STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315312	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampton Ridge Healthcare and Rehabilitation	94 Stevens Road Toms River, NJ 08755

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and review of facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to a.) properly dispose of garbage and refuse in one of two (1 of 2) garbage disposal areas (Garbage Disposal Area #2), and b.) keep 2 of 2 garbage containers/dumpsters covered, creating the potential for odors and pest infestation. This deficient practice was evidenced by the following: On 3/9/26 at 9:38 AM, the surveyor accompanied by the Executive Chef/Food Service Director (EC/FSD), toured the trash disposal areas and observed that Garbage Disposal Area #2 had trash dumped in the ground and 2 dumpsters filled with trash and uncovered. The surveyor observed garbage on the ground was exposed to the environment and included boxes, a chair, a plastic bag containing soiled adult incontinence briefs and personal protective equipment, plastic cups, plastic lids, used gloves, masks, papers, plastic pipes, and wooden pallets. During the tour, the surveyor interviewed the EC/FSD regarding Garbage Disposal Area #2. The EC/FSD stated that maintenance of the facility's garbage disposal areas was a shared responsibility between the dietary and housekeeping departments. The EC/FSD further stated that garbage should be placed in the designated dumpsters and that the dumpsters should be kept covered at all times. The EC/FSD confirmed that garbage should never be discarded on the ground and that the garbage disposal areas should always be maintained in a safe and sanitary manner. The EC/FSD acknowledged that the improperly disposed garbage posed an odor and safety hazard, potentially harboring pests. On 3/5/26 at 9:21 AM, the surveyor interviewed the Housekeeping Director (HD) regarding the facility's trash disposal and removal practices. The HD stated that garbage was not collected due to approximately two (2) feet of snow in the area. The HD further stated that trash disposal areas should be maintained free of debris and trash to avoid contamination and attracting pests. On 3/9/26 at 9:46 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that facility staff had not cleaned the garbage area due to the presence of poison ivy and that a landscaping company was contracted to clean the area. The LNHA confirmed that garbage should be properly disposed of in the dumpsters and that the dumpsters should be kept closed to prevent rodents and contamination. A review of the facility's policy titled Cleaning the Dumpster Area/Loading Dock Area, revised 3/2026, indicated that the purpose of the policy was to effectively maintain the outdoor dumpster and loading dock areas free of refuse and waste food products. The policy also included that the DH would assign staff to clean the dumpster and/or loading dock area Monday through Friday each week and that the assigned staff shall pick up all debris and trash in the immediate area of the dumpster/loading dock and place it in the dumpster. NJAC 8:39-19.7(c)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and other pertinent facility documents, it was determined that the facility failed to use appropriate infection control practices to prevent the spread or reduce the risk of infection in accordance with the Center for Disease Control & Prevention (CDC) guidelines and standards of clinical practice by ensuring, a.) respiratory device tubing, masks, and mouthpiece were stored in protective coverings between uses identified for 6 of 7 residents (Resident #118, #68, #116, #5, #216, and #31) reviewed for respiratory care, b.) proper use of personal protective equipment (PPE) for 2 of 2 residents reviewed under enhanced barrier precautions (EBP) (Resident #144, #164), and c.) a urinary drainage bag attached to a urinary catheter device did not make contact with the floor to prevent possible contamination identified in 1 of 3 residents reviewed for urinary catheter (Resident #16). This deficient practice was identified in 4 out of 5 nursing units (Smart Rehab unit, North unit, South unit, and [NAME] unit) and was evidenced by the following:A.) Reference: Enhanced Barrier Precautions are indicated for residents known to be colonized or infected with an MDRO deemed novel or targeted by the CDC. When Contact Precautions do not otherwise apply, or when the resident has an indwelling medical device or wound.
https://www.nj.gov/health/cd/documents/topics/hai/EBP_in_Nursing_Homes_Algorithm.pdf Reference: Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html Reference: Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.
https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html#:~:text=Routine%20instilla 1.) On 3/8/2026 at 9:18 AM, during the initial tour of the facility, Surveyor #1 observed Resident #118 in bed. The surveyor observed on the left side of the resident's bed, an unlabeled nasal cannula (NC) tubing (a tube with 2 prongs used to deliver oxygen directly into the nostrils) resting on the floor with the nasal prongs bent towards and touching the floor. The tubing was observed adjacent to a pair of black sneakers and open trash bin and was connected to an oxygen concentrator that was not on. An unbagged nebulizer (a machine used to administer medication in the form of mist inhaled into the lungs) mask was also observed on the resident's side table. The mask was lying on its side with the internal part exposed to air. A review of the electronic medical record (EMR) for Resident #118 revealed the following: A review of the admission Record reflected that the resident was admitted to the facility with diagnoses that included but not limited to respiratory failure and acquired COVID-19 infection while in the facility. A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 2/14/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated an intact cognition. The MDS further revealed that the resident was on intermittent oxygen therapy.
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Order Summary Report (OSR) active as of 3/8/2026, included the following Physician's Orders (PO): DuoNeb solution 0.5-2.5 (3) mg/3ml (Ipratropium Albuterol) 1 vial, inhale orally via nebulizer three times a day for asthma not to exceed 6 doses/ 24 hours. Mask care – shake out any residual medication and store mask in drawstring bag after each use; Oxygen via N/C @ 2 lpm (liters per minute) as needed for SOB (shortness of breath). A review of the individualized person-centered care plan revised on 2/9/2026, included a focus of potential for respiratory complications related to use of respiratory devices due to the diagnosis of respiratory failure. Interventions included administering medications as ordered and to monitor adverse effects. On 3/10/2026 at 10:28 AM, during an interview with the surveyor, Licensed Practical Nurse/ Unit Manager stated that respiratory tubing or masks get changed once a week and should be bagged when not being used in the resident's room. On 3/10/2026 at 11:06 AM, during an interview with the surveyor, Licensed Practical Nurse/ Infection Preventionist stated that nebulizer masks and nasal cannula/ oxygen tubing should be stored in Ziplock bags when not in use and are changed weekly. On 3/11/2026 at 9:42 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that oxygen tubing and nebulizer mask or mouthpiece should be stored in a bag at bedside to cover them from being exposed when they are not being used. A review of the facility policy date reviewed on 1/27/2026 titled Oxygen Tubing and Respiratory Products indicated under Procedure the following: Ensure if O2 (oxygen) tubing is not in use that it is in an oxygen bag labeled with the resident's name and room # as well as the date it was changed, both the tubing and the bag shall have a date. N.J.A.C. 8:39 – 19.4 (a) (k) 2.) On 3/8/2026 at 9:33 AM, Surveyor #1 observed Resident #68 in bed. The surveyor observed an unbagged nebulizer mask dated 3/5 lying sideways on top of an unlabeled plastic bag located on the side table. The internal part of the mask was exposed to air. A review of the electronic medical record (EMR) for Resident #68 revealed the following: A review of the admission Record reflected that the resident was admitted to the facility with diagnoses that included but not limited to acute upper respiratory infection, cerebral infarction (stroke), and other speech and language deficits following cerebral infarction. A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 2/1/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated a moderately impaired cognition. The MDS further revealed that the resident was on respiratory therapy. A review of the Order Summary Report (OSR) active as of 3/8/2026, included the following Physician's Orders (PO): Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/3ml (Ipratropium-Albuterol) 3 ml inhale orally four times a day for SOB (shortness of breath). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the individualized person-centered care plan initiated on 1/24/2026, included a focus for risk of respiratory complications related to recent diagnosis and history of respiratory infection. Interventions included monitoring for general signs/symptoms of infection (fever, change in mental status, lethargy, irritability, change in appetite). The interventions also included monitoring for signs/symptoms of pneumonia and/ or respiratory infection (increased shortness of breath, cough, change in sputum/secretions, chest discomfort, decreased activity tolerance) and to notify the physician of any abnormalities. On 3/10/2026 at 10:28 AM, during an interview with the surveyor, Licensed Practical Nurse/ Unit Manager stated that respiratory tubing or masks get changed once a week and should be bagged when not being used in the resident's room. On 3/10/2026 at 11:06 AM, during an interview with the surveyor, Licensed Practical Nurse/ Infection Preventionist stated that nebulizer masks and nasal cannula/ oxygen tubing should be stored in Ziplock bags when not in use and are changed weekly. On 3/11/2026 at 9:42 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that oxygen tubing and nebulizer mask or mouthpiece should be stored in a bag at bedside to cover them from being exposed when they are not being used. A review of the facility policy date reviewed on 1/27/2026 titled Oxygen Tubing and Respiratory Products indicated under Procedure the following: Ensure if O2 (oxygen) tubing is not in use that it is in an oxygen bag labeled with the resident's name and room # as well as the date it was changed, both the tubing and the bag shall have a date. N.J.A.C. 8:39 – 19.4 (a) (k) 3.) On 3/8/2026 at 9:37 AM, Surveyor #1 observed Resident #116 in bed. The surveyor observed a nebulizer machine with an unbagged mask sitting upright on the holder. The internal part of the mask was exposed to air. A review of the electronic medical record (EMR) for Resident #116 revealed the following: A review of the admission Record reflected that the resident was admitted to the facility with diagnoses that included but not limited to acute respiratory infection and cerebral infarction (stroke). A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 2/10/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated a moderately impaired cognition. The MDS further revealed that the resident was on respiratory therapy. A review of the Order Summary Report (OSR) active as of 3/8/2026, included the following Physician's Orders (PO): Albuterol Sulfate Nebulization Solution 0.63 mg/3ml 1 vial inhale orally via nebulizer three times a day for SOB. Inhalation only. Mask care – shake out any residual medication and store mask in drawstring bag after each use; Oxygen via NC @ 2 LPM as needed for SOB. A review of the individualized person-centered care plan revised on 2/6/2026, included a focus of risk for respiratory complications related to diagnosis. There was no intervention addressing the use of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	respiratory medications or treatments. On 3/10/2026 at 10:28 AM, during an interview with the surveyor, Licensed Practical Nurse/ Unit Manager stated that respiratory tubing or masks get changed once a week and should be bagged when not being used in the resident's room. On 3/10/2026 at 11:06 AM, during an interview with the surveyor, Licensed Practical Nurse/ Infection Preventionist stated that nebulizer masks and nasal cannula/ oxygen tubing should be stored in Ziplock bags when not in use and are changed weekly. On 3/11/2026 at 9:42 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that oxygen tubing and nebulizer mask or mouthpiece should be stored in a bag at bedside to cover them from being exposed when they are not being used. A review of the facility policy date reviewed on 1/27/2026 titled Oxygen Tubing and Respiratory Products indicated under Procedure the following: Ensure if O2 (oxygen) tubing is not in use that it is in an oxygen bag labeled with the resident's name and room # as well as the date it was changed, both the tubing and the bag shall have a date. N.J.A.C. 8:39 – 19.4 (a) (k) 4.) On 3/8/2026 at 11:03 AM, Surveyor #1 observed Resident #5 in bed. The surveyor observed an unbagged and unlabeled nebulizer mouthpiece lying sideways on the bedside table. The mouthpiece was touching the surface of the table and was located adjacent to a used hairbrush, unused toothbrush, a box of toothpaste and a plastic knife with brownish substance. A review of the electronic medical record (EMR) for Resident #5 revealed the following: A review of the admission Record reflected that the resident was admitted to the facility with diagnoses that included but not limited to chronic obstructive pulmonary disease, pneumonia , and chronic respiratory failure with hypoxia (insufficient oxygen reaching the body tissues) A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 2/3/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated intact cognition. The MDS further revealed that the resident was on intermittent oxygen therapy. A review of the Order Summary Report (OSR) active as of 3/8/2026, included the following Physician's Orders (PO): DuoNeb Solution 0.5-2.5 (3) mg/3ml (Ipratropium Albuterol) 1 vial inhale orally via nebulizer every 4 hours as needed for wheezing not to exceed 6 doses/ 24 hours; Mask Care – shake out any residual medication and store mask in drawstring bag after each use. A review of the individualized person-centered care plan revised on 3/9/2026, included a focus of risk for respiratory complications related to recent diagnosis/ history of pneumonia. The interventions included administering nebulization treatment as ordered, assessing status pre- treatment and post-treatment. On 3/10/2026 at 10:28 AM, during an interview with the surveyor, Licensed Practical Nurse/ Unit Manager stated that respiratory tubing or masks get changed once a week and should be bagged (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	when not being used in the resident's room. On 3/10/2026 at 11:06 AM, during an interview with the surveyor, Licensed Practical Nurse/ Infection Preventionist stated that nebulizer masks and nasal cannula/ oxygen tubing should be stored in Ziplock bags when not in use and are changed weekly. On 3/11/2026 at 9:42 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that oxygen tubing and nebulizer mask or mouthpiece should be stored in a bag at bedside to cover them from being exposed when they are not being used. A review of the facility policy date reviewed on 1/27/2026 titled Oxygen Tubing and Respiratory Products indicated under Procedure the following: Ensure if O2 (oxygen) tubing is not in use that it is in an oxygen bag labeled with the resident's name and room # as well as the date it was changed, both the tubing and the bag shall have a date. N.J.A.C. 8:39 – 19.4 (a) (k) During tour on 03/08/2026 at 9:34 AM, Surveyor #2 observed Resident #216 in bed. The nebulizer machine (a medical device that converts liquid medication into a fine, breathable mist, allowing patients to inhale drugs directly into their lungs via a face mask or mouthpiece) was observed on the dresser next to the bed. The nebulizer mask and reservoir were exposed to air and uncovered. According to the admission record Resident #216 had diagnosis which included but were not limited to asthma and respiratory failure. The 03/11/2026 admission Minimum Data Set (MDS, an assessment tool,) is in progress. A review of Resident #216's electronic health record reflected a physician's order for (Ipratropium-Albuterol 0.5-2.5 (3) milligrams/3 milliliters 1 vial inhale orally via nebulizer four times a day and budesonide suspension 0.5 milligrams/2 milliliters 1 vial inhale orally via nebulizer every 12 hours. A review of the facility provided policy, Infection Prevention and Control Program Oxygen Tubing and Respiratory Products, reviewed 1/27/26, which reflected all nebulizer tubing and equipment shall be dated and stored in a bag when not in use and replaced every 7 days. On 03/08/2026 at 09:31 AM, during initial tour, surveyor #3 observed Resident #31's nebulizer mask left on top of the night stand open to air. A review of Resident # 31's admissions record revealed that, Resident # 31 was admitted with but not limited to chronic obstructive pulmonary disorder (COPD; a progressive lung disease that makes it difficult to breathe). A review of Resident #31's admission Minimum Data Set (MDS) dated [DATE] revealed under section O that the resident received continous oxygen. A review of Resident #31's Electronical Medical Record revealed a physician's order for DuoNeb Solution, 1 vial inhale orally via nebulizer four times a day as needed for shortness of breath. A review of the Care Plan in the EMR revealed a focus for potential for respiratory complications (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	related to use of respiratory devices due to diagnosis of COPD. During an interview on 03/08/2026 at 09:33 AM with surveyor #3, Licensed Practical Nurse (LPN) #1 said that nebulizer masks should be kept in a plastic bag when not in use and should not be left open to air. B.) On 03/11/2026 at 9:51 AM, surveyor #4 observed a sign on Resident #144's room door that read, Enhanced Barrier Precautions: Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Care Activities. The Resident Care Activities listed on the sign included, Transferring and Showering/Bathing. At the same date and time, Surveyor #4 observed outside of Resident 144's room to the side of the doorway was a plastic set of drawers that contained Personal Protective Equipment (PPE) including yellow gowns. On the same date and time, Surveyor #4 observed two Certified Nurses Aide (CNA) inside the room of Resident #144. The CNAs were preparing Resident #144 for transfer to a shower bed via mechanical lift. Prior to entering the room and while preparing for transfer, both CNA did not wear a gown. On the same date at 9:59 AM, Surveyor #4 observed the CNAs exit the room with Resident #144 on the shower bed and transport him/her to the shower room. Prior to entering the shower room with Resident #144 and as they were preparing the resident for the shower the CNAs did not wear a gown. A review of Resident #144's Physician's Orders located in the Electronic Medical Record (EMR) revealed an order for Maintain Enhanced Barrier Precautions scheduled for every shift. The order was initiated on 03/04/2026. A review of Resident #144's Care Plan Activity Report located in the EMR, revealed a care plan titled, Maintain Enhanced Barrier precautions with an initiated date 04/18/2024 and revision on 03/12/2026. In the care plan, there was an intervention that revealed staff will wear a gown and gloves during high-contact resident care activities including transferring from one position to another and bathing/showering. On the same date at 10:06 AM, during an interview with Surveyor #4, CNA #1 replied, Yes. when asked if he was supposed to wear a gown. A review of the policy titled, Enhanced Barrier Precautions reviewed 01/21/2026 revealed, Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier precautions include: Bathing/Showering and Transferring . Further, the policy revealed that, staff will don the appropriate personal protective equipment (PPE) prior to performing high-contact care activities. On 03/11/2026 at 10:29 AM while outside of Resident # 164's room, Surveyor # 5 observed an orange sign outside the room door that revealed a stop sign symbol and the words, Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Adjacent to the doorway was a plastic, clear bin containing yellow, wearable gowns. At that time, Surveyor # 5 observed a hospice company Certified Nurse Aide (CNA) in the room helping maneuver Resident # 164 in bed to begin hygienic care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CNA did not have a disposable gown on while performing care on the residents. At 10:33 AM, the CNA exited the room. At that time, Surveyor # 5 asked him why he was not wearing a gown while performing care on the resident. The CNA replied, Sorry, sorry, okay, okay. A review of the policy titled, Enhanced Barrier Precautions reviewed 01/21/2026 revealed, staff will don the appropriate personal protective equipment (PPE) prior to performing high-contact care activities. N.J.A.C. 8:39-19.4(a) C.) On 3/8/26 at 11:07 AM, during the initial facility tour, the surveyor #6 observed Resident #16 lying in bed watching television (TV). The surveyor observed that the resident's urinary catheter device (UCD)drainage bag was lying on the floor and not placed in a dignity bag. Surveyor #5 reviewed the electronic medical record (EMR) for Resident #16. A review of the admission Record revealed that the resident had diagnoses including but not limited to pelvic inflammatory disease (infection of the pelvic organs) and obstructive and reflux uropathy (blockage that affects the flow of urine, causing it to back up into the kidneys). A review of the resident's admission Minimum Data Set (MDS), an assessment tool dated 1/30/26, included the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed that Resident #16 had an indwelling catheter. A review of the resident's Individual Comprehensive Care Plan (ICCP) included a focus area, initiated on 1/24/26 and revised on 1/27/26, identifying the resident as being at risk for urinary tract infection (UTI) related to (r/t) catheter use. Interventions included the use of a leg bag or privacy bag, as warranted, to maintain dignity and privacy, and to provide catheter care every shift as ordered and as needed. A review of the Order Summary Report of active orders as of 3/9/26 included a physician's order (PO), dated 1/23/26, to maintain Foley Catheter (F/C) privacy bag at all times, check placement every shift, and provide F/C care every shift. The Treatment Administration Record (TAR) for February and March 2026 indicated that the F/C privacy bag and placement tasks were documented as completed every shift. On 3/9/26 at 12:59 PM, surveyor #6 interviewed the certified nursing assistant (CNA) who stated that the UCD should not be placed on the floor in order to prevent infection. The CNA explained that the privacy bag should not be visible from the doorway and should be positioned on the opposite side of the bed to maintain the resident's dignity and privacy. On 3/10/26 at 11:56 AM, surveyor #6 interviewed the Licensed Practical Nurse (LPN), who confirmed that the UCD should not be placed on the floor for infection control purposes and should be kept in a dignity bag away from the doorway to protect the resident's privacy and dignity. On 3/11/26 at 10:29 AM, surveyor #6 interviewed Licensed Practical Nurse (LPN/UM), who confirmed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that Resident #16 had active orders for UCD care. When asked about the UCD care tasks being signed off on the TAR, the LPN/UM stated that the tasks should not have been signed off on shifts when the ordered care was not provided. The LPN/UM further stated that the UCD should be placed in a dignity bag, positioned away from the doorway, hung to gravity, and never placed on the floor to promote infection control, privacy, and dignity. On 3/11/26 at 1:10 PM, surveyor #6 interviewed the Registered Nurse/Director of Nursing (RN/DON), who stated that she expected that the UCD to be placed in a dignity bag, kept off the floor, and positioned away from the doorway at all times. The RN/DON confirmed that positioning of the UCD away from the door, and placement in a dignity bag promotes privacy, while keeping the UCD off the floor supports infection prevention. A review of the facility policy titled Foley Catheter Management and Drainage Bag Placement, reviewed 3/11/26, indicated that it is the policy of this facility to ensure safe management of indwelling urinary (Foley) catheters in order to prevent infection, maintain resident dignity. All staff responsible for catheter care must follow infection prevention standards and maintain proper drainage bag placement, privacy bag use, and unobstructed urine flow. NJAC 8:39-33.2(c)5

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and staff interview, the facility failed to ensure that pre-employment screening procedures were completed for employees prior to hire, including obtaining reference checks and/or background screenings, in accordance with the facility's abuse prevention policies. This deficient practice was found for 23 out 108 employee files reviewed. This deficient practice was evidenced by the following:On 03/08/2026 during entrance conference, the surveyor requested that the Licensed Nursing Home Administrator (LNHA) provide personnel files for all employees hired since the last annual recertification survey in 10/2024, regardless of current employment status. The requested documentation included the department of hire, date of hire, license verification, reference checks, criminal background checks, and pre-employment medical documentation, including physical examinations and two-step Mantoux test results.On 03/09/2026 at 08:56 AM the surveyor began reviewing the files, and found the following:Employee #1, hired as a [NAME] on 10/09/2024, had no documented reference checks in the personnel file at the time of review.Employee #2, hired as a Housekeeper on 11/19/2025, had no documented reference checks in the personnel file at the time of review.Employee #3, hired as a Housekeeper on 03/12/2025, had no documented reference checks in the personnel file at the time of review.Employee #4, hired as a Licensed Practical Nurse (LPN) on 01/05/2025, had no documented reference checks in the personnel file at the time of review.Employee #5, hired as a Housekeeper on 05/21/2025, had no documented reference checks in the personnel file at the time of review.Employee #6, hired as a Nurse's Aide (NA) on 04/10/2025, had no documented reference checks in the personnel file at the time of review.Employee #7, hired as a NA on 12/18/2024, had no documented reference checks in the personnel file at the time of review.Employee #8, hired as a NA on 01/03/2025, had no documented reference checks in the personnel file at the time of review.Employee #9, hired as a NA on 12/18/2025, had no documented reference checks in the personnel file at the time of review.Employee #10, hired as a Certified Nurse Aide (CNA) on 04/09/2025, had no documented reference checks in the personnel file at the time of review.Employee #11, hired as a NA on 01/15/2025, had no documented reference checks in the personnel file at the time of review.Employee #12, hired as a NA on 10/08/2025, had no documented reference checks in the personnel file at the time of review.Employee #13, hired as a Housekeeper on 11/06/2024, had no documented reference checks in the personnel file at the time of review.Employee #14, hired as a NA on 11/24/2025, had no documented reference checks in the personnel file at the time of review.Employee #15, hired as a Housekeeper on 11/26/2024, had no documented reference checks in the personnel file at the time of review.Employee #16, hired as a CNA on 10/28/2024, had no documented reference checks in the personnel file at the time of review.Employee #17, hired as a Housekeeper on 11/20/2024, had no documented reference checks in the personnel file at the time of review.Employee #18, hired as a CNA on 10/08/2025, had no documented reference checks in the personnel file at the time of review.Employee #19, hired as a NA on 11/10/2025, had no documented reference checks in the personnel file at the time of review.Employee #20, hired as a CNA on 05/21/2025, had no documented reference checks, and no evidence of a completed criminal background screening prior to the start date in the personnel file at the time of review.Employee #21, hired as a CNA on 08/27/2025, had no documented reference checks in the personnel file at the time of review.Employee #22 hired as a CNA on 11/20/2024, had no documented reference checks in the personnel file at the time of review. Employee #23, hired as a CNA on 06/04/2025, had no evidence of a completed criminal background screening prior to the start date.During an interview on 03/09/2026 at 11:28 AM with the surveyor, the Human Resources (HR) staff member said if applicants don't have a work history they look at the background check for possible employment. When asked if they would check personal references, HR said, she never thought of that.On a follow up interview with HR on 03/10/2026 at 12:52 PM, she said that the department managers look over applications, conduct interviews and then send her the applications of (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the perspective applicant to run background checks and check references. HR said for some applicants, their friends were employees and did verbally vouch for them but there was nothing documented in writing. HR also said with the applicants that have already gone through some form of a nursing program, she assumed they were vetted somewhere. When asked about the missing background checks, HR said they somehow got missed, and she was running them at this time.During an interview on 03/11/2026 at 12:59 PM with the survey team, the (LNHA) said it is very important to have background checks and references to make sure applicants aren't a serial killer, have anger issues and to ensure they are a good fit to work in healthcare. The LNHA said we know we should have a least one personal reference, going forward there will be a check off list.A review of the facility provided policy titled. Resident Abuse/Neglect Policy and Procedure revealed under Screening that, We are dedicated to thoroughly investigating the past histories of any individual we are considering hiring as an employee or otherwise engaging. All prospective employees will be carefully screened using the following processes to identify potential risks of abuse/neglect of any resident: 1. Reference Check and, 2. License check and background checks: NJAC 8:39-9.3 (b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2723157Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to report an allegation of sexual abuse to the New Jersey Department of Health (NJDOH) as mandated for 1 of 1 resident (Resident #21) reviewed for abuse and was evidenced by the following:On [DATE] at 9:33 AM, the surveyor observed Resident #21, awake in bed. When the surveyor began speaking to the resident, the resident indicated to the surveyor that they were hard of hearing.On [DATE] at 11:22 AM, the surveyor together with another surveyor observed Resident #21, awake and alert in bed. The resident was calm with no sign of distress. The resident was asked by the surveyors through written questions that the resident was able to read and understand, whether they prefer a male or female aide (CNA) (Certified Nursing Assistant) to give them care. The resident stated that they only prefer female aides to give them care. The resident was asked if they previously had a problem with a male aide. The resident narrated that a few months ago, they had a male aide who gave them a shower with the name that sounded like [name redacted] who touched them inappropriately in the groin area. The resident stated that they told one of the people that changed them or the administrator on the day or the next day when the incident happened. A review of the electronic medical record (EMR) for Resident #21 revealed the following:A review of the 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 the following: Dementia, Depression, and Mixed Anxiety Disorder.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [DATE], reflected that Resident #21 had severely impaired cognition. The MDS also revealed that the resident was dependent on staff for their activities of daily living that included toileting hygiene, shower, and lower body dressing.A review of the individualized person-centered care plan revised on [DATE], included a focus of impaired functional status related to impaired mobility due to fall at home resulting in fracture of the right shoulder. One of the interventions included no male CNAs created on [DATE].A review of the Point-of-Care (POC) documentation (care staff documentation of care activities in the EMR) in [DATE] revealed the resident was given shower on [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 10:10 AM, the Director of Nursing (DON) identified to the surveyor the male aide who gave the showers on the above dates as CNA #2.A review of the facility-initiated investigation file about Resident #21's allegation included the following: a summary of events with conclusion by the Licensed Nursing Home Administrator (LNHA) dated [DATE]; a list of female residents under the care of CNA #2 who were interviewed by LPN/ UM dated [DATE]; undated statement from CNA #2; statements from other CNAs and 2 nurses with varied dates from [DATE] to [DATE]; facility-wide re-education about Abuse, Neglect and Resident Rights from [DATE] to [DATE]; a completed background screening form of CNA #2; and Abuse and Neglect Policy and Procedure dated February 2025. The investigation concluded that there was no evidence to support the allegation of sexual abuse. CNA #2 was placed on administrative leave on [DATE] and was reinstated back to work on [DATE]. The investigation file did not include any documentation that the New Jersey Department of Health (NJDOH) was notified.On [DATE] at 9:42 AM, during an interview with the surveyor, the DON stated that when an allegation of abuse is reported, they interview the resident, check for pain and do skin assessment, do incident report, notify the family, physician, and police. The DON further stated that with the administrator already aware, investigation would be started and if the event is reportable, they report to the NJDOH. The DON stated that they report to the NJDOH within 2 hours if there's an injury and if not within 24 hours. On [DATE] at 12:58 PM, during an interview with the survey team, the Licensed Nursing Home Administrator (LNHA) stated that they should have reported the allegation to the NJDOH and that they were wrong in not doing so. The LNHA confirmed to the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey team that there was no evidence to support the allegation and that CNA #2 does not work in the facility anymore since their certification expired last [DATE].A review of the facility-provided policy revised in February 2025, titled Resident Abuse/ Neglect Policy and Procedure included under Investigative and Reporting Procedure: The Department of Health and Senior Services, and the Office of the Ombudsman if the resident is 60 or over, will be notified immediately (as soon as possible but not to exceed 2 hours) of the incident, followed by a written report within 5 days of the incident and if the alleged violation is verified, the facility shall take corrective action. N.J.A.C. 8:39-27.1(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure a resident receiving enteral feeding received appropriate care and services to prevent complications of enteral feeding by failing to complete the formula label for a resident currently receiving a feeding. This deficient practice was identified for 1 of 3 (Resident # 8) reviewed for Tube Feeding.The deficient practice was evidenced by the following:A review of Resident # 8's 12/20/2025 Minimum Data Set (MDS; and assessment tool) revealed under section K that Resident # 8 was receiving a tube feeding while a resident in the facility.A review of Resident # 8's physician's orders located in the Electronic Medical Record (EMR) revealed that Resident # 8 was receiving nutritional formula via electronic pump from 7:00 PM at 65 milliliters an hour (ml/hr) for a total volume of 700 ml and to take down when the total volume has completed.A review of Resident # 8's care plan located in the EMR revealed a focus for at risk for alteration in nutrition related to therapeutic diet, also receiving enteral feedings to meet nutrition & hydration needs.On 03/11/2026 at 10:14 AM, the surveyor observed Resident # 8 asleep in their bed. At that time, the surveyor observed the feeding pump making an audible noise and the screen displaying Caution Cassette Error. The feeding pump tubing was connected to the resident. The surveyor observed the nutritional formula that was hanging off of a mobile pole. The nutritional formula label was not filled out whatsoever. The information missing from the label included the resident's name, room number, date, start time and rate per hour.On 03/11/2026 at 10:18 AM during an interview with the surveyor, the Licensed Practical Nurse Unit Manager (LPNUM) replied, Yes, it absolutely does. It goes up at four PM after the surveyor asked if the formula bottle has to be dated, labeled and filled out.A review of the facility policy titled, Infection Prevention and Control Program Gastric Tube Feeding Management revealed under Procedure that, 14. The nurse shall label the feeding bag/bottle with the date and time the feeding was started, the amount of the feeding and the nurse's initials. The nurse shall input the rate of the feeding, based on the physician order, and the total volume to be infused (dose) over 24 hours into the pump before the initial feeding is started.N.J.A.C. 8:39-27.1(a)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review it was determined that the facility failed to ensure that a midline dressing was changed and maintained in accordance with professional standards of practice and facility policy for 1 of 1 residents (Resident # 101) reviewed for parenteral fluids. The deficient practice was evidenced by the following: A review of the physician's orders located in Resident # 101's electronic medical record (EMR) revealed an order to change a midline/PICC (Peripherally Inserted Central Catheter) intravenous (IV) dressing, extension set & cap twenty-four hours post insertion then every week and PRN (as needed). The order was started on 03/11/2026 at 09:38 AM.A review of the physician's orders also revealed an order in the EMR to insert midline for IV fluids for acute kidney injury. The order was revised on 02/28/2026.A review of the care plan for Resident # 101 located in the EMR, revealed a focus for Potential for complications related to IV access site, IV therapy due to antibiotic treatment and hydration.A review of Resident # 101's Quarterly Minimum Data Set (an assessment tool) dated 12/27/2025 revealed under section C that Resident # 101 had a brief interview for mental status score of 15/15 indicating he/she had was cognitively intact.On 03/11/2026 at 10:38 AM, the surveyor observed Resident # 101 awake in bed. At that time, the surveyor observed a midline catheter inserted into the resident's right arm. A translucent, adhesive dressing was covering the area where the catheter was inserted into his/her arm. On the dressing was a handwritten date, 3/2.At that time, during an interview with the surveyor, Resident # 101 said that no one has changed the midline dressing since then.On 03/11/2026 at 12:02 PM during another visit by the surveyor, Resident # 101 was in bed. At that time, the surveyor observed that the previous dressing with the handwritten 3/2 was removed from Resident # 101 and a new dressing was applied to the PICC Line site dated 3/11/26 in blue ink.On 03/11/2026 at 12:59 PM during an interview with the surveyor, the Director of Nursing (DON) showed the surveyor a used dressing, partially wrapped in a disposable glove. The DON told the surveyor that she was showing the surveyor the previous dressing and that a new dressing was applied to Resident # 101 today. She said that the facility recovered the old dressing from a trash can to show the surveyor.A review of the facility-provided policy titled Catheter Insertion and Care revealed under General Guidelines that, Change midline catheter dressing 24 hours after catheter insertion, every 5-7 days or if it is wet, dirty, not intact, or compromised in any way.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 documents, it was determined that the facility failed to routinely post the Nursing Home Resident Care Staff Report (NHRCSR) since 03/04/2026 (4 days) in a place within the facility readily accessible to the residents and the visitors.This deficient practice was evidenced by the following:On 03/08/2026 at 9:02 AM, the surveyor observed the NHRCSR dated 03/04/2025 for the day, evening, and night shift. Each shift indicated a census of 195. The NHRCSR was observed posted on a ledge to the left of the reception desk in the front lobby. During an interview on 03/10/2026 at 12:59 PM with the surveyor, the staffing coordinator (SC) said that she sends the NHRCSR to the receptionist daily to post, and on Fridays the SC said she sends the whole weekend. She stated she was not here over the weekend and must have forgotten to send the schedule up to the receptionist. The SC then said it is important to post daily so the families can see the ratio of the staff to residents in the building. During an interview on 03/11/2026 at 12:59 PM with the survey team the Licensed Nursing Home Administrator (LNHA) said it is important to post the NHRCSR daily because the families are very interested in seeing the staff ratios, and it is also good to show prospective families that are looking for placement.At the time of survey, the facility did not have a policy for the daily posting of NHRCSR. NJAC 8:39-41.2 (a)(b)(c)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, it was determined that the facility failed to establish a system of records for controlled drugs in sufficient detail to enable an accurate reconciliation for the dispensing of controlled medications for 1of 5 medication carts inspected under the Medication Storage Task.This deficient practice was evidenced by the following:On 03/11/2026 at 10:40 AM in the presence of Licensed Practical Nurse (LPN) # 1, the surveyor inspected medication cart 1 on the North Wing unit. While observing the controlled medications, the surveyor observed 6 Oxycodone 5 milligrams tablets (mg) (a narcotic medication used to treat pain) in the blister pack within narcotic box for Resident #13. At that time, the surveyor reviewed the Oxycodone inventory sheet. The document revealed the administration of 2 oxycodone tablets that included a beginning balance of 8 and ending balance of 6 consistent with quantity remaining in the blister pack, with no documentation of the administration date or time. At that time during the interview with the surveyor, LPN #1 stated, That was me rushing, and confirmed that the date and time were missing from the documentation. A review of Resident #13's Medication Administration Record (MAR) indicated that the oxycodone was administered on 3/11/2026 at 8:28 AM. During an interview on 03/1/2026 at 12:59 PM with the surveyor, the Director of Nursing said that the expectation is for documentation to be completed at the time the nurse is administering the medication.Review of the facility's policy titled, Controlled Dangerous Substance (CDS) Procedure revised on 03/11/2026, revealed under Declining inventory sheets that All CDS medication declining inventory sheets must be signed by the nurse administering the medication at the time the medication is prepared for administration. NJAC 8:39-29.7(c)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the medication error rates are not 5 percent or greater. This deficient practice was identified for 1 of 7 residents (Resident #18), and 1of 2 nurses on the second-floor nursing unit during the Medication Administration task. The deficient practice was evidenced by the following:On 3/10/2026 at 9:24 AM on the North Wing, the surveyor observed Licensed Practical Nurse (LPN) #1 prepare Resident #18's medication for administration. At that time, LPN #1, removed one Metoprolol tablet (used to treat high blood pressure) and place it in the medication cup. At that time, the surveyor observed the Electronic Medical Administration Record (EMAR) on the medication cart computer with LPN #1. The EMAR revealed that the Metoprolol was scheduled to be given at 8:00 AM. On the same date and time, on the North Wing, the surveyor observed LPN #1 prepare Resident #18's medication for administration. At that time, LPN #1 determined she did not have Resident #18's folic acid tablet (a vitamin supplement). At that same time, LPN#1 asked the surveyor if she could use another residents prescribed folic acid tablet and stated, That is what we normally do. The surveyor instructed LPN #1 to follow the facility's policy. LPN #1 proceeded to remove one folic acid tablet from a medication card labeled for use on Resident #182 and place it in Resident #18's medication cup. On the same date at 11:14 AM during an interview with LPN # 1, the surveyor asked if a medication is ordered to be administered at 8:00 AM when should that medication be given by, LPN #1 refused to answer the question. LPN #1 further stated that 7:00 AM and 8:00 AM medications can sometimes take up to 10:00 AM to be administered. The surveyor then asked if it was okay to give 7:00 AM and 8:00 AM medications after an hour has passed, LPN #1 stated she was unsure and further stated that she tries to give as much as possible on time but it does not always happen. At that time when asked if she should have used a medication prescribed to another resident, LPN #1 stated, that normally rather than missing a resident's dose of medication, they will use another resident's medication if it is the same. The surveyor asked the LPN if that was part of the facility's policy and LPN #1 repeated, That's what we normally do.During an interview with the surveyor on 03/11/2026 at 12:59 PM, the Licensed Nursing Home Administrator (LNHA) stated that LPN #1 should have met with the pharmacy. The Director of Nursing (DON) further stated the physician could have been contacted to obtain an order for one of the over-the-counter doses of folic acid. A review of a facility policy titled, Administering Medications, reviewed on 03/12/2026, revealed under Policy Interpretation and Implementation number 3., Medications must be administered in accordance with the orders, including any required time frame . The policy further revealed under number 9., Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time . The policy further revealed under number 16., Medications ordered for a particular resident may not be administered to another resident. N.J.A.C.8:39-29.2(d)