grievance, but started an investigation. At that time, the DON stated a grievance was important to ensure issues were resolved, tracked, trended and brought back for discussion during the Quality Assurance and Performance Improvement (QAPI) meetings. A review of the investigation file provided by the DON contained one signed witness statement from the Licensed Practical Nurse (LPN) assigned to Resident #27 on 12/29/25. The statement documented that Resident #27 refused to go to their appointment after transport arrived and the facility staff cleaned the resident. The LPN also documented that she had encouraged the resident to go. There was no witness statements from the CNA who cared for the resident on 12/29/25, from the resident, or from the RR who staff, including the DON confirmed verbalized their concerns. A review of the provided trip order #[redacted] reflected the pick-up was for Resident #27 was on 12/29/25 at 8:55 AM and was then cancelled by the same LPN who documented the single signed statement. The reason for cancelling the transportation was documented as due to appointment cancelled. On 1/9/26 at 12:02 PM, the surveyor discussed the concern regarding the missed appointment voiced by the resident, and the RR, with the survey team present, the Licensed Nursing Home Administrator and the DON. The facility was unable to provide a resolution for Resident #27 and there was no grievance initiated. A review of the provided facility policy titled; Grievance/ Complaints, Filing included that residents and their representative have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated. The administrator and staff would make prompt efforts to resolve grievances.The resident or person filing the grievance and/or complaint and/or complain on behalf of the resident will be informed verbally and in writing of the findings of the investigation and the actions that will be taken to correct any identified problems. No further information was provided. NJAC 8:39-4.1(a)(35);13.2(c)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the admission Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1resident (Resident #74) reviewed for timing of assessments and was evidenced by the following: On 1/05/26 a review of the electronic health record (EHR) reflects that resident #74 was admitted to the facility on [DATE]. The Comprehensive admission MDS was noted to be in progress.On 1/07/2026 at 10:56 AM, the surveyor interviewed the MDS coordinator (MDSC), who stated she worked remote and was rarely in the facility. She further stated that an admission MDS must be completed by day 14 (of the resident's stay in facility). The MDSC stated I know that I am behind She explained that was hired part time for this facility and that she worked at another facility full time which was causing her difficulty in keeping up with the work. She further explained that she was doing the best she could to follow the CMS regulation. She also stated I prioritize the Medicare assessments (typically these are the revenue generating assessments), so they get done first that's why his didn't get done. That's how it works. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2025, page 2-17, the Comprehensive admission assessment must be completed no later than admission date + 13 calendar days (12/21/25 for Resident #74). NJAC 8:39-11.2 (e)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of medical records, other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 1 resident reviewed (Resident #74). This deficient practice was evidenced by the following:On 1/05/26 a review of the electronic health record (EHR) reflects that resident #74 was admitted to the facility on [DATE]. The Comprehensive admission MDS was noted to be in progress. On 1/07/2026 at 10:56 AM, the surveyor interviewed the MDS coordinator (MDSC), who stated she worked remote and was rarely in the facility. She further stated that an admission MDS must be completed by day 14 (of the resident's stay in facility). The MDSC stated I know that I am behind She explained that was hired part time for this facility and that she worked at another facility full time which was causing her difficulty in keeping up with the work. She further explained that she was doing the best she could to follow the CMS regulation. She also stated I prioritize the Medicare assessments (typically these are the revenue generating assessments), so they get done first that's why his didn't get done. That's how it works. On 1/8/25, the surveyor noted the MDS to be complete. Review of section Z0400B revealed that section F was completed by the Activities Director on 12/26/25, Z0040C revealed that section K was completed by the dietician on 12/27/25, and Z0400D revealed that sections A, B, GG, H, I, J, L, M, N, O, and P were completed by the MDS Coordinator on 1/7/06. Review of Section Z0500 revealed the MDS Coordinator's signature and date of 12/21/25, verifying that the MDS assessment was completed 12/21/25.Review of facility provided Batch #162 (the validation report for MDS transmission to CMS) indicated that Resident #74's admission MDS was transmitted and accepted on 1/7/26.According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2025, page Z-5 - Z-8, the importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for:The development of an individualized care planThe Medicare Prospective Payment SystemMedicaid reimbursement programsQuality monitoring activities, such as the quality measure reportsThe data-driven survey and certification processThe quality measures used for public reportingResearch and policy development Coding InstructionsAll staff who completed any part of the MDS must enter their signatures, titles, sections of portions(s) of the section(s) they completed, and the date completed.Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.Z0500 Signature of RN Assessment Coordinator Verifying Assessment CompletionFederal regulations require the RN assessment coordinator to sign and thereby certify that the assessment is complete.For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date must be equal to the latest date at Z0400 or later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members. N.J.A.C 8:39-11.1

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The Fountains of Atco	114 Hayes Mill Road Atco, NJ 08004

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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 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. Based on observation, interview and record review, it was determined that the facility failed to ensure respiratory care services were provided per physician orders for 1 of 1 residents reviewed for respiratory care and services (Resident #73). This deficient practice was evidenced by the following:On 1/5/26 at 9:30 AM, the surveyor observed Resident #73 in bed. The head of the bed was elevated, the resident was receiving Oxygen at 4 liters via Nasal Cannula. The resident asked the surveyor to adjust the head and informed the nurse who was in the hallway.On 1/5/25 at 12:30 PM, the surveyor returned to the room and observed the resident in bed with their eyes closed. The oxygen was running at 4 liters.On 1/5/26 at 1:30 PM, the surveyor reviewed the resident clinical record. The admission Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, multiple fractures of ribs, acute respiratory failure with hypoxia, pleural effusion and pneumonia.The 5-day Minimum Data Set Assessment with a target date of 1/10/26 reflected that Resident #73 had intact cognition. Resident #73 scored 13 out 15 on the Brief Interview for Mental Status (BIMS). The admission orders transcribed by the Registered Nurse (RN) night supervisor reflected an order for respiratory treatment via nebulizer every 6 hours. A physician's order dated 1/4/25, reflected an order for Acetylcysteine inhalation solution (medication used as a mucolytic to thin mucus for respiratory conditions), 20% 4 milliliter inhalation Solution orally every 6 hours for mucolytic. Albuterol sulfate Inhalation Nebulization Solution (fast-acting bronhodilator medication used as a fine mist to open airways for quick relief from wheezing and shortness of breath)(2.5) milligrams/ 3 ml 0.083% (Albuterol Sulfate) 3orally via nebulizer every 2 hours as needed for wheezing.Ipratropium-Albuterol Inhalation Solution (anticholinergic medication that helps open airways and ease breathing) medication 0.5-2.5 (3mg(milligrams) /3 ml 3 ml inhale orally every 6 hours as needed for wheezing.)A review of the Progress Notes dated 1/4/26 timed 12:22 AM, revealed that the nebulizer treatment was not administered, Nebulizer Machine unavailable. Medical Doctor informed, no new orders received. On 1/5/26 at 1:30 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the unit. The LPN informed the surveyor that the nebulizer machines were stored in the supply room. The surveyor followed the LPN to the supply room of the unit, there were no nebulizer machines. The LPN then stated that there was a storage room on the 3rd floor the nebulizer machines were stored also on the 3rd floor.On 1/6/25 at 9:15 AM, the surveyor interviewed the central supply staff and requested an inventory of the facility's nebulizer machine. The Central supply staff escorted the surveyor to the 3d floor central supply, there were no nebulizer machines. The staff informed the surveyor that the facility had 5 nebulizer machines, all were already assigned to other residents. The central supply staff informed the surveyor that she was made aware of the concern on 1/5/26 and she received authorization from the Licensed Nursing Home Administrator (LNHA) to order 8 nebulizers. The nebulizer machines would arrive possibly today. The surveyor requested and received the invoice dated 1/5/26 for the nebulizer.On 1/6/26 at 9:30 AM, a review of the Progress Notes with the Charge Nurse confirmed that the nebulizer treatment was not administered because the facility did not have a nebulizer machine. When inquired regarding the admission process, the Charge Nurse revealed the admission Coordinator will inform the nursing department of the admission and the medical equipment needed prior to admission. She informed the surveyor that she was on vacation and just returned to work. She reviewed the orders at home and was not aware that the facility did not have a nebulizer machine available for the resident. The Charge Nurse further stated that the admission Nurse was responsible for the assessment and ensure the physician orders were followed.On 1/7/26 at 10:15 AM, the surveyor reviewed the Medication Administration Record (MAR) and observed that the Acetylcysteine inhalation solution was not administered on 1/4/26 at 6:00 PM, 1/5 at 12:00 AM, and 6:00 AM, on 1/7/26 at 06:00 AM. The surveyor reviewed the Medication Administration Record with the Licensed Practical Nurse (Charge Nurse) she stated, there was no nebulizer machine available (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	although the nurses initialed the MAR that the medication was administered on1/4/26 at 12:00 PM and 6:00 PM, 1/5//26 at 12:00 PM and 6:00 PM and 1/6/26 at 12:00 AM 6:00 AM, 12:00 PM and 6:00 PM.On 1/6/26 at 11:30 AM, the surveyor interviewed the admission Coordinator regarding the admission protocol. She stated the Liaison Management reviewed the hospital record, uploaded the information into the facility computerized system and reviewed the medical record with the nursing staff. The nursing staff was to review and ensure all medical equipment needed were available.On 1/8/26 at 8:45 AM, the surveyor interviewed the Director of Nursing regarding Resident #73 not receiving their nebulizer treatment as ordered by the physician, the DON informed the surveyor that she was not made aware of the admission nor that the resident did not receive their treatment.The DON was to provide the admission policy for review, none was provided. On 1/9/26 at 12:30 during the pre-exit conference the administrator confirmed that he authorized the purchase for the nebulizer machine but he was not aware of the issue. NJAC 8:39 -6.1(b)

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure a resident with history of post-traumatic stress disorder (PTSD) received the appropriate treatments and services, when on 12/21/25, the resident (Resident #74) became increasingly anxious when they had not received their breakfast timely. The resident reported that they had a panic attack and called 911 emergency services since they were diabetic and received insulin. This deficient practice was identified for one 1 of 1 resident (Resident #74) reviewed for PTSD and was evidenced by the following:Refer F 610 On 1/05/26 at 10:18 AM, the surveyor observed Resident #74 in bed. When asked about how their stay had been at the facility, Resident #74 stated it's bad here, and that I am paralyzed. Resident #74 stated they wanted to be transferred to [another facility name]and the Social Worker (SW) had been made aware. Resident #74 also reported that a couple weeks ago they called 911 emergency services because the staff did not feed me breakfast. Resident #74 stated they were worried because it was after 10:00 AM, and the staff did not feed me, and Resident #74 stated that they were a diabetic and they started feeling unwell. On 1/06/26 at 10:00 AM, the surveyor reviewed the medical record for Resident #74 which revealed the following: According to the resident's facility admission Record, an admission summary, reflected that Resident #74 was admitted to the facility with diagnoses that included but were not limited to; quadriplegia (paralysis affecting all four limbs), C1-C4 complete (level of injury in the cervical (neck) spinal cord), depression (mental health disorder), type 1 diabetes mellitus (chronic autoimmune disease), hypothyroidism (thyroid gland dysfunction), gastro-esophageal reflux disease (GERD; digestive disorder), and anemia (low red blood cells). The resident's facility admission Record did not include the diagnosis of PTSD. A review of the resident's hospital record included a Spinal Cord Injury Note, documented by the clinical Neuropsychologist from the hospital, dated 12/02/25. The progress notes revealed Resident #74's past medical history included a history of PTSD, alcohol use disorder, opioid use, neurosis (mental and emotional difficulties), and generalized anxiety disorder. The Visit Summary revealed: mildly depressed mood. Impressions revealed: . rule out adjustment disorder with mixed anxiety and depressed mood. The plan included individual psychotherapy to further address adjustment to spinal cord injury and post discharge follow-up for reassessment of adjustment status. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/08/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. In Section D, Mood, reflected that an interview was conducted and the resident was assessed. In the two weeks prior to the assessment, the resident had reported feelings of being down, depressed and/or hopelessness on 12-14 days (nearly every day), and the resident reported feeling bad about themself-or that they were a failure or have let themself or their family down 7-11 days (half or more of the days). A review of Section I., Active Diagnoses was left blank. A review of the individualized comprehensive care plan (ICCP) did not include a focus area, interventions, or goals related to the resident's diagnosed history of PTSD. A review of the initial Psychiatric Evaluation dated 12/10/25, included that the resident reported feeling depressed about their condition but feels there is nothing they can do about it. Resident #74 continued their current dose of Zoloft for depression, and a gradual dose reduction (GDR) was not recommended. The assessment plan included supportive and individualized non-pharmacologic interventions, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings and family involvement. The Psychiatric Evaluation did not include the diagnosis of PTSD. There were no psychotherapy consultations (consults) included in the medical record. A review of the Social Service History and Initial assessment dated [DATE], revealed in Section C., question 4. Does the (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient have a mental health diagnosis other than dementia, the responses were; a. yes, 4a. specify: depression. The diagnosis of PTSD was not included on the Social Service History and Initial Assessment. A review of the Social Services Notes from December 2025 to January 2026, did not reflect the provisions of behavioral health services related to PTSD. A review of the Physician History and Physical note dated 12/21/25, revealed that Resident #74 was seen in bed talking to 911 and reporting not being fed breakfast. On 1/06/26 at 11:14 AM, the surveyor interviewed the Director of Social Work (DSW) regarding Resident #74's diagnosis of PTSD. The DSW stated Resident #74 was one of the facility's veterans, and that she was not aware of a diagnosis of PTSD and that, I have to double check. The DSW stated that the Admissions department screened new admissions and notified Social Services (SS) via email about the resident's psychological conditions. The DSW further stated if a resident had a history of PTSD, she would have consulted the facility's Psychologist and Psychiatrist. The DSW stated she would have only developed an individualized plan of care for a resident with PTSD if their behaviors were an issue. The DSW stated it was important to know if a resident had PTSD because we needed to know if there was a PTSD trigger that may have caused the resident to re-experience trauma. The DSW stated if a resident had a diagnosis of PTSD, it should have been documented in the Social Service History and Initial Assessment. On 1/06/26 at 12:01 PM, the DSW approached the surveyor to inform them that she found a note from the facility's physician (MD) that referenced a PTSD diagnosis. The DSW acknowledged that the PTSD diagnosis should have been listed on Resident #74's diagnosis list; PTSD should have been included in the Social Service Initial Assessment; and there should have been an individualized plan of care developed. On 1/06/26 at 11:34 AM, the surveyor interviewed the Director of Nursing (DON) regarding Resident #74's call made to 911 emergency services on 12/21/25. The DON stated if the resident had called 911, the incident should have been documented in the medical record and investigation should have been completed. The DON stated she was not aware that Resident #74 called 911 emergency services, and no investigation was initiated or completed. On 1/06/26 at 1:01 PM, the surveyor re-interviewed the DON, who stated that it was important to know the if a resident had a diagnosis of PTSD because they may need psychological help. The DON continued if a resident had a diagnosis of PTSD and had not been provided with services, it was a bad thing. The DON added that the diagnosis should also have been coded on the MDS and added to the diagnosis list. On 1/07/26 at 9:03 AM, the DON informed the surveyor that a care plan for PTSD was now initiated, approximately one month after admission, and more than two weeks after the resident called 911 emergency services for not being fed their meal timely while on insulin for diabetes which resulted in the resident having an untreated panic attack. On 1/08/26, the DON provided the surveyor with a Grievance Report dated 1/07/26. A review of the Grievance Report revealed that Resident #74 reported that they became increasingly anxious when they had not received their breakfast on 12/21/25. Resident #74 stated that they had a panic attack and called 911. No further information was provided by the facility. NJAC 8:39-27.1(a); 28.1(c)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, it was determined that the facility failed (a).to ensure that a medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified for (one) 1 of three (3) residents (Resident#77), administered by one (1) of two (2) nurses, observed during medication administration and (b). 1of 1 resident (Resident #74) reviewed for urinary catheter and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.a. On 1/6/26 at 9:08 AM, the surveyor observed Licensed Practical Nurse (LPN) who was assigned to the odd number rooms, prepared medications for Resident #77. The medications included a physician's order (PO) for Fluticasone (Flonase), two (2) sprays in each nostril one time day for nasal congestion and allergy. The PO was started on 12/23/25.On 1/6/26 at 9:24 AM, the LPN stated she was ready to administer the medications to Resident #77, turned and entered the resident's room.On 1/6/26 at 9:25 AM, the surveyor observed Resident #77 awake, seated and conversant.On 1/6/26 at 9:29 AM, the surveyor observed the LPN administer, one (1) spray of Flonase into Resident #77 nostrils and provided the resident tissues.On 1/6/26 at 9:33 AM, the LPN and the surveyor exited the resident's room, and the LPN began to clean her devices.On 1/6/26 at 9:35 AM, the surveyor observed the LPN signed the electronic Medication Administration Record (eMAR) and placed the Fluticasone back into the medication cart.At that time, the surveyor and the LPN reviewed the eMAR together. The LPN confirmed and acknowledged that she should have administered two (2) sprays into each nostril instead of the one (1) spray.On 1/9/26 at 12:02 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern with the LPN who failed to administer Resident #77's Flonase as prescribed. b. On 1/05/26 at 10:18 AM the surveyor observed two (2) 4% lidocaine patches with packages cut open on the bedside table in Resident #74's room. Resident #74 stated the nurse was going to administer the lidocaine patches, but they did not want them applied at that time. Resident #74 stated they got applied to their shoulder. When the surveyor inquired when this occurred, Resident #74 stated it was about 2 days ago. There were no other residents seen in the vicinity of Resident #74's room. On 1/06/26 at 11:10 AM The surveyor reviewed the medical record for Resident #74. According to the facility admission Record, an admission summary, reflected that Resident #74 was admitted to the facility with diagnoses that included, Quadriplegia (paralysis affecting all four limbs), C1-C4 complete (level of injury in the cervical (neck) spinal cord, Depression (mental health disorder), Type 1 Diabetes Mellitus (chronic autoimmune disease), Hypothyroidism (thyroid gland dysfunction), Gastro-Esophageal Reflux Disease (GERD) (digestive disorder) and Anemia (low red blood cells). The facility admission record did not include the diagnosis of PTSD. The hospital record included a Spinal Cord Injury Note documented by the clinical Neuropsychologist from the hospital dated 12/02/25. The progress notes revealed Resident #74's past medical history included a history of PTSD, alcohol use (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorder, opioid use, neurosis (mental and emotional difficulties), and generalized anxiety disorder. The Visit Summary revealed: mildly depressed mood. Impressions revealed: . rule out adjustment disorder with mixed anxiety and depressed mood. The plan included individual psychotherapy to further address adjustment to spinal cord injury and post discharge follow-up for reassessment of adjustment status. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/08/25 reflected the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the Medication Administration Record (MAR) for January 2026 revealed the physician's order for lidocaine External Gel 4% (Lidocaine) Apply to bilateral shoulders topically one time a day for pain apply 2 patches was not signed on January 2nd 2026 at 9:00 AM, the MAR was blank. On 1/05/26 at 10:33 The surveyor interviewed the License Practical Nurse (LPN) who stated she did not leave lidocaine patches on the bedside table in Resident's #74 room, in addition she stated that she has not been in the resident's room today. The LPN stated, it could have been the night nurse. When asked if the medications should have been left at the bedside table the LPN stated, of course not the medications should not be left at the bedside, they should be kept locked up. The Nurse directed the surveyor to Unit Manager (UM). On 1/05/26 at 10:36 AM The UM accompanied the surveyor to Resident #74's room, the UM confirmed that the two lidocaine patch packages were cut open and left on the bedside table. The UM stated if the resident refused them, they should have been thrown away. The UM asked the resident if it was the night nurse who left the medication on the bedside table, and Resident #74 stated no, they were left there two days ago. The Unit Manager threw the two lidocaine patches in the garbage in the resident's room and said she would inservice the staff. On 1/06/26 at 9:15 AM The surveyor interviewed the Assistant Director of Nursing (ADON) who stated on January 2nd, 2026, the day shift nurse called out she took over the cart and worked 7AM-3 PM. The ADON stated that Resident #74 received all medications administered by mouth at 9:00 AM, but Resident #74 did not receive treatments including cream and lidocaine patches. She did not recall taking out the lidocaine patches. The ADON stated if the resident had refused the lidocaine patches, the refusal should have been documented on the Treatment Administration Record (TAR). The ADON acknowledged that the lidocaine patches should not have been left on the bedside table in the resident's room. A review of the provided facility policy, titled; Administering Medications dated/revised April 2019 included medications are administered in a safe, timely manner and as prescribed. No further information was provided. NJAC 8:39-29.2(d), 2