STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King Manor Care and Rehabilitation Center	2303 West Bangs Ave Neptune, NJ 07753

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 168449 Based on observation, interview, record review, and review of facility provided documents it was determined that the facility failed to consistently provide appropriate and timely incontinence care for residents who were dependent on staff for Activities of Daily Living (ADLs) care. This deficient practice was identified for 2 of 3 residents (Resident #3 and #184) reviewed for ADL care and was evidenced by the following: 1. On 10/21/24 at 8:20 AM, the surveyor conduced an initial tour of the [NAME] Unit and observed a strong urine odor in the hallway. On 10/21/24 at 8:21 AM, the surveyor observed Resident #3 in bed in their room. The surveyor inquired regarding the care received at the facility, and Resident #3 stated that they were soiled and needed to be changed. The resident, then activated the call light, and stated that staff took a long time to answer the call light. Resident #3 stated sometimes it could take one hour for staff to answer the call light and incontinence care was not provided timely. The surveyor exited the room and informed the certified Nursing Assistant (CNA #1) in the next hallway of Resident #3's request. The CNA informed the surveyor that she was on light duty but she would get another CNA to assist. On 10/21/24 at 8:45 AM [24 minutes later], CNA #2 entered the room to provide incontinence care to Resident #3. The surveyor observed that the incontinence brief was bulging from the front to the back, and Resident #3 was wearing two incontinent briefs which were both saturated with urine and feces. The surveyor observed that the bed pad was yellow stained. CNA #2 then informed the surveyor that she had not yet provided care to the resident. On 10/21/24 at 11:30 AM, the surveyor interviewed CNA #1 who confirmed she delivered the breakfast tray to the resident around 7:50 AM. CNA #1 stated she did not ask the resident if they were soiled and did not check to see if they needed incontinence care prior to providing the resident with the breakfast meal. On 10/23/24 at 9:04 AM, the surveyor entered the room and observed Resident #3 was in bed. A CNA was also in the room and Resident #3 stated in the presence of the CNA the they were last changed yesterday, referring to the 3:00 PM to 11:00 AM shift. The incontinence brief was again observed bulging to the front and Resident #3 was soiled with feces and urine. The bed pad to protect the bed was again observed yellow stained. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 8:32 AM, the surveyor observed Resident #3 in bed. Resident #3 stated that they already ate breakfast. When inquired if they received incontinence care, Resident #3 stated in the presence of the Licensed Practical Nurse (LPN), I was last changed yesterday. The LPN checked the resident with the surveyor present and observed that the brief was soiled with urine and feces. On 10/24/24 9:40 AM, a telephone interview was conducted with CNA #2 who provided care to Resident #3 on 10/21/24 who stated that she provided incontinence care to the resident at 5:00 AM. CNA #2 stated that she placed two incontinent briefs on Resident #3 because the resident requested two briefs. She then stated that did not inform the nurse that she had been placing two briefs on the resident. When inquired about what could happen with two briefs that were saturated with urine and feces, she stated the skin could break down. On 10/24/24 at 10:30 AM, the surveyor reviewed Resident #3's medical record which revealed the following: -Admission Record (AR) revealed, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: Anemia, difficulty walking, acute respiratory failure with hypoxia, metabolic encephalopathy. -The quarterly Minimum Data Set (MDS) assessment tool dated 09/16/24, revealed that Resident #3 had intact cognition. Resident #3 received a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS). Section G of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #3 was totally dependent on staff for care. -Review of the Care Plan for Resident #3 initiated on 06/08/22, included a Focus for ADL Self Care Performance Deficit related to: Activity intolerance, fatigue and impaired balance. The goal was for Resident # 3 to improve current level of function in bathing, dressing, toileting, transfers and walking through the review date. Revised 03/07/2024. The interventions were to provide all necessary supplies for each ADL task and assist as needed. The care plan did not indicate the frequency for staff to provide incontinence care to the resident. On 10/24/24 at 9:39 AM, the surveyor interview the Registered Nurse/ Unit Manager (RN/UM) regarding Resident #3's incontinence care. The RN/UM revealed that she was not aware that direct care staff were placing two incontinent briefs on the resident. The RN/UM stated she was made aware on 10/21/24 of the double incontinent briefs being used on residents. The RN/UM added that double briefs should not be used on residents as they could cause skin irritation. When inquired regarding the frequency of incontinence care should be provided, the UM stated that incontinence should be provide every two hours. The 7:00 AM- 3:00 PM shift were supposed to check residents for incontinence care as soon as they received their assignment. The surveyor asked about Resident #3 wearing two incontinent briefs and she stated that staff should only apply only one incontinent brief and Resident #3 did not request double briefs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 10/21/24 at 9:30 AM, the surveyor entered a room and observed Resident #184 in bed. Resident #184 stated that incontinence care was not being provided in a timely manner. Resident #184 stated that they wore a Condom Catheter (a gender specific external catheter to facilitate urinary flow) and all the staff did not know how to properly apply the Condom Catheter (CC). The resident stated that most of the time the CC would be dislodged and they would be wet and staff did not check for incontinence care in a timely manner. Resident #184 added sometimes staff would not be available for 4 to 5 hours. The CC would be leaking and they would be soaked with urine. The surveyor then asked Resident #184 to activate the call light, and a CNA entered the room within 5 minutes and inquired regarding the call light. The CNA assisted with the incontinence care and the surveyor observed Resident #184's hospital gown and incontinence brief was soaked with urine. Resident #184 informed the surveyor that they were not checked during the night, or before breakfast. The CNA confirmed that she did not check Resident #184 prior to serve the breakfast meal. On 10/23/24 at 8:00 AM, the surveyor reviewed Resident #184's medical record which revealed the following: - The admission Face Sheet, an admission summary revealed that Resident #184 had diagnoses which included but were not limited to; quadriplegia (severe medical condition characterized by the partial or total loss of function in all limbs and the torso). -The Admission Minimum Data Set (MDS), dated [DATE], an assessment tool used by the facility to prioritize care reflected that Resident #184 was alert and able to make their needs known. Resident #184 received a score of 15 on the Brief Interview for Mental Status (BIMS) indicative of intact cognition. -Resident #184 care plan had a Focus for ADLs self-care performance deficit related to quadriplegia, initiated 08/05/24. The goal was for Resident #184 to improve current level of functioning. Interventions included: Provide all necessary supplies for each ADL task and assist as needed. Resident #184 is totally dependent on staff for toilet use. On 10/23/24 at 11:30 AM, the surveyor reviewed the TASK (electronic record where the CNA documented the care provided to each resident). The ADL task page which included toileting was left blank for 10/21 and 10/22. On 10/24/24 at 12:30 PM, during the pre-exit conference with the Assistant Administrator (AA) and Director of Nursing (DON), the above findings were presented. A review of the facility policy titled, Activities of Daily Living (ADL) Supporting, last revised 2018, indicated the following: Policy Statement revealed: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to 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 persona and oral hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-27.1 (a)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 27193 Based on observation, interview and record review, it was determined that the facility failed to follow a physician order for a treatment to treat a moisture associated dermatitis identified on 10/21/24. This deficient practice was identified for 1 of 21 residents reviewed (Resident #3) for quality of care and was evidenced by the following: On 10/21/24 at 8:45 AM, with the Certified Nursing Assistant (CNA) present and observed that Resident #3, a CNA #2 entered the room to provide incontinence care to Resident #3. The surveyor observed that the incontinence brief was bulging from the front to the back, and Resident #3 was wearing two incontinent briefs which were both saturated with urine and feces. The surveyor observed that the bed pad was yellow stained. CNA #2 then informed the surveyor that she had not yet provided care to the resident had visible redness on the groin and buttocks areas. The concerns were reported to the Registered Nurse (RN) Unit Manager (UM) who then generated a wound consult for Resident #3. On 10/23/24 at 11:00 AM, the surveyor reviewed the medical record for Resident #3 which revealed: -On 10/22/24 the resident was evaluated by the wound practitioner and diagnosed with MASD (Moisture-Associated Skin Damage). The order indicated the resident was to have Nystatin External 10,000 Unit/GM) gram Nystatin Topical (antifungal) Apply to bilateral groin topically every shift for MASD after washing area with mild soap and water, Pat it dry,leave open to air. -The diagnoses included, but were not limited to, acute kidney failure, essential hypertension and acute respiratory failure. On 10/23/24 at 9:04 AM, the surveyor entered the room and observed Resident #3 was in bed. A CNA was also in the room and Resident #3 stated in the presence of the CNA the they were last changed yesterday, referring to the 3:00 PM to 11:00 AM shift. The incontinence brief was again observed bulging to the front and Resident #3 was soiled with feces and urine. The bed pad to protect the bed was again observed yellow stained. The surveyor observed that the groin and buttocks areas were still reddened. The surveyor reviewed the Treatment Administration Record (TAR) and could not locate the order from the wound practitioner. On 10/24/14 at 1:30 PM, the surveyor reviewed the wound practitioner consultation with the Registered Nurse / Unit Manager (RN/UM) who confirmed that Resident #3 had been evaluated and was ordered to have the Nystatin Cream applied to the buttocks and groin areas. The surveyor reviewed the Physician Order Sheet (POS) and the TAR dated October 2024, that was provided by the Assistant Administrator (AA) with the Licensed Practical Nurse (LPN) that was assigned to the unit. The order was not transcribed on the TAR and could not be located. Resident #3 did not receive the treatment ordered on 10/22/23, 10/23/24 and 10/24/23 as ordered by the physician. On 10/24/14 at 1:30 PM during an interview with the Director of Nursing (DON) and the AA, the DON stated if a medication was ordered that the medication should be administered immediately. The AA informed the survey team that she was not aware that Resident #3 did not receive the treatment as ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 11:00 AM, the AA informed the survey team that the Unit Manager failed to transcribe the order. No further information was provided. NJAC 8:39-27.1 (a)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure a system was in place to ensure a resident with a pressure ulcer, who was dependent on staff for care, was turned and repositioned. This deficient practice was identified for 1 of 1 resident (Resident #56) reviewed for care and services for pressure ulcers and was evidenced by the following: On 10/21/2024 at 8:32 AM, the surveyor observed Resident #56 lying in bed on their back on a scoop type mattress (a mattress with a concave center) and a Certified Nursing Aide (CNA) was assisting the resident with breakfast. CNA #1 stated that she was not too sure about the resident but knew there was a wound dressing on the resident's hip. On 10/22/2024 at 9:48 AM, the surveyor observed Resident #56 lying on their back in bed on a scoop mattress with a fall mat on one side and the bed pushed against one wall. On 10/23/2024 at 9:05 AM, the surveyor, again, observed Resident #56 lying on their back in bed on a scoop mattress. At 10:01, CNA #2 was in the room and showed the surveyor a dressing on the resident's left hip area. CNA #2 stated that the staff should be turning the resident every two hours but stated there was no documentation to show that all staff turned the resident. On 10/23/24 at 11:00 AM, the surveyor reviewed Resident #56's medical record which revealed: -Admission Record with diagnoses which included but were not limited to; toxic encephalopathy (neurological disorder caused by exposure to a toxin), muscle weakness, age-related osteoporosis, and mood disorder due to known physiological condition. -The Order Summary Report included an order dated 04/13/2024, to document any disruptive behavior during the shift; dated 10/16/2024, to cleanse with normal saline and apply betadine and a bordered gauze day shift to the left trochanter wound; dated 02/27/2024, to apply zinc oxide to buttocks for skin protection every shift; dated 07/16/2024, for a scoop mattress for positioning; and dated 10/16/2024, cleanse with normal saline and apply zinc oxide paste to sacral/coccyx area wound every shift. -The ongoing resident-centered on-going Care Plan (CP) included but was not limited to; a focus area of at risk for skin breakdown . left trochanter opening, sacral wound date initiated 04/18/2023. Left trochanter opening to resolve, date initiated 01/23/2024. Interventions included but were not limited to; turn and position q (every) 2-3 hours and prn (as needed). A focus area of limited physical mobility r/t (related to) weakness date initiated 06/09/2023 and revised 05/21/2024. Goals which included remain free of skin-breakdown. Interventions included scoop mattress to bed for positioning and comfort and nursing restorative program AROM (assisted range of motion) to BUE/BLE (bilateral upper extremities and bilateral lower extremities). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of the quarterly Minimum Data Set (MDS) an assessment tool used to facilitate resident care, dated 08/19/2024, included but was not limited to; the resident was not able to complete a Brief Interview for Mental Status; there were no behaviors exhibited during a 7-day look back period; the resident was dependent on staff for Activities of Daily living and for rolling, sitting, standing, and transferring; the resident was documented as having one Stage 2 pressure ulcer, one Stage 3 pressure ulcer, and one Stage 4 pressure ulcer and not on a turning/repositioning program. -The facility provided, Braden Scale for Predicting Pressure Sore Risk dated 05/17/2024, included but was not limited to; completely immobile, bedfast, and problem with friction and shear. Resident #56's score was an 8 which indicated Very High Risk for pressure sores. On 10/23/2024 at 10:03 AM, the Registered Nurse (RN) caring for Resident #56 stated that the scoop mattress was to prevent falls. She stated that the resident had pressure ulcers and that the CNAs would turn and reposition the resident and that would be documented in the electronic medical record. The RN accessed the electronic medical record in the presence of the surveyor and acknowledged there was no documentation that Resident #56 was being turned and repositioned. On 10/23/2024 at 10:29 AM, the Director of Nursing (DON) stated that the wound team would come once or twice a week. She stated that she was in charge of that unit at that time and would be responsible for tracking, trending, and wound assessments. The DON stated, the buck stops with me. On 10/23/24 at 1:10 PM, the Rehabilitation Director (RD) stated that the scoop mattress was used to help keep Resident #56 mid-line in the bed and that it was ordered previously by hospice in May 2024, and not the facility. The RD stated, the thin layer (scoop mattress) was to keep the resident mid-line and lays on [Resident #56's] back, but [Resident #56] can't move. The RD further stated that the staff would need to turn and reposition the resident and that there was a restorative CNA who was responsible. The RD stated that when the resident was not on hospice any longer that she would have expected the resident to have been put on a restorative program with therapy. On 10/24/2024 at 8:19 AM, the Assistant Licensed Nursing Home Administrator (AA) stated she was unable to locate any documentation that Resident #56 was on a turning and repositioning schedule. She stated a restorative log noted bed mobility A x 1, but the AA was unable to explain what that entailed and that the restorative activities were for 15 minutes a day only. A review of the facility provided, Restorative Progress Report dated October 2024, included Resident #56 was being provided AROM to BUE/BLE; bed mobility Ax1; and splint/brace to palm protector to be worn throughout the day all for only 15 minutes a day. A review of the facility provided policy, Prevention of Pressure Ulcers/Injuries revised July 2017, included but was not limited to; Purpose . to provide information regarding identification of pressure ulcer/injury risk factors and interventions . Risk Assessment 4.e. reposition resident as indicated on the care plan. Mobility/Repositioning. 1. Choose a frequency for repositioning based on the resident's mobility . 2. At least every hour, reposition residents who are chair-bound or bed-bound . 3. At least every two hours, reposition residents who are reclining and dependent on staff for repositioning. 4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort. Support Surfaces and Pressure Redistribution select appropriate support surfaces . Monitoring 2. Review the interventions and strategies for effectiveness on an ongoing basis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/2024 at 11:15 AM, the above concerns were presented to the facility. On 10/25/2024 at 8:29 AM, the AA and DON were in the conference room with the survey team. The AA acknowledged there was no documented turning and repositioning program for Resident #56. NJAC 8:39-27.1(a)(e)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to follow the Facility Assessment and facility policy to ensure that staff were educated to care for residents who required hemodialysis and had different types of access sites. The deficient practice was identified for 2 of 2 residents reviewed for dialysis (Resident #57 and #185) and was evidenced by the following: A review of the facility provided, Facility assessment dated ,d+[DATE], included but was not limited to; Requirement . resident population and the resources our facility needs to care for our residents as per the recommended guidelines: The facility assessment must address or include: (1) the facility's resident population, including, but not limited to, . b. the care required by the resident population considering the types of diseases, conditions, physical, and cognitive disabilities, overall acuity, and other pertinent facts that are present with in that population; c. the staff competencies that are necessary to provide the level and types of care needed for the resident population; . Additional References to the Facility Assessment: 1. Nursing Services - the facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care . 7. Training Requirements. A facility must develop, implement, and maintain an effective training program . consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified. Acuity describe your residents' acuity levels . to understand potential implications regarding the intensity of care and services needed. Special Treatments: Other Dialysis' Staff Training and Education: based upon our population, the following staff training and educational topics will be offered throughout the year and available for all staff to attend. We will reach out to our vendors for specialty in-services in their areas of expertise . Competency Assessed Dialysis AVF (arteriovenous fistula)/Perma Cath Care. 1. On 10/22/2024 at 9:54 AM, the surveyor observed Resident #185 sitting in a wheelchair (w/c). The resident stated that they had to go to dialysis later in the day, and that they had a chest access (Permacath). A subsequent review of the medical records revealed that Resident #185 was admitted with diagnoses which included but were not limited to; end stage renal disease. A review of the resident-centered Care Plan included a focus area of receiving dialysis for Stage 4 chronic kidney disease via a right neck Permacatheter [permacath]. Interventions included but were not limited to: monitor for signs and symptoms of infection to the access site. A review of the Order Summary Report included an order dated 10/07/2024, check for bruit on the central line (a tube that goes into the neck and flows into the large vessel by the heart) on right side of neck. A review of the Treatment Administration Record (TAR) revealed that staff had been signing off that they had checked the Permacath every shift for a bruit. On 10/23/2024 at 9:03 AM, the Registered Nurse (RN) #1 stated that her responsibility was to monitor the Permacath dressing. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/2024 at 9:31 AM, during a second interview, RN #1 reviewed the resident's medical record with the surveyor and stated that the staff were to check the Permacath for a bruit (a swooshing sound made by blood flow). RN #1 stated she would, put my finger on the site to feel the bruit or I can use a stethoscope. RN #1 further stated, as far as my practice, we don't do a bruit for a Permacath. On 10/23/2024 at 11:44 AM, RN #1 informed the surveyor that she had never had a competency on the assessment and care of the dialysis Permacath. 2. On 10/22/2024 at 11:34 AM, the surveyor observed Resident #57 in a w/c in their room. The resident stated the facility staff did not check their dialysis site. Resident #57 showed the surveyor their AVF on the left upper arm and showed the surveyor how they check their own AVF. A review of the medical record revealed that Resident #57 had been admitted with diagnoses which included but were not limited to; end stage renal disease. A review of the Order Summary Report revealed an order dated 09/02/2024, to check AV fistula for thrill and bruit every shift and to monitor for bleeding. A review of the resident-centered Care Plan included a focus area of end stage renal disease receiving hemodialysis. Interventions included to monitor for any signs of infection. Monitor AVF for bruit and thrill. On 10/23/2024 at 12:18 PM, RN #2 stated that she would monitor Resident #57 for active bleeding and vital signs and for a bruit and thrill. RN #2 stated that she had never had any competencies on the assessment and care of the dialysis AVF. On 10/23/2024 at 12:05 PM, during a telephone call, Resident #185's physician stated that her expectation would be to assess the Permacath site for redness, fever and to ensure the dressing was clean. The physician stated there was no bruit or thrill for a Permacath, but only for an AVF. On 10/24/2024 at 8:32 AM, the Assistant Licensed Nursing Home Administrator stated that the facility did not have nurse competencies for the assessment and care of the hemodialysis accesses. A review of the facility provided policy, Hemodialysis Catheters - Access and Care of undated, included but was not limited to; Purpose hemodialysis catheters will only be accessed by medical staff who have received training and demonstrated clinical competency regarding use of this catheter. Types of Hemodialysis Catheters: 1. AVF . AVG (arteriovenous graft) . Central catheters [Permacatheter]. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King Manor Care and Rehabilitation Center	2303 West Bangs Ave Neptune, NJ 07753

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to consistently perform hand hygiene to prevent the spread of potential infection. This deficient practice was identified for 1 of 2 licensed nurses observed during the medication administration observation, and for 2 staff members observed assisting during the meal service and was evidenced by the following: 1. On 10/22/24 at 8:27 AM, Surveyor #1 observed a Licensed Practical Nurse (LPN) during the medication administration pass. The LPN was observed to enter a resident bathroom, turn on the water, applied soap to her hands, and washed her hands under the stream of water for 12 seconds. Next, the LPN dried her hands and used a paper towel to turn off the water. On 10/22/24 at 8:53 AM, the same LPN was observed in another resident bathroom. She turned on the water, applied soap, applied friction for 8 seconds outside the flow of water and next proceeded to wash her hands for 13 seconds under the flow of water. On 10/22/24 at 9:09 AM, the LPN stated that the procedure for hand washing was to turn on the water, use soap and wash for 10 to 15 seconds outside the stream of water to kill germs, rinse the hands, use a paper towel to dry her hands, and a new paper towel to turn off the water. When asked about the two observations, the LPN stated, I don't know why I did it that way. A review of the facility provided, Medication Pass Observation dated 09/17/2024, included but was not limited to; 10. Hand washing (alcohol-based hand rub or soap and water per facility policy) . c. between every resident even if patient contact is not made. The medication observation was for the LPN and signed that the LPN successfully performed hand hygiene. A review of the facility provided policy and procedure, Administering Medications revised April 2019, included but was not limited to; 25. Staff follows established facility infection control procedures (e.g. handwashing, .) for the administration of medications, as applicable. 2. On 10/21/24 at 12:14 PM, Surveyor #1 observed a staff member identified as the Director of Activities (DA) enter the dining room with a portable oxygen tank. She attached the oxygen tank on the back of a resident's wheelchair. The DA then touched the resident's back then without performing hand hygiene (HH) went to the front of the dining room to the drink cart and poured two sodas that were distributed to residents. On 10/21/24 at 12:19 PM, the DA used her hands to open a drink container for a resident, then without first performing hand hygiene, she went to another table, Table 7, and placed both her bare hands on the table while speaking to the residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 11:26 AM, Surveyor #2 observed the lunch meal in the facility dining room. Surveyor #2 observed a Certified Nursing Aide (CNA) was wearing gloves, removed her gloves and discarded the gloves in the trash next to Surveyor #2. The CNA failed to perform HH, and proceeded to assist residents at a table of three by opening the hand wipes for each and washing their hands, and without first performing HH she began opening drinks and assisting with the meal set up. The CNA left the used dirty hand wipes that the residents used on the table and walked away. On 10/22/24 at 11:57 AM, Surveyor #1 observed the CNA pour a resident's milk and place a spoon on the plate. The CNA next, without first performing HH, tried to place a clothing protector on another resident at the same table. She then sat next to the first resident and used her bare hand to brush away the residents hair. The CNA had not performed any hand hygiene in between residents. On 10/22/24 at 12:01 PM, Surveyor #1 observed the DA deliver a grilled cheese sandwich to a resident. The DA next walked to supply closet for a cup, poured water and delivered the water to another resident without first performing HH. On 10/22/24 at 12:21 PM, during an interview with Surveyor #1, the Infection Preventionist stated that HH must be performed by staff upon entering the room, during passing out meals, absolutely yes use [HH] between different residents. She stated the purpose of hand hygiene was to stop the spread of infection. The Infection Preventionist stated that the hand washing process was to use friction for 20-30 seconds. She further stated that friction for 20 seconds was to be performed outside the stream of water, so the soap is not rinsed off. On 10/22/24 at 12:29 PM, the DA stated, it's my fault I'm just too quick when asked about performing hand hygiene in between residents and tasks. On 10/22/24 at 12:33 PM, the CNA stated the process was to use hand hygiene in between residents and when hands were visibly dirty. A review of the facility provided, Hand Hygiene Competency Validation dated 09/04/24, revealed that the DA had performed the competency successfully and was signed. A review of the facility provided, Hand Hygiene Competency Validation dated 02/06/24, revealed the CNA performed the competency successfully and was signed. A review of the facility provided, Hand Hygiene policy and procedure revised 04/26/24, included but was not limited to; Purpose: prevent the spread of infection and to ensure the safety of employees, residents, vendors, and visitors. Handwashing: hands should be washed for at least 20 seconds . wash your hands for at least 20 seconds Hand Hygiene: . before and after contact with a resident, equipment, food or drink, medication, soiled material, objects in the immediate vicinity of a resident . before, after, and during preparing food or drink. NJAC 8:39-19.4(a); 27.1(a)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48782 Based on observation and interview on 10/22/2024 in the presence of the Director of Maintenance (DOM) and Assistant Administrator (AA), it was determined that the facility failed to ensure that the call bell system was properly functioning in 1 of 5 tested rooms and was evidenced by the following: An observation at 1:45 PM revealed, the call bell button for room [ROOM NUMBER] window bed did not function when tested by the DOM. The facility's Assistant Administrator was informed of the deficient practice at the Life Safety Code exit conference at 1:30 PM. N.J.A.C 8:39-31:2(e)