STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Optima Care Harborview		STREET ADDRESS, CITY, STATE, ZIP CODE 178-198 Ogden Ave Jersey City, NJ 07307	

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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 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 the interview and review of facility documentation, it was determined that the facility failed to; a.) ensure that facility wide assessment included the resources required to establish policies and procedures for the management of staffing contingency plans, b.) update to include the New Jersey (NJ) Mandated law for staffing, c.) update to include the day to day operations with regard to the physical environment, and d.) ensure to include accurate and updated information in order to meet the requirements and needs of all residents in the facility. This failure had the potential to affect all 139 residents who currently live in the facility.This deficient practice was evidenced by the following:During the entrance conference on 1/8/26 at 10:29 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON) a copy of the Facility Assessment (FA). The LNHA stated that the facility's census (the number of residents currently under the care of a specific facility) was 139. A review of the facility's Facility Wide Staffing and Resource Assessment (also known as the FA) revealed a date of assessment or update date of 7/29/25, and assessment was reviewed in QAPI (Quality Assurance Performance Improvement) committee on 7/29/25, did not include information about the facility's contingency plan for staffing. The Staffing Plan revealed, the facility does not take a census-based approach to staffing but looks at the acuity levels of the residents in order to provide the best staffing possible. The above staffing plan did not include information about the NJ Mandated minimum staffing law for census. Further review of the above FA revealed under Part 3: Resident Profile, Special Treatments and Conditions-Per Category as of April-June 2023. The FA did indicate appropriate assessment date for Part 3 on which the update date was on 7/29/25 (over two years). Furthermore, the above FA indicated that the Physical Environment and Building/Plant Needs, under the tabulated information for physical equipment that included the bath benches, showers, bathrooms, and safety features, the applicable, process to ensure adequate supply, appropriate maintenance, replacement were left blank. There was no information on how to address the concerns for physical equipment or environment. A review of the Nurse Staffing Report for two weeks of staffing prior to survey from 12/21/25 to 1/3/26, the facility was deficient in CNA (Certified Nursing Aide) staffing for residents on 8 of 14 day shifts. On 1/15/26 at 8:16 AM, the surveyor interviewed the LNHA regarding FA. The surveyor asked the LNHA what guidance the facility followed for staffing, and he responded that the facility followed the NJ Mandated law for minimum staffing, that was 7-3 shift 1:8 ratio of CNA to residents, 3-11 shift 1:10, and 11-7 shift 1:14. The surveyor then notified the LNHA of the above concern about their staffing plan did not consider the census based approach. The LNHA confirmed that the census based approach was considered the NJ Mandated law requirement and should have been in the FA. On that same date and time, the LNHA informed the surveyor that he was unaware of the updates and new memo from CMS (Centers for Medicare and Medicaid Services) about the FA, effective 8/8/24. He further stated that the facility followed the NJ Mandated law for staffing, and that should be in their FA. The LNHA acknowledged that the FA should address the needs of the residents in the facility. At that same time, the surveyor notified the concern with regard to the Part 3: Resident Profile (continued on next page)

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

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	information for date April-June 2023, which was not in accordance with the period that the facility management reviewed for date of 7/29/25 as a team, and the LNHA did not respond. The LNHA did not respond when asked why the physical environment process to ensure adequate supply, appropriate maintenance, replacement were left blank. On that same date and time, the surveyor asked the LNHA if he was aware of the short staffing in the facility, and the LNHA responded Yes, we were working on addressing that. At that time, the surveyor notified the LNHA of the concern that the submitted FA did not include information about the contingency plan for staffing. On 1/15/26 at 10:08 AM, the LNHA in the presence of the survey team informed the surveyor that after surveyor's inquiry during QAPI meeting, they meet as a team to update the FA because there was an error in the previously provided FA about the Part 3: Resident Profile, and now highlighted to include updated information: Special treatments and Conditions-Per Category as of January 2026. He also stated while showing the highlighted areas in the FA, that they (facility management that included the LNHA) updated the Physical Environment and Building/Plant Needs to include the applicable, process to ensure adequate supply, appropriate maintenance, replacement-Facility will identify issues related to physical plant operations (e.g. chipped tiles, stained ceiling tiles, stained floors, chipped molding, equipment needing clang-IV (intravenous) poles, medical equipment, vents), and develop a plan to address in timely fashion. Linen cart covers need replacement order placed. On that same date and time, the LNHA also confirmed that they did not have the contingency plan in the provided FA and now added after surveyor's inquiry. The LNHA showed the highlighted information for staffing shortages: facility will follow staffing contingency plan and the Mandated CNA staffing ratios for NJ 1:8, 1:10 and 1:14. He also highlighted that the updated FA was dated today 1/15/26, after surveyor's inquiry. At that time, the surveyor asked the LNHA how often the FA should be updated, and he responded at least annually and as needed if there were changes including the change in the regulation for FA. The surveyor asked if they have a separate policy for facility assessment and he said he would check. A review of the facility's Annual Facility Assessment Policy that was provided by the Regional Nurse, with last review date of 6/16/25, revealed that it was the policy of the facility to conduct and document a facility wide assessment to determine the resources necessary to care for our residents competently during both day to day operations and emergencies to ensure that quality of care and quality of life are maintained. Purpose: .The facility assessment must address or include: 1. The facility's resident population, including but not limited: .d. The physical environment, equipment, services, and other physical plant considerations that are necessary for this population and . Responsibility: Administrator. Procedure: 1. Responsible for ensuring that the facility assessment is completed no less than annually and whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment . On 1/15/26 at 11:47 AM, the survey team met for an exit conference with LNHA, DON, and Regional Nurse. The LNHA did not provided additional information. NJAC 8:39-5.1(a); 33.2(b)(c)(13); 33.1(a); 34.1(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, it was determined that the facility failed to; a.) consistently document enteral tube feeding (TF) flush administration to assure the total volume administered was in accordance with physician's orders (PO), b.) administer TF per PO, c.) clarify PO, and d.) properly store and date TF supplies to ensure appropriate care and services for a resident receiving enteral feedings . This deficient practice was identified for 3 of 5 residents (Residents #1, #15, and #43), reviewed for enteral tube feeding.This deficient practice was evidenced by the following: 1. On 1/8/26 at 10:54 AM, Surveyor #1 (S #1) entered Resident #1's room and observed that the resident was not in the room. S #1 observed a TF pump that was empty and on the dresser was a piston syringe in a container that was not dated. On 1/8/26 at 11:03 AM, S #1 observed Resident #1 seated in a wheelchair receiving therapy services in the therapy department. A review of Resident #1's admission Record (AR; an admission summary) face sheet reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; cerebral infarction (also known as an ischemic stroke, is the death of brain tissue caused by a lack of blood flow, typically due to a blood clot), gastrostomy (a surgically created opening (stoma) from the abdomen directly into the stomach, allowing a feeding tube (G-tube) to deliver nutrients, fluids, and medications (meds), bypassing the mouth and esophagus for people who can not eat or swallow safely, often due to illness, trauma, or developmental issues), and hepatic encephalopathy (a serious condition caused by liver dysfunction that leads to a buildup of toxins in the blood, affecting brain function). A review of Resident #1's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision making was moderately impaired. Further review of the MDS reflected that the resident had a feeding tube. On 1/9/26 at 9:28 AM, S #1 interviewed the 3rd (third) floor Licensed Practical Nurse/Unit Manager (LPN/UM), who stated that the piston syringe and bottle were usually changed by the 11-7 shift on a daily basis and that they date the bag that it came in. The LPN/UM stated that when they are done with the piston syringe and bottle the nurse would put it back in the bag. On 1/9/26 at 9:35 AM, S #1 showed the LPN/UM a picture of the observed piston syringe in the bottle that was on the dresser that was not dated and not in a bag for Resident #1 from 1/8/26. The LPN/UM stated that it should not be that way. The LPN/UM stated that today, the piston syringe and bottle were in a bag that was dated. S #1 and LPN/UM entered Resident #1's room and observed that there was a piston syringe and bottle that were in a dated bag hung from the TF pump. In addition, a piston syringe in a bottle that was undated was sitting on the resident's dresser. The LPN/UM confirmed that the undated piston syringe in the bottle should not be there and discarded it in the trash container. On 1/9/26 at 10:58 AM, S #1 interviewed the Director of Nursing (DON) who stated that the piston syringe and bottle should be contained in a bag, and the bag should be dated. The DON further stated (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that it should always be placed in the bag for infection control. S #1 and DON entered Resident #1's room and observed that the piston syringe and bottle that was in a bag hung from the TF pump pole was no longer there. S #1 and DON observed a piston syringe in a bottle that was not in a bag and was not dated on the resident's dresser. The DON discarded the piston syringe and bottle in the trash container and stated that she would educate the staff. On 1/14/26 at 11:53 AM, S #1 notified the Licensed Nursing Home Administrator (LNHA), DON, and Regional Nurse, the concern that Resident #1's piston syringe and bottle was not dated on 1/8/26 and that after the LPN/UM discarded an undated piston syringe and bottle, there was another undated piston syringe and bottle observed again on 1/9/26. On 1/15/26 at 11:11 AM, in the presence of the LNHA and DON, the Regional Nurse stated that the staff were in serviced regarding TF. A review of the facility's Tube Feedings Policy with a reviewed date of 7/22/25, included the following: Piston syringes are changed every 24 hours on the night shift. The policy did not contain any information on dating the piston syringe. 2. On 1/8/26 at 10:20 AM, Surveyor #2 (S#2) observed Resident #15 lying on an air mattress bed, asleep with a tracheostomy tube (an opening in the neck to create an airway). S #1 observed a TF (a tube that delivers nutrients through the stomach or small intestine) pole in the room. At that same time, S #2 interviewed the 4th floor Registered Nurse/Unit Manager (RN/UM) regarding how the resident receive their nutrition. The RN/UM stated that the resident was on a TF Vital 1.5, with a Total Volume (TV) of 1000 ml/24 hr (1000 milliliters/24 hour) and goes up (starts) at 1:00 PM (1 PM). On 1/9/26 at 9:44 AM, S #2 observed the resident with a TF Vital 1.5 running at 50 ml/hr via a pump. The resident was observed with their eyes closed and unable to be interviewed. On 1/9/26 at 11:23 AM, S#2 reviewed the medical records of Resident #15, and revealed: A review of the AR reflected the resident was admitted to the facility with diagnoses that included but not limited to; hypoxic ischemic encephalopathy (brain injury from lack of oxygen): anoxic brain damage, acute respiratory failure with hypoxia (lungs cannot get oxygen into the blood), cardiac arrest (heart suddenly stops beating), tracheostomy, gastrostomy, and dysphagia (difficulty swallowing). A review of the most recent quarterly MDS, with an assessment reference date (ARD) of 10/10/25, reflected the cognitive skills for daily decision making was rarely understood. Under section K for nutritional status revealed the resident was on a TF. A review of the Care Plan revealed, the resident required TF related to nothing by mouth (NPO)/anoxic brain injury, dysphagia history: anoxic brain injury. Date Initiated: 4/15/25, with revision on 7/10/25. A review of the December 2025 and January 2026 Order Summary Reports (OSR) revealed the following Physician Orders (PO): (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enteral Feed Order one time a day Enteral feeding type: Vital 1.5 liquid via PEG to run at 50 ml/hr via pump. TV to be infused: 1000 ml/24hr. Up at 1 PM and down when TV was infused. (remember to set specific hang time .) -Start Date 9/25/25. - Enteral Feed Order every 6 hours (hrs) water flush - flush tube with 200 ml of water every 6 hrs. TV of flush = 800 ml/day (excluding medication (med) flush). TV of nutrient + flush = 1700 ml/day. -Start Date 7/8/24. -Enteral Feed Order every shift Document TV of feeding infused -Start Date 9/25/25. On 1/9/26 at 11:30 AM, S #2 reviewed the December electronic medication administration report (eMAR) which revealed the TV of Vital 1.5 tube feeding administered: 12/1/25 600 ml; 12/2/25 600 ml; 12/5/25 2,132 ml; 12/6/25 1200 ml; 12/8/25 1400 ml; 12/9/25 1550 ml; 12/11/25 1200 ml; 12/13/25 1,513 ml; 12/14/25 1,689 ml; 12/15/25 1,878 ml; 12/16/25 1200 ml; 12/17/25 1200 ml; 12/18/25 1200 ml; 12/19/25 1200 ml; 12/20/25 1200 ml; 12/22/25 1200 ml; 12/23/25 1200 ml; 12/25/25 1200 ml; 12/29/25 800 ml; 12/31/25 1200 ml; 1/1/26 1220 ml; 1/2/26 1200 ml; 1/3/26 1400 ml; 1/5/26 1200 ml; 1/6/26 800 ml; and on 1/7/26 1200 ml. The water flushes ordered for 200 ml every 6 hrs, with a TV of flush=800 ml/day revealed: on 1/1/26 =1600 ml was administered and on 1/2/26= 1400 ml was given. On 1/12/26 at 11:58 AM, S#2 interviewed the 4th floor RN/UM, regarding the TF TV for December and January that were incorrectly administered including the water flushes. The RN/UM confirmed that it should be 200 ml for 7-3 (7:00 AM-3:00 PM) shift, 400 ml for 3-11 (3:00 PM-11:00 PM) shift, and 400 ml for 11-7 (11:00 PM-7:00 AM) shift. The RN/UM state that they were incorrect. She further stated that the nurses were responsible for that and were not reading the orders correctly. On 1/14/26 at 11:40 AM, S #2 notified the LNHA, the DON, and the Regional Nurse regarding concerns with TF and water flushes. A review of the facility's Tube Feedings Policy dated 7/22/25, which revealed under Policy, tube feedings will be given as per PO via gastrostomy tube utilizing the enteral pump . Under Procedure Responsibility Licensed Nurse: Action #9, reflected, ensure enteral pump is set up with the proper volume to be delivered, rate of flow and proper auto flush as per Medical Doctor (MD) order . A review of the facility's Physician's Orders Policy date reviewed 11/4/25, revealed under Purpose, to ensure that the plan of care is followed in accordance with the orders established by the physician and/or nurse practitioner . 3. On 1/8/26 at 11:22 AM, Surveyor #3 (S #3) observed Resident #43 in bed with a Certified Nursing Aide (CNA) at the bedside. There was a Jevity 1.2 that was hung, and machine was off. Surveyor #4 (S #4) reviewed the medical records of Resident #43, and revealed: A review of the AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to; dysphagia unspecified, other seizures (is abnormal electrical activity in brain. It causes changes in awareness and muscle control), cerebral palsy (a group of neurological disorders that affect movement, posture, and coordination, caused by abnormal brain development or damage to the developing brain), and bed confinement status. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent quarterly MDS reflected the cognitive skills for daily decision making was coded 3 (severely impaired cognition). Under Section K-Swallowing/Nutritional Status revealed that the resident was on feeding tube. A review of the January 2026 OSR revealed the following PO: -start date 12/19/25, enteral feed order every day shift, enteral feeding down. Document TV (1000/24hrs [hours]) infused. -start date 12/19/25, enteral feed order one time a day, enteral feeding type: Jevity 1.2 liquid via [TF] to run at 70 ml/hr via pump. TV to be infused: 1150 ml. Up at 2 PM (2:00 PM) and down when TV is infused. The above order on 12/19/25 had two different TV for 24 hours (1000 ml and 1150 ml) were both being signed by nurses as administered every day. -start date 9/19/25, enteral feed order every 6 hours, water flush-flush tube with 200 ml of H2O (water) every shift, total 800 ml/24 hrs. The above order for 9/19/25 was plotted at 0000 (12 midnight), 0600 (6:00 AM), 1200 (12 noon), and 1800 (6:00 PM) with no ml amount. -start date 2/16/25, enteral feed order every shift, document TV of feeding infused. The above order on 2/16/25 was plotted at 6:30 AM, 2:30 PM, and 10:30 PM. The TV did not match the expected TV of 1150 ml/day to be infused from 1/1/26 to 1/9/26. On 1/9/26 at 10:50 AM, S #4 asked the DON to accompany S #4 to the resident's room and both observed the resident lying on bed, awake, and nonverbal. The TF machine was off, and no TF formula was hung. S #4 asked the DON to check the TF machine for TV infused for the day, and after the DON turned on the machine the number 60 came out from the machine. The DON informed S #4 that the 60 was the rate per hour, which meant 60 ml/hr the rate. The DON also stated that TV was cleared already. On 1/9/26 at 10:55 AM, S #4 interviewed the LPN about the resident's TF order. The LPN confirmed that the 60 ml/hr in the machine was the rate per hour of the resident. The LPN also stated that when he came today at 7:10 AM, the resident's TF was off, and nothing was hung. The surveyor then asked what the order for the resident's TF was, and the LPN checked the eMR, and he stated that the order was Jevity 1.2 at 70 ml/hr, up at 2 PM and to complete TV of 1150 ml for 24 hours. At that same time, the LPN stated that he did not know why the machine was set up at 60 ml/hr. S #4 also asked the above orders for 1000 ml/24 hours vs the same order on 12/19/25 for total of 1150 ml, and he stated that he could not speak with other nurses as to why it was being signed both, but it should have been clarified. S #4 also asked about the order for documenting the TV at 6:30 AM, 2:30 PM, and 10:30 PM, as to why the 2:30 PM for January 2026 only one time a nurse documented for 30 ml and the 6:30 AM and 10:30 PM TV infused for TF formula did not match the signed 1000 ml and 1150 ml, and the LPN responded, I don't know. He also stated that the orders should have been followed and the TV to be infused should have been delivered according to the order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/26 at 11:30 AM, S #4 notified the Dietician of the above findings and concerns. The Dietician stated that the resident had 0.6 pounds (lbs) weight loss between November 2025 and December 2025, but not significant, and actually the resident had weight gain, not a weight loss in total, and still met the goal in the care plan. He further stated that he would check the resident today about S #4's concerns. On 1/14/26 at 11:37 AM, the survey team met with the LNHA, DON, the Regional Nurse, and S #4 notified them of the above findings and concerns. On 1/15/26 at 11:10 AM, the survey team met with the LNHA, DON, and the Regional Nurse stated, for TF concerns we did in service for nurses, the nurses claimed there was a confusion with calculations and what was documented in the eMAR. She further stated that in service was provided to nurses also to read the pump but not just to figure out the TV, so they have a reference point. On that same date and time, the Regional Nurse informed the surveyors that there was no negative effect to the resident, the resident was not dehydrated and stable. A review of the facility's Tube Feedings Policy that was provided by the LNHA, with last review date of 7/22/25, revealed, TF will be given as per PO via naso-gastric or gastrostomy tube utilizing the enteral pump .Procedure: Responsibility: Action, Licensed Nurse: .9. Ensure enteral pump is set up with the proper volume to be delivered, rate of flow and proper auto flush as per MD order .18. All resident to remain in semi-Fowler's position during the feeding and for one hour following the feeding to prevent aspiration On 1/15/26 at 11:47 AM, the survey team met for exit conference with LNHA, DON, and Regional. The LNHA did not provide additional information. NJAC 8:39-27.1 (a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of other pertinent documents, it was determined that the facility failed to: a.) ensure appropriate hand hygiene was performed and use of personal protective equipment (PPE) and b.) ensure appropriate storage of clean linen supplies. The deficient practice occurred on 2 of 3 resident units (3rd and 5th floor), 1 of 3 clean linen rooms, 4 of 11 staff (1 Licensed Practical Nurse, 1 Housekeeper, and 2 Certified Nursing Aides), failed to follow appropriate infection control practices to prevent the spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy.This deficient practice was evidenced by the following:According to CDC, Clinical Safety: Hand Hygiene for Healthcare Workers, February 27, 2024, Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with: Handwashing with water and soap (e.g., plain soap or with an antiseptic). Antiseptic hand rub (alcohol-based foam or gel hand sanitizer).Cleaning your hands reduces: The potential spread of deadly germs to patients.The risk of healthcare personnel colonization or infection caused by germs received from the patient.Know when to clean hands: Immediately before touching a patient. Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal.Know How to wash hands with soap and water:. Note: Other entities recommend cleaning hands with soap and water for at least 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times and scrubbing hands and fingers with soap. 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. 1. On 1/12/26 at 6:30 AM, the surveyor went to 5th floor unit and saw Certified Nursing Aide #1 (CNA #1) wearing a double surgical mask, and with linen cart in front of room [ROOM NUMBER]. The surveyor asked CNA #1 to accompany the surveyor inside room [ROOM NUMBER] and asked if Resident #116 was incontinent, and she stated yes. The surveyor also observed CNA #1 donned (put on) gloves without performing hand hygiene and proceeded to check the resident's incontinence brief. Afterward, the surveyor interviewed CNA #1 regarding her double surgical mask and not performing hand hygiene prior to donning of gloves. CNA #1 confirmed the double mask and stated that she should have performed hand hygiene prior to donning of gloves. 2. On 1/12/26 at 6:37 AM, the surveyor went to 5th floor nursing unit and interviewed the Licensed Practical Nurse (LPN) regarding 11-7 shift staffing. Both the surveyor and the LPN observed Certified Nursing Aide #2 (CNA #2) walked in the hallway with gloves in use while carrying a plastic bag. On that same date at 6:39 AM, the surveyor interviewed CNA #2 in the presence of the LPN. CNA #2 informed the surveyor that she did incontinence care to resident in room [ROOM NUMBER]. CNA #2 acknowledged that she should not be using gloves in the hallway. 3. On 1/12/26 at 6:44 AM, the surveyor and the LPN went to room [ROOM NUMBER] for incontinence round. The LPN performed handwashing inside the resident's room for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nine seconds under the stream of running water, then donned a new pair of gloves. The resident refused the LPN to check their incontinence brief, and both the surveyor and LPN left the room. Outside the resident's room, the surveyor interviewed the LPN regarding handwashing and notified of the above concern. The LPN informed the surveyor that handwashing should be at least 30 seconds. The LPN further stated that I meant to do handwashing for 30 seconds, and that she was trying to finish. She acknowledged that she was washing her hands under the stream of running water. 4. On 1/12/26 at 7:20 AM, the surveyor in the presence of Certified Nursing Aide #3 (CNA #3) observed the Housekeeping Staff (HS) in the hallway of 3rd floor unit walking toward the exit door with gloves in use, doffed (remove) off used gloves, and CNA #3 notified the HS not to use gloves in the hallway. At that time, both the surveyor and CNA #3 observed HS immediately touched the pin pad of the exit door and proceeded to exit the unit without performing hand hygiene. The DON walked toward the surveyor and CNA #3 and was notified of the above concerns with HS, and the CNA confirmed to the DON. 5. On 1/12/26 at 6:47 AM, the surveyor in the presence of the Certified Nursing Aide #4 (CNA #4), outside room [ROOM NUMBER], both observed a linen cart (linen cart #1) parked, and CNA #4 confirmed there were clean linen supplies (fitted sheets, linens, and incontinence pads) inside the linen cart. Both the surveyor and CNA #4 observed the linen cart cover with multiple brown and whitish stained, plastic wrapper inside the linen cart pocket cover. CNA #4 stated that the plastic wrapper garbage should not be in the linen cart cover. She also acknowledged that the linen cart cover was dirty. On 1/12/26 at 6:55 AM the surveyor asked the Director of Nursing (DON) to accompany the surveyor in resident's room [ROOM NUMBER]. Both the surveyor and the DON observed outside the room small linen cart (linen cart #2) with stained on the cover, stained with blackish and brownish substances, and with holes. There were clean linen supplies inside the cart. On 1/12/26 at 7:05 AM, the surveyor asked the Director of Housekeeping (DH) to accompany the surveyor inside the 5th floor clean linen room in the presence of the DON. The surveyor, DH, and the DON observed the area near the edge of the door floor blackish color with accumulation of dust, the 1st shelf of the clean linen area with multiple brownish dried stain which the DH stated that it could be from coffee drippings. The surveyor then asked the DH were staff allowed to drink coffee inside the clean linen room, and the DON responded that she would investigate why there were dripping of coffee inside the clean linen room. The surveyor, DON, DH also observed the floor tiles and lower shelf of the clean linen room with accumulation of dust and coffee dried substances, and the clean linen supplies were not all stored inside a bag (open to air). The DON instructed the DH to clean the floor. The DON acknowledged that the room should have been cleaned. On 1/12/26 at 7:15 AM, the surveyor went to the 3rd floor unit. The surveyor in the presence of Certified Nursing Aide #5 (CNA #5) observed A side linen cart (linen cart #3) with linen cart cover stained with whitish substance, with holes, and ripped. CNA #5 stated that it was probably from soap drippings. CNA #5 confirmed there were clean linen supplies inside the A side linen cart. On 1/12/26 at 7:17 AM, in the presence of the Registered Nurse (RN), both observed A linen cart (big cart) stained with holes and ripped. Both the surveyor and the RN also observed B side (big) linen cart (linen cart #4) yellow cart stained with brownish and blackish substances. The RN unable to state how often linen cart covers were being washed. The DON came and was notified the above concerns with linen carts covers and she stated that the Licensed Nursing Home Administrator (LNHA) would be notified and housekeeping. On 1/13/26 at 11:48 AM, the surveyor interviewed the Registered Nurse/Infection Preventionist (RN/IP), who stated that she's responsible for in service for infection control including hand hygiene, PPE use, of all staff that included housekeepers, dietary, and nursing. The RN/IP informed the surveyor that staff were not allowed to wear PPE, including gloves in the hallway, and hand hygiene should be done before and after use of gloves. The surveyor notified the RN/IP of the above findings and concerns with regard to hand hygiene and PPE use. The RN/IP stated that handwashing should be at least 30 seconds and not under the stream of running water. On that same date and time, the surveyor also notified the RN/IP of the above concerns with linen cart covers and clean linen room. The RN/IP responded that the LNHA had ordered the linen cart covers. The RN/IP (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also stated that the linen cart covers should be clean because the inside of the cart were clean linens and should observe proper storage of clean linen supplies. She further stated that the clean linens should be covered and free from dust. The RN/IP stated that I was aware of the above concerns because she was notified after surveyor's inquiry. On 1/14/26 at 8:21 AM, the surveyor interviewed the DH regarding the above findings and concerns, who informed the surveyor that there were no spare (no replacement) linen carts covers. The DH stated that we ordered and never came last year, even when the last Administrator who left July 2025, the ordered linen covers were not delivered. He further stated that we washed the linen carts cover last month. The HD confirmed that there were no documented log that the linen carts covers were washed. At that same time, the DH stated that the clean linen room did not look that it was deep cleaned, and the floor was stripped off. He further stated that staff should not be drinking coffee inside the clean linen room, and I informed the housekeepers that all linen supplies should be inside the bags to prevent from dust. On 1/14/26 at 8:50 AM, the surveyor interviewed the Laundry Staff (LS) in the 3rd floor unit. The LS informed the surveyor that the linen cart covers were being washed but not specific dates. She further stated that the linen cart covers had stains and unable to remove the stains even after they washed them. On 1/14/26 at 11:37 AM, the survey team met with the LNHA, DON, the Regional Nurse, and the surveyor notified them of the above findings and concerns. On 1/15/26 at 11:10 AM, the survey team met with the LNHA, DON, and the Regional Nurse. The Regional Nurse stated, with regard to the hand hygiene of the identified CNAs, Nurse, and HS, and gloves, we did competency for each of them, we did housekeeping department in service, and all staff in service again reminding them of handwashing. A review of the facility's Handwashing/Hand Hygiene Policy that was provided by the LNHA, with last review date of 12/22/25, revealed, the facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub (ABHR), etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies .7. Use an ABHR containing at least 62% alcohol; or, alternatively, soap and water for the following situations. Before and after direct contact with residents; .f. Before donning sterile gloves .l. After contact with objects in the immediate vicinity of the resident. m. After removing gloves .8. Hand hygiene is the final step after removing and disposing of PPE (personal protective equipment) .Procedure: Equipment and supplies 1. The following equipment and supplies are necessary for hand hygiene; a. ABHR b. c. soap .Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature .Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves .4. Hold the removed glove in the gloves hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. A review of the facility's Linen Carts Policy that was provided by the LNHA, with last review date of 11/22/25, revealed, to ensure the safe, sanitary, and efficient handling, storage, and transport of clean and soiled linen in order to prevent infection, maintain resident dignity, and comply with federal, state, and local regulations. Policy Statement-the facility shall maintain clean and organized linen carts that are used exclusively for the transport and storage of clean linens .Definitions-clean linen: that have been laundered, dried, and stored in a sanitary manner .Linen cart: a designated, covered cart used solely for transporting and storing clean linens. Policy Guidelines: 3. Linen carts shall remain covered when not actively being stocked or accessed .5. Linen carts shall be stored in designated clean areas away from soiled utility rooms, trash, or chemicals . A review of the above Linen Carts Policy did not include information about linen cart covers maintenance and cleanliness. On 1/15/26 at 11:47 AM, the team met for an exit conference with LNHA, DON, and Regional Nurse, and the LNHA did not provide additional information. NJAC 8:39-19.4(a)(n); 21.1(d)(f)(g)(h)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a clean, safe, and sanitary environment for 4 of 4 common areas (2nd, 3rd, 4th, and 5th floors), 2 of 3 day rooms (3rd and 4th floor), and 1 Resident's room (room [ROOM NUMBER]).This deficient practice was evidenced by the following: 1.On 1/9/26 at 11:44 AM, Surveyor #1 (S #1), with Surveyor #2 (S #2), and in the presence of the Regional Quality Assurance Nurse (RQAN) toured the 3rd floor shower room and observed the following: -Upon entry, there was one floor tile missing. -The wall beneath the entrance door was broken and with hole. The surveyor asked the RQAN what the importance of ensuring the flooring was even and no missing tiles was. The RQAN acknowledged it was for safety of the residents who were using the shower room. -The right side upon entry, was another door, the door bottom part a metal part that was scratching the floor and was making a sound. Inside the toilet room the sink with water faucet continuously dripping water. The floor with accumulation of dust and blackish in color, there were total of five ceiling tiles with blackish and brownish discoloration. The RQAN had no response when asked why the floor had blackish discoloration and what happened to the ceiling tiles, and the water faucet, and the door. -There were total of two shower cubicles, the 2nd shower cubicle had one broken floor tile. There were three shower chairs with stained brownish and yellowish in color. -One sprinkler head with no cover and the ceiling tile was open around the sprinkler head with no cover. One sprinkler head with cover and loose to the ceiling tile. On 1/9/26 at 11:53 AM, S #1 and S #2 both notified the Director of Maintenance (DM) while inside the 3rd floor shower room of the above findings and concerns. The DM stated that the three shower chairs concerns were responsibility of the housekeeping department, and the rest will be fixed by maintenance. 2. On 1/9/26 at 12:05 PM, S #1 observed room [ROOM NUMBER]'s (R501's) toilet room with plastic pipe on the floor next to the toilet seat and the light over the sink was blinking. On 1/12/26 at 6:55 AM, S #1 asked the Director of Nursing (DON) to accompany S #1 inside R501, and both observed the plastic pipe on the floor and the blinking light on top of the sink. S #1 notified the DON that both concerns were observed also on 1/9/26. The DON responded that she did not know as to why the plastic pipe was on the floor and it should not be there. S #1 observed the DON picked up the plastic pipe on the floor, placed inside a plastic bag, went outside R501, and performed hand hygiene with use of ABHR (alcohol base hand rub). 3. On 1/12/26 at 7:05 AM, S #1 and the DON went to 5th floor day room, and both observed on top of a table upon entry to the room in the right side the table was covered with a towel that had a brownish (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stained, with two water pitchers dated 1/12/26. The two water pitchers had a cover of saran plastic wrap, both pitchers had no appropriate covers. The DON stated that it should not be like that. On that same date and time, both S #1 and the DON observed one floor tile in the middle of the day room broken. The garbage receptacles with no cover, and then the DON called the Director of Housekeeping (DH) to look at the garbage receptacle. Both S #1 and the DON also observed the middle window with paper and plastic on the side, the floor tiles with scattered brownish discoloration and accumulation of dust. S #1 observed the DON removed the paper and plastic that was on the side of the window and stated that it should not be there. On 1/13/26 at 9:44 AM, the DM went to the conference room and notified S #1 in the presence of the survey team that all the concerns with environment that were brought to the facility's attention were all addressed after surveyor's inquiry. On 1/14/26 at 8:21 AM, S #1 interviewed the DH, who stated that the shower rooms cleanliness were housekeepers' responsibility. He further stated that it looked like it was not deep cleaned upon him checking the shower rooms after surveyor's inquiry. The DH added that there were no logs for deep cleaning and cleaning of the shower rooms. At that same time, the DH acknowledged that the linen room did not look that it was deep cleaned and stripped the floor. He stated the staff should not be drinking coffee inside the clean linen room. Furthermore, the DH stated that it was okay not to cover the garbage receptacle even though room was being used by residents during mealtime. On 1/14/26 at 11:37 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, the Regional Nurse, and S #1 notified them of the above findings and concerns. On 1/15/26 at 11:47 AM, the team met for an exit conference with LNHA, DON, and Regional Nurse, and the LNHA did not provide additional information. 4. On 1/14/26 at 9:37 AM, the Surveyor #3 (S #3) observed the 4th floor, day room with both sides of the entrance with broken moldings. On 1/14/26 at 10:19 AM, S #3 called the 4th floor Registered Nurse/Unit Manager (RN/UM) to the day room entrance, and the RN/UM confirmed the broken moldings on both sides of the entry way. S #3 asked the RN/UM if she was aware how long the moldings had been broken and she stated that she did not know. She also stated that the Maintenance department was responsible for broken moldings and that we have a system where we log what needs to be worked on. The RN/UM confirmed the day room was used by the residents for activities and for dining. On 1/14/26 at 11:35 AM, S #3 notified the LNHA, DON, and the Regional Nurse regarding the concern with the broken moldings. On 1/14/26 at 12:55 PM, S #3 interviewed the Maintenance Staff (MS) who was in the hallway at the time, who informed S #3 that MS did daily rounds of the facility. S #3 notified the MS of the above findings and concerns with the broken moldings and he stated, Work goes in the system and my boss, will send it to me. The MS also stated that there were three of them in the department and I noticed this yesterday, but I was busy doing something else. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/26 at 11:10 AM, the survey team met with the LNHA, DON, and the Regional Nurse stated that the molding in the day room was fixed after surveyor's inquiry. 5. On 1/13/26 at 10:39 AM, S #2 observed an air circulation vent on the side of the wall, of the 2nd floor hallway, near the stairway. S #2 observed that the vent had an accumulation of black colored substance on grills and dust like substance. S #2 also observed that the 2nd floor was accessed by residents for therapy services, recreation, and the outside smoking area. On the same date, at 11:45 AM, S #2 observed an air circulation vent on the ceiling above the nurses' station on the 5th floor. S #2 observed that the vent had an accumulation of a black and grayish substance, and a dust like substance. On 1/14/26 at 11:37 AM, the survey team met with LNHA, DON, and Regional Nurse, and S #2 notified them of the above findings and concerns. S #2 asked if the vents looked clean or homelike, and there was no response from the LNHA, DON, and Regional Nurse. On 1/15/26 at 11:10 AM, the survey team met with the Regional Nurse, DON, and the LNHA stated that the vents were cleaned after surveyor's inquiry. A review of the facility's Quality of Life-Homelike Environment Policy that was provided by the LNHA, with a review date of 12/20/25, revealed, residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation: 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment. b. Comfortable yet adequate lighting . The policy did not reveal anything about air vents or cleaning of air vents. NJAC-8:39-31.2(e); 31.4 (a)(b)(f)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's QAPI (quality assurance and performance improvement) program for 5 of 5 Certified Nurse Aides (CNAs) reviewed for mandatory education (CNA #1, #2, #3, #4, and #5). This deficient practice was evidenced by the following:On 1/9/26 at 11:33 AM, the surveyor requested from the Staff Educator (SE) the mandatory annual education and any related attendance logs or documents that was done for five randomly selected CNAs based on their date of hire (doh). The surveyor asked the SE if QAPI was part of the educational in-services, and the SE stated yes, it was a mandatory.On 1/12/26, the surveyor reviewed the individual mandatory in-service education hours for five randomly selected CNA files. The individual mandatory in-service sheets did not reflect under TOPIC any mention of QAPI for CNA #1 doh 10/15/24, CNA #2 doh 9/9/16, CNA #3 doh 7/29/29, CNA #4 doh 7/18/16, or CNA #5 doh 7/29/19.The surveyor reviewed the facility provided staff development in-service program sign in logs specific for QAPI education.The Staff Development In-service Program Logs, provided by the facility, dated 12/9/25, revealed the following: The first page reflected under TOPIC: Trauma Informed Care and QAPI process. The second page reflected under TOPIC: Trauma Informed Care. The third page reflected under TOPIC: Trauma Informed Care/Restraints. The fourth and last page reflected under TOPIC: Trauma Informed Care.The Logs did not reflect CNA #1 had any QAPI training.The Logs reflected that CNA #2's name appeared on the second page with TOPIC Trauma Informed Care.The Logs did not reflect CNA #3, #4, or #5 had any QAPI training.On 1/13/26 at 11:37 AM, the surveyor interviewed CNA #6 and asked if they had in-service for QAPI. CNA #6 stated they were unsure and could not recall. On 1/13/26 at 11:51 AM, the surveyor interviewed CNA #7 about QAPI in-service. CNA #7 stated they could not recall, and they get quite a few different in-services.On 1/14/26 at 9:32 AM, the surveyor interviewed the SE. The surveyor asked the SE of all relevant in-services and attendance sign in sheets. The SE stated yes, but we can look in the binder which contains the whole year.The surveyor reviewed the facility provided Mandatory/Competency Annual Calendar 2025. The calendar did not reflect any mention of QAPI or QAPI process. The surveyor, in the presence of the SE and the Director of Nursing (DON), reviewed the facility binder for staff education/in-services. The binder did not reveal any further information or documents related to or referencing QAPI or QAPI process.On 1/14/26 at 11:37 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Regional Nurse, and the surveyor notified the facility of the concern that selected CNAs did not have mandatory QAPI education. On 1/15/26 at 11:10 AM, the survey team met with the LNHA, DON, and Regional Nurse stated that QAPI process was added to the master list of mandatory education and staff will be re-educated. The DON stated that staff may not have had a clear understanding of what QAPI was. The LNHA did not provide any further pertinent information. N.J.A.C. 8:39-33.1

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to follow the provider's order and plan of care with regard to resident's laboratory need according to facility's policy and standard of clinical practice for 1 of 31 residents (Resident #43) reviewed.This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and 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. On 1/8/26 at 11:22 AM, Surveyor #1 (S #1) observed Resident #43 in bed with a Certified Nursing Aide (CNA) at the bedside. Surveyor #2 (S #2) reviewed the medical records of Resident #43, and revealed: A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; dysphagia (or difficulty swallowing is a symptom of many different medical conditions. These conditions include nervous system and brain disorders, muscle disorders and physical blockages in the throat) unspecified, other seizures (is abnormal electrical activity in brain. It causes changes in awareness and muscle control), cerebral palsy (a group of neurological disorders that affect movement, posture, and coordination, caused by abnormal brain development or damage to the developing brain), and bed confinement status. A review of the most recent quarterly Minimum Data Set (qMDS), with an ARD of 11/6/25, reflected the cognitive skills for daily decision making was coded 3 (severely impaired cognition). Under Section I-Diagnosis revealed that the resident had an active diagnosis that included but was not limited to; aphasia, cerebral palsy, and seizure disorder. Under Section K-Swallowing/Nutritional Status revealed that the resident was on feeding tube. A review of the Physician's Orders (PO) dated 10/9/25, signed by the Advance Practice Nurse (APN), had an order to check Vimpat (or lacosamide is an anticonvulsant drug. In addition to being approved for use as adjunctive therapy in the treatment of partial-onset seizures), Keppra (an anti-epileptic drug, also called an anticonvulsant), and Topamax (was originally FDA (food and drug administration)-approved as a seizure medicine, also called an anticonvulsant) level. A review of the Centers Lab (laboratory), revealed, there was no requisition for 10/9/25 order of the APN to check Vimpat, Keppra, and Topamax level. A review of the Progress Notes (PN) dated 10/9/25, Neurology Monthly follow-up note that was electronically signed by the APN reflected a plan check Keppra, Vimpat, and Topamax levels in AM (morning). Further review of the medical records revealed there was no documented evidence as to why the APN's order on 10/9/25 and plan was not followed. On 1/9/26 at 11:20 AM, S #2 asked the Director of Nursing (DON) in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM) regarding the PO dated 10/9/25 by the APN to check Vimpat, Keppra and Topamax level if they were followed. The DON stated that she would get back to S #2. At that same time, the DON stated that if the recommendation and order for lab work were not done or the resident refused, it should have been documented to the resident's eMR, specifically in the PN. On 1/9/26 at 1:01 PM, the DON provided a copy of the resident's lab results. The DON stated that the lab order for Vimpat and Keppra level was done on 10/31/25, and the Topamax level was done on 12/2/25. At that same time, S #2 asked the DON as to why the lab order for 10/9/25 was done after 22 days for Keppra and Vimpat, and after 54 days for (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Topamax. The DON stated that the expectation was to follow the physician or APN's order. The DON also stated that she was unsure as to why the order was done after almost after a month. She further stated that there should be a documentation as to why it was not followed timely. The DON added that she would get back to S #2 to determine what had happened. On 1/14/26 at 11:37 AM, the survey team met with the Licensed Nursing Home (LNHA), DON, the Regional Nurse, and S #2 notified them of the above findings and concerns. On 1/15/26 at 11:10 AM, the survey team met with the LNHA, DON, and the Regional Nurse. The Regional Nurse stated that I looked at the lab and there was delay in 10/9/25 PO and it was done on 10/31/25. She further stated that the facility staff believed the resident refused. The Regional Nurse also stated that education provided to the nurses that they have to document the refusal. On that same date and time, the Regional Nurse informed the surveyors that there was no negative effect to the resident, the resident was not dehydrated and stable. A review of the facility's Physician's Orders Policy that was provided by the LNHA, with last review date of 11/4/25, revealed, it is the policy of the center to write PO to establish a plan of care to follow for the care of the resident .General Information: PO are grouped into types of orders .treatment , diagnostic, medications, dietary orders, and therapy orders .Diagnostic: orders for labs, x-rays and tests should indicate if the order is for one time or repeating at specific intervals. Reason for the order must be included (diagnosis) .Dietary: include type of diet, consistency, route and type of liquids . On 1/15/26 at 11:47 AM, the survey team met for exit conference with LNHA, DON, and Regional. The LNHA did not provide additional information. NJAC 8:39-11.2(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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident with pressure ulcers (PU) received necessary treatment and services by failing to; a.) ensure accurate skin assessment, b.) appropriate and routine documentation of skin impairment progress, c.) follow the physician order with regard to wound doctor consult, and d.) care plan reflected accurate skin condition and information for 1 of 2 residents reviewed for PU (Resident #1), consistent with professional standards of practice and facility's practice and policy. This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and 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.On 1/8/26 at 11:03 AM, the surveyor observed Resident #1 seated in a wheelchair receiving therapy services in the therapy department. A review of Resident #1's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; cerebral infarction (also known as an ischemic stroke, is the death of brain tissue caused by a lack of blood flow, typically due to a blood clot), gastrostomy (a surgically created opening (stoma) from the abdomen directly into the stomach, allowing a feeding tube (G-tube) to deliver nutrients, fluids, and medications, bypassing the mouth and esophagus for people who can't eat or swallow safely, often due to illness, trauma, or developmental issues), and hepatic encephalopathy (a serious condition caused by liver dysfunction that leads to a buildup of toxins in the blood, affecting brain function). A review of Resident #1's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision making was moderately impaired. A review of Resident #1's care plan (CP), indicated the resident had a focus area of break in skin integrity due to presence of wounds with an initiated date of 11/15/25. The CP did not indicate where the wounds were located. A Review of Resident #1's January 2025 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) included the following order which was started 1/2/26 and revised on 1/13/25: Silver Sulfadiazine Cream 1 % apply to right buttock topically every day shift for wound care post cleansing with NSS (normal saline solution) pat to dry & apply dressing.Further review included the following order: Skin Assessment every day shift every Tue (Tuesday), Fri (Friday) document using the following codes: 0 - NO skin impairments 1 - Previous skin impairment present 2 - Newly identified skin impairment If you respond with a *2*, further documentation in progress notes was required. The nurses documented on 1/2/26, 1/6/26 and 1/9/26, the code 0 which indicated no skin impairment. The skin assessment was documented incorrectly. A review of Resident #1's Progress Note (PN) dated 1/2/2026 at 8:40 PM, included the following: During care, an open area was observed on the resident right buttock, measuring approximately 1 cm (centimeter) x 1 cm. No depth or drainage was noted. Resident did not verbalize pain or discomfort to the affected area. assessment done. Area cleansed with normal saline. Nurse Practitioner notified; wound care consult ordered. applied tx (treatment) to the affected area per (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order. Supervisor, DON (Director of Nursing), and residents family were notified and were aware of the wound. A review of the paper medical chart included a Universal Transfer form dated 11/14/25, from the hospital which included that the resident had a skin condition which was a Stage 2 pressure ulcer on the left buttock. A review of Resident #1's readmission assessment dated [DATE], included that the resident had a Stage I pressure ulcer on the sacrum measuring 3 cm x 5 cm. On 1/13/26 at 10:14 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that the skin assessment was an order in the computer and that it was a head to toe assessment for any abnormality. The LPN stated that if a new impairment was noted that they would document it in a note. The LPN stated that if a new wound there would be a wound doctor consult but that he was not sure where they documented the visit. The LPN stated that they document the measurements and if improving or not. The LPN stated that Resident #1 had a PU on the right buttock that was healing. On 1/13/26 at 10:23 AM, the surveyor interviewed the Unit Manager (UM) who stated that the wound doctor consult visits were uploaded in the miscellaneous section of the electronic medical record. The UM stated that the ADON went on the wound rounds and that the wound doctor visits would be emailed to her and she would check if there were any changes to the tx and then change it in the computer. The UM confirmed that Resident #1 did not have and wound doctor visits uploaded. On 1/13/26 at 10:41 AM, the surveyor asked the DON to provide the surveyor a timeline of Resident #1's wounds since 11/12/25. On 1/13/26 at 1:00 PM, the surveyor reviewed the facility provided timeline of Resident #1's wounds which included but was not limited to the following:DOA (date of admission) 11/12/25admitted with: Sacral redness-resolved 11/14/25Current sites: Right buttock ST 2-Initial date 1/2/26, measurement 1 x 1 cm, and receiving tx with Silvadene every day shift A review of Resident #1's November 2025 and December 2025 eMAR and eTAR included the following order: Vitamins A & D Ointment apply to sacrum topically every shift for redness after hygienic wash -with a start date of 11/15/2025, and was administered every shift through the rest of November and all of December. Further review included the following order: Skin Assessment every day shift every Tue, Fri document using the following codes: 0 - NO skin impairments, 1 - Previous skin impairment present, 2 - Newly identified skin impairment If you respond with a *2*, further documentation in progress notes is required with a start date of 11/18/2025. A review reflected that the nurses documented the code 1 (previous skin impairment) on 11/18/25, 11/21/25, 11/25/25, and 11/28/25. A review of Resident #1's PN did not include any documentation of what the skin impairment that was noted on those days was. Further review of the November 2025 eMAR and eTAR included multiple tx orders for multiple skin impairments on different parts of the resident's body. On 1/14/26 at 9:58 AM, the surveyor interviewed the Assistant DON/Infection Preventionist (ADON/IP), who stated that for a Stage 1 PU a weekly wound PN would be expected. The ADON/IP stated that if there was a tx ordered for a Stage 1 PU and the PU was resolved then the tx order would be discontinued. The surveyor asked the ADON/IP about Resident #1's weekly wound notes and wound doctor consult notes for the current PU on the right buttock. The ADON/IP stated that she would go with the wound doctor every Monday to see the residents. The ADON/IP stated that Resident #1 was out of bed and in therapy on 1/5/26, and that they did not go back to see the resident on their unit later that day. The ADON/IP stated that she checked the resident on 1/12/26, and the PU was about to close. She added that the wound doctor did not visit on 1/12/26, and that the wound doctor was scheduled for today (1/14/26). At that same time, the surveyor asked the ADON/IP what was the reason a PU size and description should be documented and how often. The ADON/IP stated that it should be done weekly to see the progress of the wound to see if the tx was effective. The ADON/IP stated that it was unfortunate the wound doctor did not see the resident and that they could do a weekly PN. The surveyor asked the ADON/IP how the surveyor would know what the previous skin impairment that was documented on the November 2025 eMAR and eTAR were if there was no corresponding note to reflect the location and description of the impairment(s) noted. The ADON/IP stated that there was usually a note and that she would look into it. On 1/14/26 at 11:28 AM, the DON provided an additional (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound timeline for Resident #1. The surveyor reviewed the timeline which contained weekly measurements for the sacral redness from 11/15/25 until 1/6/25 when it was resolved. The additional timeline also included an additional measurement for the right buttock St 2 PU on 1/9/26. The surveyor asked the DON where the measurements were from since they were not in Resident #1's hybrid (paper and electronic) medical record. The DON stated that she had to ask the ADON/IP. On 1/14/26 at 11:59 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON, and Regional Nurse, the following concerns for Resident #1: January 2026 eMAR and eTAR had an incorrect skin assessment documented; the initial timeline provided to the surveyor had the redness sacrum was resolved on 11/14/25; there was no weekly documentation in the hybrid medical record of the Stage 1 sacral PU measurement and description; there was no weekly documentation in the hybrid medical record of the right buttock PU measurement and description; did not follow an order for wound doctor consult; CP for break in skin integrity did not contain where the presence of the wounds were. On 1/14/26 at 12:01 PM, in the presence of the LNHA and DON, the Regional Nurse stated that the ADON/IP had a wound tracker and that was where the measurements were in her computer. The surveyor asked if the wound tracker was part of the resident's medical record. The Regional Nurse stated that the ADON/IP could upload the information into the resident's medical record. A review of the facility's Skin and Wound Management Skin Risk Assessment Policy with a reviewed date of 12/17/25, included the following: Note: Wound rounds are conducted weekly on each unit. The above policy did not contain any information about weekly documentation or wound doctor consults. A review of the facility's Infection Control: Wound Management Policy with a reviewed date of 12/22/25, included the following: Wound Care Provider: 14. Rounds weekly and provides wound documentation which is uploaded in the resident's electronic record. NJAC 8:39-25.2(b), (c)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure that residents that received oxygen (O2), CPAP (continuous positive airway pressure) and nebulizer treatments received the necessary respiratory care and services, according to the standard of clinical practice, specifically a.) the O2 tubing and sterile water bottle utilized for humidification of O2 was dated for 1 of 3 residents reviewed for respiratory care (Resident #17) and b.) that respiratory equipment were stored in accordance with infection control measures for 1 of 3 residents reviewed for respiratory care (Resident #17).This deficient practice was evidenced by the following:On 1/8/26 at 10:40 AM, the surveyor observed Resident #17 laying on their bed and receiving O2 via nasal canula (n/c) tubing at 4 liters per minute (lpm) via concentrator. The surveyor observed that the O2 tubing and the water bottle that the tubing was connected was not dated. The surveyor observed that the resident's nebulizer (neb) treatment tubing and CPAP (machine is one of the most common treatments for sleep apnea) mask was laid out on the dresser and not stored in a plastic bag. On that same date and time, the surveyor interviewed Resident #17, who stated that they were doing better, and that they were in the hospital a few days before Christmas for pneumonia and flu and had been intubated. The surveyor asked Resident #17 about the neb treatment tubing. Resident #17 stated that they had not used it since before they went to the hospital and that they did not like to use it because it made them jittery. A review of Resident #17's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; chronic obstructive pulmonary disease (a progressive group of lung diseases, primarily emphysema and chronic bronchitis, that block airflow, causing shortness of breath, chronic cough (often with mucus), wheezing, and chest tightness), obstructive sleep apnea (a common sleep disorder where throat muscles relax too much, causing the airway to repeatedly narrow or block during sleep, leading to pauses in breathing), and hypertension (high blood pressure). A review of Resident #17's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #17 was cognitively intact. Further review of the MDS reflected that the resident received O2 therapy. A review of Resident #17's Order Summary Report included the following order:O2 inhalation via n/c at 4 lpm every shift. A review of Resident #17's care plan (CP) included that the resident had congestive heart failure and an intervention of O2 therapy 2 lpm as ordered. The CP was not updated to reflect the current physician order (PO) for O2 at 4 lpm. On 1/12/26 at 9:59 AM, the surveyor observed Resident #17 laying in their bed receiving O2 via n/c tubing at 4 lpm. The surveyor observed that the O2 tubing was dated 1/12/26, however the water bottle was not dated. The surveyor observed the neb tubing stored in a plastic bag, however the CPAP mask was not stored in a plastic bag and was laid in the dresser drawer. On 1/12/26 at 10:01 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the process for respiratory equipment. The LPN stated that O2 tubing should be labeled and dated and also the water bottle. The LPN stated that the neb treatment tubing and CPAP mask should be dated and stored in a plastic bag when not in use to make sure it was not exposed to any bacteria. On 1/12/26 at 10:06 AM, the surveyor interviewed the 3rd floor LPN/Unit Manager (LPN/UM) regarding the process for respiratory equipment. The LPN/UM stated that the 11-7 shift changed the O2 tubing and neb treatment tubing and dated it. The LPN/UM stated that any respiratory equipment should be placed in a plastic bag when not in use. The LPN/UM further stated that the water bottle should also be dated. The surveyor showed the LPN/UM the pictures of the observations the surveyor made on 1/8/26 and 1/12/26, and the LPN/UM stated that the equipment should not be like that because of possible infections. On 1/14/26 at 11:51 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON, and Regional Nurse, the following concerns for Resident #17; O2 tubing and bottle of water for humidification was not dated, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the neb treatment tubing was not stored in a plastic bag and was laid out on the dresser, and the CPAP mask was not stored in a plastic bag and laid out on the dresser under clothes on 1/8/26, the O2 tubing was dated but the bottle of water for humidification was not dated, and the CPAP mask was not stored in a plastic bag and sitting in the dresser drawer on 1/12/26, and the CP was not updated to reflect the current PO for O2 at 4 lpm. On 1/15/26 at 11:12 AM, in the presence of the LNHA and DON, the Regional Nurse stated that the DON did an in service on O2 and neb treatment tubing for the nursing staff. The Regional Nurse further stated that they rechecked this morning and was in compliance. The Regional Nurse stated that the CP was based on an older version of the O2 order and they had not updated it. She added that the 2 lpm CP was resolved and the current CP has O2 as ordered. The LNHA did not provide any additional information. A review of the facility's Oxygen Administration Policy with a reviewed date of 10/22/25, included the following: Under General Guideline, Note: O2 tubing is changed weekly. Tubing is dated with the date when changed. A review of the facility's Respiratory Care-Nebulizer Policy with a revised date of 1/1/25, included the following: Policy: It is the policy of this facility to ensure that all respiratory equipment is handled in a manner which follows infection control strategies. Purpose: To comply with the Department of Health guidelines promote respiratory health and prevent nosocomial infections related to the use of respiratory treatments/therapy. Procedure:.6. Ensures that nebulizers are for single resident used and are cleaned and stored as per facility policy. A review of the facility's BIPAP (Bilevel Positive Airway Pressure is a noninvasive breathing therapy using a machine to deliver pressurized air through a mask, providing a higher pressure for inhaling (IPAP) and a lower pressure for exhaling (EPAP) to help people with respiratory issues breathe more easily, commonly used for sleep apnea, COPD, and lung conditions, making it more comfortable than standard CPAP for some by reducing exhalation resistance) /CPAP Policy with a reviewed date of 7/28/25, did not contain any information on storing the CPAP mask. N.J.A.C. 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, it was determined that the facility failed to follow a physician's order for a fluid restriction for a resident that received hemodialysis for 1 of 1 resident reviewed for dialysis (Resident #14).This deficient practice was evidenced by the following:On 1/8/26 at 10:32 AM, the surveyor entered Resident #14's room, observed that the resident was not in the room, and the resident's breakfast tray was on the bedside table. The surveyor observed that the meal ticket did not have a fluid restriction listed and that it had listed 4 fl (fluid) oz (ounce) apple juice, 4 fl oz apple juice, and 4 fl oz hot tea (Decaf). The surveyor also observed an additional two 4 oz juices on the dresser and a 16-20ml bottle of soda on the bedside table. The Certified Nursing Assistant (CNA) stated that Resident #14 was at dialysis. On 1/9/26 at 9:11 AM, the surveyor interviewed Resident #14, who stated that they went to dialysis on Tuesday, Thursday, and Saturday, and left the facility at 5:00 AM ,and came back at 9:00 AM. The surveyor observed Resident #14's breakfast meal ticket which had 4 fl oz apple juice, 4 fl oz apple juice, and 4 fl oz Hot Tea (Decaf). The meal ticket did not indicate the resident was on a fluid restriction (FR). A review of Resident #14's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; end stage renal disease (the final stage of chronic kidney disease where kidneys can no longer function adequately to sustain life, requiring dialysis or a kidney transplant for survival), dependence on renal dialysis (relying on a machine (hemodialysis) to filter waste and excess fluid from the blood due to permanent kidney failure), and hypertension (high blood pressure). A review of Resident #14's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #13 was cognitively intact. Further review of the MDS reflected that the resident received hemodialysis (HD). A review of Resident #14's care plan, indicated the resident was at risk for malnutrition related to but not limited to HD, significant weight changes, and fluid restriction with the following interventions but not limited to: 1000 mL (milliliters) FR Breakdown - 280 nursing (7-3 100 mL, 3-11 100mL, 11-7 80 mL) - 720 mL dietary (breakfast (bfast) 240 mL, lunch 240 mL, dinner 240 mL) monitor compliance with an initiated date of 12/16/2025; and encourage more than 75% consumption of all fluids provided. A review of the Physician order (PO) set in the electronic medical record included the following order: 1000 mL FR Breakdown- 280 nursing (7-3 100 mL, 3-11 100 mL, 11-780 mL) - 720 mL dietary (bfast 240 mL, lunch 240 mL, dinner240 mL) which was initiated on 12/16/25. The order was discontinued (dc'd) on 1/8/26, and a new order was initiated on 1/8/26 at 9:46 AM, which was the same FR order with ONS (on nutritional supplement) not included in FR added to the previous order. A review of Resident #14's Progress Notes included a Dietician note dated 11/26/2025 at 13:50 (1:50 PM), which included the following but was not limited to: Diet: NAS/CCD/RENAL (no added salt/Consistent Carbohydrate Diet/Renal) diet, regular texture, thin liquids, 1000 ml/day FR (720 ml dietary).Food Preferences: Reviewed with res (resident) and relayed to the kitchen. Supplement: ProStat SF (sugar free) 30 ml 1x/d (100kcal, 15 g (gram) protein) RD (Registered Dietician) recommends continuing the current diet and protein supplement as ordered. Resident is aware and understands 1000 ml FR. On 1/9/26 at 11:09 AM, the surveyor interviewed the Food Service Director (FSD) in the presence of the Regional FSD (RFSD) regarding the process of diet communication. The FSD stated that the dietician would assess the resident, order the diet and gave the diet slip to her, and she would put the order into their computer system. The surveyor asked the FSD to print resident's meal ticket for 1/8/26 and 1/9/26, and the resident's meal pattern.A review of Resident #14's meal ticket included the following fluids with a reference of 1 fluid oz equals 29.6 ml:Breakfast: 4 fl oz apple juice, 4 fl oz apple juice, and 4 fl oz hot tea (Decaf) (a total of 355.2 ml)Lunch: 4 fl oz apple juice, 4 fl oz apple juice, 4 fl oz cranberry juice, and 4 fl oz hot tea (Decaf) (a total of 473.6 ml)Dinner: 4 fl oz apple juice, 4 fl oz apple juice, 4 fl oz apple juice, and 4 fl oz hot tea (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Decaf) (a total of 473.6 ml)Resident #14 was provided 1302.4 ml of dietary fluids in a 24 hour period which was above the ordered total of dietary and nursing fluid of 1000 ml. A review of Resident #14's Meal Pattern did not include that the resident was on a FR. On 1/9/26 at 11:22 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #14 had a fluid schedule for the nursing dependent which meant the resident could only receive that amount on each shift and not more than that. The LPN stated that he was not sure about the dietary part. The LPN stated that the resident was compliant with the FR. On 1/9/26 at 11:38 AM, the surveyor interviewed the Registered Dietician (RD) regarding residents on dialysis. The RD stated that he would communicate with the dialysis facility's dietician at least once a month and it would be the dialysis facility's dietician that would inform me if the resident was on a FR. The RD stated the doctor would order the FR and the amount of fluid would be broken up between nursing and dietary in the computer. The RD stated that the dietary staff saw it in the orders and nursing can notify them also. The RD stated that the order gets flagged to the kitchen when placed in the computer. The RD stated that the paper dietary communication sheets that were duplicate were no longer used since November 2025. At that same time, the RD confirmed that the last Dietary Alert Sheet (communication sheet) in Resident #14's paper medical record was dated 11/12/25, which included handwritten add FR. The surveyor asked the RD if the dietary department should have seen that sheet. The RD stated yes. The RD confirmed that Resident #14 was on a FR of 1000 and that he believed the resident was compliant with the restriction. The RD added that they did an audit of the meal tickets once a month. The surveyor showed the RD the printed meal tickets for Resident #14. The RD confirmed that the dietary portion was a little over a thousand, and that the resident's total between nursing and dietary should have been 1000 ml. The RD stated that Resident #14 should have gotten 720 ml from dietary. On 1/9/26 at 12:03 PM, the surveyor asked the FSD, in the presence of the RFSD, if Resident #14 was on a FR. The FSD stated that if a resident was on a FR, the dietician would tell us how many ounces. The FSD stated that according to her computer, Resident #14 was not on a FR. On 1/13/26 at 10:42 AM, in the presence of the Director of Nursing (DON), the Regional RD (RRD) stated that she spoke with the dialysis facility's dietician that day and they suggested to discontinue the FR and the physician agreed. The RRD stated that the resident had no sign of fluid overload. The RRD stated that the FR was on dietary slips in the past and that on 1/8/26, the order was updated and they needed clarification. A review of the order that was placed in the computer was created at 9:46 AM on 1/8/26, which was after breakfast meal tickets were printed and distributed for breakfast on 1/8/26. On 1/14/26 at 11:55 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON, and Regional Nurse, the concern that Resident #14's PO for FR was not followed. On 1/15/26 at 11:13 AM, in the presence of the LNHA and DON, the Regional Nurse stated that when they looked into the concern regarding the FR and the remote (not at the facility) Dietician clarified the FR order on 1/8/26, and it was not until 1/9/26 the Dietary Staff received the order. The Regional Nurse stated that the Dietician had written in her notes to encourage meals and fluid because the resident had been losing weight. The Regional Nurse stated that everyone agreed that the FR should be dc'd and it was on the 1/13/26. The Regional Nurse stated that the staff were in-serviced on FR and communication. The LNHA did not provide any additional information. A review of the facility's Fluid Restrictions Policy with a reviewed date of 8/7/25, included the following: Policy: It is the policy of this center to maintain FR as per MD/NP (Medical Doctor/Nurse Practitioner) order and/or in accordance with the recommendations from nephrology or dialysis.Under General Information:MD/NP order FR for a 24 hour period. Ex. 1000 ml/24 hours, 1200/24 hrs.The Dietician/designee determines the fluid break down and communicates with nursing regarding the amount of fluid allowed for each medication pass. The Dietician/designee determine the amount of fluid that will be provided on the dietary tray and communicates this with the dietary department. Orders are written to include the total daily fluid, the allotment for dietary, and allotment for nursing. A review of the facility's Diet Communication Policy and Procedure with a reviewed date of 11/23/25, included the following: Purpose To ensure accurate, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timely, and effective communication among nursing, dietary services, medical providers, and interdisciplinary team members regarding residents' nutritional needs, diet orders, preferences, and changes in condition, in order to promote resident safety, regulatory compliance, and optimal nutritional outcomes.PolicyThe facility shall maintain a structured system of dietary communication that ensures all diet orders, changes, and resident-specific nutritional needs are promptly communicated, implemented, and documented. Communication shall be interdisciplinary, resident-centered, and compliant with federal and state regulations. ProceduresDiet Order Changes 1. All diet changes must be ordered by a medical provider. 2. Nursing shall notify dietary services upon receipt of the order. 3. Dietary services shall update diet lists and meal preparation systems.4. Changes shall be documented in the medical record. N.J.A.C. 8:39-27.1 (a)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure the accurate daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for 3 of 6 days during the annual re-certification survey. This deficient practice was evidenced by the following:On 1/8/26 at 9:05 AM, upon entry to the facility, the surveyor observed a Nursing Home Resident Care Staffing Report (NHRCSR) posted on a wall next to the reception area. The NHRCSR reflected a date of 1/7/26, Day Shift, Shift Hours 7:00 AM - 3:00 PM, and a Current Resident Census (CRS) of 140. The Director of Nursing (DON) stated that the current census was 139.On 1/9/26 at 9:23 AM, the surveyor observed a NHRCSR and a Facility Staffing Sheet (FSS) posted in the facility lobby. The NHRCSR reflected the number of Certified Nursing Assistant (CNA) on the shift as 19. The FSS reflected the number of CNA on the shift as 18. The FSS also reflected 1 CNA with c/o (called out) next to the name.On 1/12/26 10:16 AM, the surveyor observed the NHSCR and FSS posted in the lobby. The NHSCR reflected a census of 145 and 18 CNA for the shift. The surveyor reviewed facility provided NHSCR and FSS for 1/10/26. The NHSCR for all three shifts reflected a census of 143 On 1/13/26 at 10:23 AM, the surveyor requested a Midnight Daily Census Report (MCR) for 1/10/26 from the Admissions Director (AD). The AD contacted the Licensed Nursing Home Administrator (LNHA) and asked if he could provide that to the surveyor. Afterward, the surveyor reviewed the MCR for 1/10/26, which revealed a total residents of 144.On 1/14/26 at 11:37 AM, the survey team met with LNHA, DON, and Regional Nurse to discuss above findings and concerns. The surveyor notified the facility of a concern with the posting accuracy for three days. The surveyor asked what the procedure was for posting and who would be responsible for it. The Regional Nurse stated that it was the Staffing Coordinator (SC) or Supervisor who were responsible for posting an accurate staffing and census.On 1/15/26 at 9:32 AM, the surveyor interviewed the SC. The surveyor asked if the SC was aware of the importance of posting accurately and when the NHSCR should be posted. The SC stated yes, it should be posted daily at the beginning of the shift so visitors can see it. The surveyor asked about the times or days when the SC was not there. The SC stated that they were always on duty, works from home remotely, and usually calls the facility or texts for updates. The SC stated that the Assistant Director of Nursing (ADON) or Supervisor on duty will do the physical posting if they were not in the building. The surveyor asked if the NHSCR or FSS were posted late or not at all. The SC stated that sometimes the Supervisor could get busy with an emergency and not update it, post it late or forget to post it. On that same date at 10:14 AM, the surveyor interviewed the SC again. The surveyor notified the SC of the above findings and concerns with regard to accuracy of posted information in the NHSCR. The SC stated they were late that day due to a [personal] and came in at around 11:00 AM, and the staffing was posted late. The surveyor asked if someone should had posted it. The SC stated yes.On 1/15/26 at 11:10 AM, the survey team met with the LNHA, DON and Regional Nurse stated that the SC and off shift Supervisor were educated on proper and timely posting of accurate staffing and census.The LNHA did not provide any further pertinent information. A review of the facility's Staffing Policy and Procedure, dated 11/16/25, revealed, the policy did not reflect any mentions of posting of staffing or census, or the accuracy of posting.NJAC 8:39-41.2

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services by ensuring the accurate administration of a medication, Midodrine, (medication used to increase the blood pressure), with a parameter according to the physician's order to meet the needs of the resident. The deficient practice was identified for 1 of 28 residents reviewed (Resident #11). The deficient practice was evidenced by the following:On 1/8/26 at 10:18 AM, the surveyor observed Resident #11 laying in bed with their eyes closed. A review of Resident #11's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; hemiplegia (complete paralysis on one side of the body) and hemiparesis (weakness or partial paralysis on one side), hypotension (low blood pressure), and chronic atrial fibrillation (a continuous, irregular heartbeat that doesn't stop on its own, often lasting over a week or even years). A review of Resident #11's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision making was severely impaired. On 1/9/26 at 12:59 PM, the surveyor reviewed Resident #11's January 2026 electronic Medication Administration Record (eMAR) which included the following order:Midodrine HCl Tablet 10 mg (milligram) give 1 tablet (tab) via PEG-Tube (Percutaneous Endoscopic Gastrostomy, is a soft feeding tube inserted through the abdominal wall directly into the stomach, allowing liquid nutrition, fluids, and medications to bypass the mouth and esophagus for people who can't swallow or eat normally due to conditions like stroke, cancer, or head injury) every 8 hours related to other hypotension, hold for systolic BP (blood pressure) over 110 with a start date of 8/31/25. Further review revealed the following:1/2/26 at 10:00 PM, the nurse signed a check mark that the midodrine was administered for a BP of 114/74, which according to the order should have been held and not given. 1/3/26 at 6:00 AM, the nurse signed a check mark that the midodrine was administered for a BP of 118/64, which according to the order should have been held and not given. On 1/12/26 at 11:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that if the midodrine order had a hold order than the nurse would check the BP and if it was outside the parameter then the medication (med) would not be given. The surveyor asked the LPN what the check mark meant on the eMAR. The LPN stated that she believed it meant that it was given. The surveyor asked the LPN to view Resident #11's eMAR and the two doses that were administered with a BP outside the parameter. The LPN stated that it looked like the med had been given and it should not have been. On 1/12/26 at 11:41 AM, the surveyor interviewed the 3rd floor LPN/Unit Manager (LPN/UM) who stated that a check mark meant that the med was given. The LPN/UM stated that midodrine should not be administered if the BP was above the parameter in the order. On 1/13/26 at 10:49 AM, the surveyor interviewed the Director of Nursing (DON) who stated that a check mark meant administered. The DON viewed Resident #11's eMAR and stated that the order should be followed and should not have been given. On 1/14/26 at 11:57 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), DON, and Regional Nurse the concern that Resident #11 received midodrine outside of the ordered parameter on 1/2/26 and 1/3/26. On 1/15/26 at 11:16 AM, in the presence of the LNHA and DON, the Regional Nurse stated that the DON interviewed the nurses, and the nurses stated that they had not given the midodrine but signed it as given. The Regional Nurse stated that the DON educated the nurses, and a med error report was done. The Regional Nurse stated that prior to this, in November, a QAPI (Quality Assurance Performance Improvement) was done that included electronic medical record documentation and the BP had not always been followed, and that education had been ongoing. The DON stated that the physician was also made aware. The LNHA did not provide any additional information. A review of the facility's Medication Administration and Documentation Policies, Procedures & Information with a reviewed date of 6/4/25, included the following:Policy: It is the policy of this facility to ensure that Med Administration and Documentation occurs in a timely and accurate manner.4. The eMAR is the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form onto which all med orders are transcribed from physician electronic orders, from which medications (meds) are poured and administered and on which med doses are documented. The eMAR is a permanent part of the resident's medical record.7. Monitors vital signs when appropriate prior to med administration. 10. Assures the 5 rights: compares the med name, strength, route and dosage schedule on the med administration record against the prescription label. 16. Administers med according to parameters listed in the order (if any).17. Documents administration of med in the eMAR immediately following administration. Notes in eMAR meds not administered (i.e. refused, etc.) and identifies reason. N.J.A.C. 8:39 11.2 (b); 29.2(a,d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were stored and labeled appropriately. This deficient practice was identified in 1 of 3 medication carts and one 1 of medication refrigerators inspected on 3 of 3 units. This deficient practice was evidenced by the following:On [DATE] at 10:47 AM, the surveyor began inspecting the medication (med) storage room located on the facility 3rd floor in the presence of the 3rd floor Unit Manager (UM3). The surveyor observed a package containing an opened vial of tuberculin, purified protein derivative, diluted. Aplisol. (PPD) (an injectable solution used for testing and diagnosing tuberculosis). The surveyor did not observe a date when the vial was opened marked on the vial or the box. The surveyor asked the UM3 if the vial should be dated when opened and if they could identify a date when the vial was opened and first used. The UM3 stated that the vial should be dated when opened and that there was no date present and should be discarded. The surveyor continued the inspection on the 4th floor. The surveyor inspected the B side medcart (medication cart) in the presence of the Registered Nurse (RN) assigned to the medcart. The surveyor observed in the top drawer, a plastic bag labeled Humalog (a rapid acting insulin- a drug used to lower blood sugar), containing a vial of the generic equivalent, Insulin Lispro. The surveyor observed, handwritten on the label open [DATE] exp (expired) [DATE], and a printed label reflecting Store using directions provided. Throw away any medicine that remains 28 days after first use. The surveyor asked RN if the date [DATE] should be [DATE]. The RN stated yes, that what was meant. The surveyor then asked the RN if this was labeled exp [DATE], should this med still be in the medcart if today was [DATE]. The RN stated no, it should be disposed. The surveyor observed the controlled substance lock box in the same medcart. The surveyor was able to open the lid of the lock box without the use of a key, and that it would not latch or lock when closed. The surveyor asked the RN if the lock box should always be locked and only accessible with a key by an authorized person. The RN stated yes, it should be locked. The RN attempted to close the lid but found it difficult as it was blocked by items in the next row of the drawer. The surveyor concluded the observation. The surveyor reviewed the manufacturer package insert for PPD which revealed the following: Storage Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. The surveyor reviewed the manufacturer package insert for Humalog which revealed the following: Storage and Handling Do not use after the expiration date. In-use Humalog vials. should be stored at room temperature, below 86 F (30 C) and must be used within 28 days or be discarded. On [DATE] at 11:37 AM, the survey team met with Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional Nurse to discuss concerns. The surveyor asked if PPD vials should be dated when opened. The Regional Nurse stated yes. The surveyor asked if medications (meds) should be removed from a medcart and disposed if marked as expired, and the Regional Nurse stated yes. The surveyor asked if controlled substances should be always kept in a separate locked compartment, and the DON stated yes, the lock box should be locked. On [DATE] at 11:10 AM, the survey team met with the LNHA, DON, and the Regional Nurse stated that education was done for staff regarding proper med storage, dating of vials, and locking of the lock box. The DON stated that the drawer with lock box in question was re-arranged so the top locks properly. The LNHA did not provide any further pertinent information. A review of the facility's Medication Storage Policy, dated [DATE], reflected, under Policy: All meds shall be stored, secured, labeled, and maintained in a manner that ensures resident safety, preserves med effectiveness, and meets regulatory standards. General Storage Requirements 7. Expired.meds shall be removed immediately per facility procedure. Security and Access 1. All med storage areas shall remain locked at all times when not in active use . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Controlled Medications Accountability and Storage Policy, dated [DATE], revealed, under 3. Controlled meds remain locked at all times .NJAC 8:39-29.4(h)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure that all listed menu items were consistently provided at the meal during lunch meal rounds on 1 of 3 units (5th floor).The deficient practice was evidenced by the following:On 1/9/26 at 11:56 AM, the surveyor observed the 5th floor day room for lunch, there were four tables (1st table with 3 residents, 2nd table with 4 residents, 3rd table with 4 residents, and 4th table with 4 residents), 2 small tables (1 resident seated in a Geri chair and 1 small table with 1 resident), and with five staff assisting for lunch. At that time, the surveyor observed all residents received their lunch meals. The surveyor observed Resident #7 seated alone with lunch meal that included breaded fish fillet, yellow rice, seasoned green beans, 4 fluid (fl) ounce (oz) whole milk, 12 fl oz ginger ale diet, 6 fl oz regular hot tea which also corresponded to the diet slip that was on top of their table, except for a 4 oz of jello. The surveyor asked Certified Nursing Aide #1 (CNA #1) about the missing jello, and she stated that she was unsure as to why Resident #7 did not receive it but will notify the nurse. Resident #7 stated she would like to have the jello. The surveyor also observed another table, an unsampled resident with filet of fish, yellow rice, seasoned green beans, 4 fl oz apple juice, 4 fl oz whole milk, 6 fl oz reg hot tea, and peanut butter and jelly wheat sandwiches, with no 4 oz rosy pears, and according to the diet slip the unsampled resident should had. The surveyor asked about the unsampled resident's missing rosy pears, and CNA #2 stated that she did not know why everyone had the dessert except the unsampled resident. On 1/14/26 at 11:37 AM, the survey team met with the Licensed Nursing Home (LNHA), Director of Nursing (DON), the Regional Nurse, and the surveyor notified them of the above findings and concerns. On 1/15/26 at 11:10 AM, the survey team met with the LNHA, DON, and the Regional Nurse. The Regional Nurse stated, we did in service to staff that the meal served should match the tickets (diet slip). A review of the facility's Diet Communication Policy and Procedure that was provided by the LNHA, with a last review date of 11/23/25, revealed under purpose: to ensure accurate, timely, and effective communication among nursing, dietary services, medical providers, and interdisciplinary team members regarding residents' nutritional needs, diet orders, preferences, and changes in condition, in order to promote resident safety, regulatory compliance, and optimal nutritional outcomes .Dietary Services: .maintains up-to-date diet cards, meal tickets, or electronic diet lists . On 1/15/26 at 11:47 AM, the survey team met for an exit conference with LNHA, DON, and the Regional Nurse. The LNHA did not provide additional information. NJAC 8:39-17.4 (a) (1) (3)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Complaint #2613337Based on interview, and review of other facility documentation, it was determined that the facility failed to provide services in compliance with applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles for a resident who was denied admission to the facility to provide services. This deficient practice was identified for 1 of 20 resident referrals reviewed, Resident #154.This deficient practice was evidenced by the following:According to the Centers for Disease Control (CDC) guidelines dated 4/24/24, which revealed, the Transmission-Based Precautions (TBP) and Enhanced Barrier Precautions (EBP) for Candida Auris (C. Auris) are similar to those used for other multidrug-resistant organisms (MDROs). In most instances, facilities equipped to care for patients with other MDROs . can also care for patients with C. Auris. In nursing homes and skilled nursing facilities, healthcare providers should use either Contact Precautions or EBP (infection control intervention to wear gown and gloves during high contact care), based on the situation and local or state jurisdiction recommendations .According to the local and state guidance from NJ (New Jersey) Department of Health, dated 3/24/23, revealed, C. Auris: Identification, Reporting and Infection Prevention Guidance Updates, under Key Points .2) Most healthcare facilities can provide adequate care for C. Auris positive individuals and therefore should not deny admission to patients based upon their C. Auris diagnosis . On 1/8/26 at 12:45 PM, the surveyor requested from the Director of Nursing (DON), the admission referrals for the last seven months.On 1/9/26 at 9:40 AM, the DON provided the referral list from 6/10/25 thru1/8/26. The referral list revealed 20 resident referrals for admission to the facility, which included Resident #154. The referral list indicated Resident #154 was denied admission, reason for refusal Medical.A review of the facility's Electronic Medical Record (EMR) system revealed that Resident #154 had a previous admission stay in the facility, from the nearby hospital, and living arrangement was within the vicinity of the facility.On 1/9/26 at 1:40 PM, the surveyor interviewed the Regional admission Director (RAD), in the presence of the Medicaid Manager in the admission office, regarding their process for referrals, admissions, and denials. He stated that the referrals from the hospitals were sent electronically to the facility, an outside clinical team will review the referrals remotely, then will send to the admission team within the building, including the License Nursing Home Administrator (LNHA). He further stated that it will be in the portal if the patient (also known as the resident) was accepted or denied admission. He stated the reasons for denial of admission could be for intravenous drug use, a ventilator, 1:1 behavior issue, and insurance denial. The surveyor asked why Resident #154 was denied admission and what was the meaning of Medical as the reason of denial. The RAD responded that it was due to C. Auris (C. Auris-type of yeast that can cause severe illness and spread easily among very sick patients in healthcare facilities). He further stated that they did not accommodate a C. Auris unit in the facility, it was more of an infection control issue and we did not have the isolation for that. On 1/12/26 at 10:39 AM, the surveyor interviewed the Infection Preventionist/Assistant Director of Nursing (IP/ADON), regarding the process for admitting residents on EBP, and Contact precautions. The IP/ADON informed the surveyor that aside from the EBP we have contact precaution residents. The IP/ADON stated that before the resident come in, we need to know so that we were ready for precautions. The surveyor asked if the facility would admit a resident with C. Auris, and the IP/ADON replied, Yes. The IP/ADON acknowledged that the facility staff had the knowledge to care for residents who were on contact precautions. The surveyor requested for the facility policies for EBP and Contact precautions.On 1/12/26 at 1:30 PM, the surveyor requested from the LNHA to provide the bed board from 9/1/25 through 9/7/25.On 1/13/26 at 8:12 AM, the surveyor reviewed the bed board provided by the LNHA, which revealed on 9/4/25, there were 30 available beds on the 3rd floor which included one private room, 27 available beds on the 4th floor with four private rooms (continued on next page)

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Optima Care Harborview	178-198 Ogden Ave Jersey City, NJ 07307

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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available, and 30 available beds on the 5th floor with two private rooms. On 1/13/26 at 10:33 AM, the surveyor interviewed the LNHA, regarding the admission process and who was responsible for reviewing the admission referrals. The LNHA informed the surveyor that Our initial process, we received referrals through the portal from the hospitals and etc. The LNHA stated that the outside clinical team reviewers will review the referrals, including the in-house admission team, and at times I get involved. The surveyor asked the LNHA who made the final decision for admission, and the LNHA responded It depends and it was case by case. The surveyor also asked the LNHA how the facility determined on whom not to admit, and he stated, Residents that would not be appropriate for the facility like those on a ventilator, again it is case by case. On that same date and time, the surveyor asked the LNHA if the facility had residents for referrals that were on EBP, contact, droplet precautions that you would not admit in the facility, and he responded, Generally, not the case, we do have patient with EBP, contact precautions. The surveyor then asked the LNHA if the facility staff meet the needs of residents admitted for EBP, and contact precautions, and he was aware of the CDC guidelines. The LNHA stated, Yes, we do have residents with those needs.On 1/14/26 at 11:40 AM, the surveyor met with the LNHA, DON, and the Regional Nurse regarding the concern with Resident #154, denied of admission due to the diagnosis of C. Auris. The Regional Nurse stated that they had another facility that was dedicated unit for isolation for C. Auris, and that they notified the resident of the isolation unit (the sister facility was 15 miles away). The surveyor asked, if they considered Resident #154's (who was a previous resident), and Resident Representative's (RR's) preferences for choosing the facility. The Regional Nurse acknowledged and stated, Of course we consider the resident's and RR's preferences, but at the time, we did not really accept C. Auris. The Regional Nurse further stated that in order to accept Resident #154, we have to have a protocol for contact precautions. At that same time, Surveyor #2 (S #2) asked the LNHA, DON, and the Regional Nurse, if the facility staff had a knowledge and facility had appropriate equipment and supplies to address the need and care of resident with contact precautions, and the Regional Nurse responded yes. S #2 also asked if C. Auris considered contact precautions, and the Regional Nurse stated yes. The Regional Nurse confirmed that they did have the EBP and Contact precaution protocols in place at that time. S #2 then asked why Resident #154 was denied of admission, and there was no response from the LNHA, DON, and Regional Nurse.On 1/15/26 at 11:10 AM, the survey team met with the LNHA, DON, and the Regional Nurse stated that we did an in service yesterday with the admission Office Staff regarding denials after surveyor's inquiry. A review of the signed Administrator's Job Description, dated 7/22/25, revealed under Purpose of Your Job, the primary purpose of your position is to direct the day-to-day functions of the facility in accordance with current Federal, State and Local standards guidelines, and regulations that govern nursing facilities A review of the facility's admission Criteria Policy with a review date of 11/22/25, revealed under Policy Interpretation and Implementation, #1a. provide uniform criteria for admitting residents to the facility .A review of the facility's Enhanced Barrier Precaution Policy review date 7/1/25, revealed under General Information, EBP require no private room required .A review of the facility's Infection Prevention and Control Program Policy, reviewed 7/3/25, revealed under Policy Interpretation and Implementation #2. Based on CDC definitions, three types of Transmission-Based Precautions (.and contact) have been established .A review of the undated facility's C Auris Policy and Procedure revealed under Policy, All staff will follow the guidelines by the CDC . Under Transmission Based Precautions #1. Patients with C. Auris should be placed in single room and managed using Contact Precautions or Enhanced Barrier Precautions .NJAC 8:39-5.1(a),5.2(b)