| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315313 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Careone at Cresskill | 221 County Road<br>Cresskill, NJ 07626 |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to include in the written notification of emergency transfer that was provided to the Resident or Resident Representative, the facility's bed hold reserve payment for 3 of 3 residents, (Residents #3, #33 and #93), reviewed for hospitalizations. This deficient practice was evidenced by the following:<br><br>1. On 3/12/26 at 12:37 PM, Surveyor #1 (S #1) reviewed the hybrid (electronic and paper) medical records of Resident #3.<br><br>A review of Resident #3's admission Record or face sheet (AR; admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Type 2 diabetes mellitus (a chronic metabolic disorder characterized by high blood glucose resulting from insulin resistance and relative insulin deficiency) and heart failure (a chronic, serious condition where the heart cannot pump enough blood to meet the body's needs).<br><br>A review of Resident #3's most recent Discharge Assessment Return Anticipated Minimum Data Set (DRAMDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision making was modified independence. Further review of the DRAMDS indicated that the resident was transferred to a short term general hospital.<br><br>A review of Resident #3's electronic medical record (eMR) included a letter to the resident's representative (RR) dated 12/21/25, which included that the resident was transferred to the hospital for a higher level of care and that every resident was entitled to a ten-day bed-hold privilege. The letter did not include the bed hold reserve payment amount. The letter included information related to an insurance, which the facility did not participate in.<br><br>On 3/17/26 at 12:25 PM, S #1 interviewed the Business Office Manager (BOM) who stated that she was covering for the Admissions Director (DA) who no longer worked at the facility. The BOM stated that she would call the RR and asked if they wanted to hold the bed and if they said yes, she would charge the RR. The BOM confirmed that the facility did not participate in Medicaid insurance and that Medicare insurance did not hold the bed. The BOM stated that a resident that was a private pay may want to hold the bed. The BOM stated that every room was a different cost and that if the RR wanted the bed held that she would tell them the price. The BOM confirmed that the reserve payment was not on the notice and that the admission agreement had the rates.<br><br>On 3/18/26 at 1:14 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), the concern that Resident #3's written emergency transfer notification did not<br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | include the bed hold reserve payment and contained information about an insurance that the facility did not participate in.<br><br>On 3/19/26 at 10:56 AM, in the presence of the DON, the LNHA stated that the bed hold information was brought to the home office to ensure they were compliant with new regulation and that they would monitor it.<br><br>The LNHA did not provide any additional information.<br><br>2. On 3/12/26 at 12:37 PM, Surveyor #2 (S #2) reviewed the hybrid medical records of Resident #33.<br><br>A review of Resident #33's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to encounter for other orthopedic aftercare, unspecified fracture of upper end of right humerus.<br><br>A review of Resident #33's most recent DRAMDS reflected that the resident's cognitive skills for daily decision-making was intact. Further review of the DRAMDS indicated that the resident was transferred to the hospital on [DATE] and 1/13/26.<br><br>A review of Resident #33's eMR included a letter to the resident and RR dated 10/5/25 and 1/14/26, which included that the resident was transferred to the hospital for a higher level of care and that every resident was entitled to a ten-day bed-hold privilege. The letter did not include the bed hold reserve payment amount. The letter included information related to an insurance, which the facility did not participate in.<br><br>On 3/18/26 at 9:52 AM, S #2 interviewed the admission Coordinator who stated that the DA was responsible for the Bed Hold Notifications.<br><br>On 3/18/26 at 1:05 PM, the survey team met with the LNHA and DON, and S #2 notified them of the concerns regarding the reserve payments for bed holds.<br><br>3. On 3/18/26, Surveyor #3 (S #3) reviewed the hybrid medical records of Resident #93.<br><br>A review of the AR revealed that the resident had diagnoses that included but were not limited to, paroxysmal atrial fibrillation (a type of irregular, rapid heart rhythm that starts and stops on its own) and hypertensive heart disease with heart failure (a condition where long-term high blood pressure forces the heart to work harder and eventually weaken).<br><br>The Universal Transfer Form (UTF; a standardized document used by licensed healthcare facilities to ensure safe, consistent communication when transferring a patient to another facility) reflected that Resident #93 was transferred to a hospital on 1/27/26.<br><br>A review of the Discharge MDS with an ARD of 1/27/26, revealed under Section A, that the resident had an unplanned discharge to a hospital on 1/27/26.<br><br>The Notice of Transfer to Acute Care Facility (NTACF), dated 1/27/26. The NTACF did not reveal any information that reflected the amount of reserve bed hold payment.<br><br>The medical record also revealed an admission Agreement (AA) dated 7/28/23 for Resident #93. The (continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | AA reflected on page 13, Bed Hold Policy. The Bed Hold Policy did not reflect any information that reflected the amount of reserve bed hold payment.<br><br>On 3/18/26 at 10:16 AM, S #3 interviewed the LNHA. S#3 showed the LNHA the NTACF, line 4 and asked if there was any mention of the reserve bed payment information. The LNHA stated they would get back to S #3.<br><br>On 3/18/26 at 1:05 PM, the survey team met with the DON and LNHA, and S #3 notified them of the above concerns. The LNHA stated that the admission packet had the bed hold reserve payment, it was not on the transfer documents. The survey team asked the LNHA if they were aware of the regulations for acute transfers and notification of reserve bed hold payment, and the LNHA stated they would get back to the survey team.<br><br>On 3/19/26 at 10:49 AM, the survey team met with the DON and the LNHA stated that the concern with bed hold payment reserve notifications would be brought to corporate for compliance review.<br><br>A review of the facility's Bed-Holds and Returns Policy, dated 10/22, the policy reflected under 4. b. the reserve bed payment policy as indicated by the state plan.<br><br>The policy did not reflect any mention of bed hold reserve payment amounts or notification of reserve bed hold payment amounts with every acute transfer.<br><br>NJAC 8:39-4.1, 5.1(a) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure 1 of 19 residents (Resident #81) call bell was within reach and able to use to accommodate residents' needs.This deficient practice was evidenced by the following:On 3/12/26 at 11:20 AM, the surveyor observed Resident #81 in their room and observed that the call bell was wrapped around the side rail of the bed while the resident was seated in a specialized wheelchair (w/c) while watching a movie on their tablet. The resident's call bell was not within reach of the resident. The resident was unable to locate their call bell when asked by the surveyor if they could reach their call bell if needed an assistance. On that same date and time, the surveyor asked a Certified Nursing Aide (CNA) and the Licensed Practical Nurse (LPN) who were currently in the nursing station to accompany back the surveyor inside Resident #81's room to verify if the resident was able to reach the call bell. Inside the resident's room, the CNA immediately removed the call bell as being wrapped around the side rail and placed it in resident's left hand under the blanket. Outside the resident's room, in the nursing station, the surveyor interviewed the LPN who claimed that she was the assigned nurse of the resident. The LPN further stated that the resident was unable to reach the call bell. The LPN acknowledged that the call bell should not be wrapped around the side rail. She also stated that the resident had limitations to both upper and lower extremities. The surveyor reviewed the medical record for Resident #81.A review of the admission Record or face sheet (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; hydrocephalus unspecified (excessive accumulation of cerebrospinal fluid (CSF) within the brain's ventricles, causing increased pressure, tissue damage, and potential neurological impairment), nontraumatic subarachnoid hemorrhage unspecified (bleeding in the area between your brain and the thin tissues that cover and protect it), other lack of coordination, and dysphagia oropharyngeal phase (difficulty moving food or liquid from the mouth to the throat and into the esophagus). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/3/26, revealed in Section C-Cognitive Patterns with a brief interview for mental status (BIMS) score of 10 out of 15, which reflected that resident had moderately impaired cognition. On 3/17/26 at 8:35 AM, the surveyor notified the Director of Rehabilitation (DOR) and the assigned Occupational Therapist (OT) of the above concerns with call bell not within reach of the resident and if the current call bell was appropriate for the resident. The DOR informed the surveyor that they would re-evaluate the resident regarding the current call bell of the resident. On 3/17/26 at 2:20 PM, the DOR provided a copy of the Occupational Therapy Treatment Encounter Note ([NAME]) dated 3/17/26, that was electronically signed by the OT at 2:07 PM, reflected that the resident demonstrated ability to retrieve call bell and press it. The [NAME] also include that once the resident seated in w/c, resident's call bell should be clipped to w/c and positioned in lap. On 3/17/26 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns regarding the resident's call bell. On 3/19/26 at 10:49 AM, the survey team met with the DON and LNHA who stated that on 3/17/26, an assessment was completed with Resident #81's current call bell, did follow up assessment on 3/18/26, and the resident declined the flat call bell. The LNHA acknowledged that resident's call bell should not be wrapped around the side rail but in the resident's lap for accessibility. A review of the facility's Accommodation of Needs Policy that was provided by the DON, with a revision date of November 2025, revealed that the resident has the right to reside and receive services in the facility with reasonable accommodation of their needs and preferences.Under Policy Interpretation and Implementation.2. The resident's individual needs and preference, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis. On 3/19/26 at 12:31 PM, the survey<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | team met with the LNHA, Regional Nurse, and the DON for an exit conference. The LNHA and the DON did not provide additional information and did not refute the findings. NJAC 8:39-31.8 (c)(9) |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on interview and review of other facility documentation, it was determined that the facility failed to complete in writing the issued required beneficiary notice for 1 of 3 residents reviewed for Beneficiary Protection Notification, (Resident #106). This deficient practice was evidenced by the following:On 3/17/26 at 10:53 AM, the surveyor reviewed the provided Skilled Nursing Facility (SNF) Beneficiary Protection Notification (SNFBPN) Review completed by the facility for Resident #106, and revealed:-The SNFBPN Review indicated Resident #106 last covered Medicare A day was 10/5/25, and Resident #106 remained in the facility. The SNFBPN Review had an attached Notice of Medicare Non-Coverage (NOMNC) which indicated that the Medicare coverage for skilled nursing services will end on 10/5/25, that was signed by the resident on 10/2/25. The SNFBPN Review further revealed that a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) form was not provided. A review of the most recent Discharge Return Not Anticipated Minimum Data Set (DRNAMDS) of Resident #31, revealed that the resident was discharged (d/c'd) to the community. A review of the Progress Notes that was electronically signed by the Registered Nurse (RN) on 10/10/25, revealed that the resident was d/c'd home with resident representative (RR). On 3/17/26 at 11:31 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC) who stated that the NOMNC will be prepared by the Social Worker (SW) and the SW would asked the resident or RR to sign the NOMNC. She also stated that the SNFABN would be my responsibility. The RN/MDSC also stated that there were times that the SNFABN would be provided to the resident or RR at the same time the NOMNC would be given but most of the time, the SNFABN would be provided once the resident or RR decided to stay at the facility. At that same time, the surveyor asked the RN/MDSC what the importance was of providing the NOMNC and the SNFABN to the resident and/or RR, and she responded, so they are aware of the financial liability. The surveyor asked if there was a specific timeframe to provide SNFABN, she responded I cannot say exactly. The surveyor notified the concern with Resident #106, with no SNFABN provided when the resident stayed for five more days after the resident signed the NOMNC for ending 10/5/25. The surveyor asked if she knew why it was not provided, and she responded that she had to get back to the surveyor. On 3/17/26 at 12:02 PM, the RN/MDSC provided a copy of Resident #106's appeal paper and stated that the resident had an appeal twice. The RN/MDSC further stated that she was unsure if another NOMNC was done for the resident. The surveyor then asked the RN/MDSC if the facility should provide SNFABN to the resident since the resident appealed twice, with an intention to continue with services, and she responded no. On 3/17/26 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns regarding the resident's SNFABN that was not provided for a resident who had an intention to continue services as evidenced by two appeals made, and had stayed for another five days in the facility after the NOMNC was provided. On 3/19/26 at 10:49 AM, the survey team met with the DON and LNHA stated that the NOMNC was provided on 10/5/25, there should be another NOMNC done but was not presented to the surveyor. The LNHA further stated that the previous SW did another NOMNC on 10/7/25. The LNHA further stated that there was no financial liability that was why there was no SNFABN provided to the resident. The surveyor asked the LNHA and DON if the resident had appealed twice, why the facility did not provide the SNFABN with resident's intention to continue services, and the LNHA stated, I understand what you mean. A review of the facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notices Policy that was provided by the RN/MDSC, with a revision date of September 2024, revealed, under policy statement, a resident is informed in advance and in writing when Medicare payment denial or change in coverage is likely.Skilled Nursing Facility Advance Beneficiary Notice:.2. The SNFABN provides information to the resident so that he or she can decide whether to get the care that may not be paid for by Medicare and assume financial responsibility. 3. The SNFABN is only issued if the resident/beneficiary intends to continue services,<br>(continued on next page) |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and the facility believes the services may not be covered under Medicare. On 3/19/26 at 12:31 PM, the survey team met with the LNHA, Regional Nurse, and DON for an exit conference. The LNHA and the DON did not provide additional information and did not refute the findings. NJAC 8:39-4.1(a)(8); 5.1(a) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to adequately monitor target behavior for the use of a psychotropic medication (med) specifically an antipsychotic med and ensure an antipsychotic med was ordered for an appropriate diagnosis for 1 of 5 residents (Resident #99), reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 3/12/26 at 11:37 AM, the surveyor observed Resident #99 lying in a bed that was low to ground. The surveyor interviewed Resident Representative (RR) about the low bed and she stated that the resident fell two times. A review of Resident #99's admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to type 2 diabetes mellitus (a chronic metabolic disorder characterized by high blood glucose resulting from insulin resistance and relative insulin deficiency) and abnormalities of gait and mobility (irregular, walking, or movement patterns often caused by pain, neurological diseases, or musculoskeletal issues like arthritis). A review of Resident #99's most recent comprehensive Minimum Data Set (cMDS), with an Assessment Reference Date (ARD) of 1/15/26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated that Resident #99's cognition was severely impaired. Further review of the MDS reflected that the resident received an antipsychotic med (prescribed to manage psychosis, primarily in individuals with schizophrenia but also can reduce or relieve symptoms of psychosis, such as delusions (false beliefs) and hallucinations (seeing or hearing something that is not there). The cMDS did not indicate any active diagnosis that the antipsychotic med was ordered for. A review of Resident #99's comprehensive care plan (CP) reflected the following focus area: at risk for adverse effects related to use of antipsychotic med; use of antianxiety/anxiolytic med. The CP did not include the resident's target behaviors that were to be monitored. A review of Resident #99's January electronic Medication Administration Record/Treatment Administration Record (eMAR/TAR) included the following orders:Divalproex sodium oral capsule (cap) delayed release (DR) sprinkle 125 mg (milligram), give 2 capsules (caps) by mouth at bedtime (HS) for mood stabilizer 2 caps = 250 mg total with a start date of 1/8/26 and a d/c (discontinue) date of 1/12/26.Divalproex sodium oral cap DR sprinkle 125 mg, give 2 caps by mouth at HS for mood stabilizer 2 caps = 250 mg total with a start date of 1/13/26 and a d/c date of 1/23/26.Quetiapine fumarate oral tablet (tab) 25 mg, give 1 tab by mouth one time a day for agitation with a start date of 1/9/26 and a d/c date of 1/12/26. Agitation was not an appropriate diagnosis for administering this med.Quetiapine fumarate oral tab 25 mg, give 1 tab by mouth one time a day for Mood disorder with behavior with a start date of 1/14/26 and a d/c date of 1/29/26.Intrusive Wandering every shift with a start date of 1/8/26 and a d/c date of 1/12/26.There was no other behavior monitoring documented for the use of Quetiapine or Divalproex in the month of January. A review of Resident #99's February eMAR/TAR included the following orders:Quetiapine fumarate oral tabl 25 mg, give 1 tab by mouth every 8 hours for mood disorder (d/o) with a start date of 1/29/26 and a discontinued date of 2/18/26. The med was increased from once a day to three times a day without any behavior monitoring.Quetiapine fumarate oral tab 25 mg, give 1 tab by mouth every 8 hours for mood d/o target sx (symptoms) restlessness, agitation with a start date of 2/18/26 and was held from 2/26/26 to 3/1/26 and then discontinued 3/5/26. The target sx restlessness and agitation were not appropriate for administering this med.Behavior monitoring: paranoia every shift (Provide any additional detail as needed in progress note) with a start date of 2/17/26.Behavior monitoring: restlessness to exhaustion every shift (Provide any additional detail as needed in progress note) with a start date of 2/17/26. A review of the psychiatric APRN (Advanced Practice Registered Nurse) visits included the following:1/23/26 visit-initial evaluation of resident with dementia and a history of mood lability, insomnia and sundowning behaviors.per nursing staff, the (continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | patient was cooperative with treatment and medications (meds) and was frequently noted to be restless in the evenings in the setting of confusion, without aggression, exit-seeking behaviors or psychotic symptoms. Diagnosis 1. Dementia w/ behavioral disturbance 2. Mood d/o NOS (not otherwise specified) 3. Delirium or Sundowning. Plan 1. D/c Depakote, elevated LFT's (liver function test) concerning. 2. Increase Seroquel to 25 mg every (q) 8 hrs for mood d/o NOS, target sx are restlessness, agitation, sx are mild and ongoing. Hold for lethargy/sedation.Continue monitoring/documenting moods/behaviors, notify psychiatry with and concerns.1/29/26 visit-follow-up visit.per nursing report, patient remained cooperative with treatment and meds was frequently observed pacing and speaking loudly, at times disrupting other residents and staff, requiring frequent redirection. Plan 2. Increase Seroquel to 25 mg q 8 hrs for mood d/o NOS, target sx are restlessness, agitation, sx are worsening. Hold for lethargy/sedation.7. Continue monitoring/documenting moods/behaviors, notify psychiatry with and concerns. On 3/16/26 at 11:47 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that when a resident received an antipsychotic, there would be a list of the target behavior and they would be monitored. The surveyor asked about Resident #99's Quetiapine order. The LPN stated that the psychiatrist wrote the order for Quetiapine. On 3/16/26 at 11:56 AM, the surveyor interviewed the Unit Manager (UM) who stated that the diagnosis for the antipsychotic med was determined by the psychiatrist who rounded weekly or as needed. The surveyor asked if restlessness and agitation were appropriate diagnosis for an antipsychotic. The UM stated that they did not use those for the diagnosis and that they were not accepted and they would update the order. On 3/16/26 at 12:52 PM, the surveyor interviewed the UM who stated that if the resident was on a antipsychotic that there would be a CP for antipsychotic and behavior and if seeing a behavior then the target behavior. The UM stated that behavior monitoring was in the computer as an order. The surveyor asked the reason behavior monitoring was done. The UM stated that it was to justify the efficacy of the resident being on the med and to discuss a dose reduction if the physician agreed. The surveyor informed the UM that Resident #99 did not have a CP for antipsychotic med and behavior monitoring, behavior monitoring when the antipsychotic was increased and that agitation and restlessness were the behaviors for the antipsychotic med. The surveyor asked the UM for information regarding those concerns. On 3/16/26 at 1:02 PM, the surveyor interviewed the Director of Nursing (DON) who stated that there would be a CP side effect and behaviors for someone on an antipsychotic. The DON stated that if a resident was on an antipsychotic then they would have behavior monitoring in the eMAR each shift documented by the nurses. The surveyor asked if the diagnosis for an antipsychotic was restlessness and agitation if that was appropriate. The DON stated that it was not an appropriate diagnosis. The DON stated that the reason for behavior monitoring was to see if the med was effective or not and if not needed then a gradual dose reduction would be done. On 3/18/26 at 10:50 AM, the DON stated that Resident #99 had behavior monitoring originally and that when they went to the hospital and returned, it was not restarted. The DON stated that the med order for restlessness and agitation should have been clarified. The DON stated that the psychiatrist wrote to increase the Quetiapine when he discontinued the depakote and melatonin. On 3/18/26 at 1:10 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #99's antipsychotic med was ordered for restlessness and agitation, there was no behavior monitoring for the antipsychotic until 2/12/26 (there was 4 days of intrusive wandering from 1/8/26 to 1/12/26), and the med was increased during that time and no CP for antipsychotic med related to behaviors. On 3/19/26 at 11:00 AM, in the presence of the LNHA, the DON stated that she spoke to the psychiatrist this morning related to Resident #99's antipsychotic med order for agitation and that they were going to review weekly all the residents and new admission for an appropriate diagnosis. The DON stated that the resident had went to the hospital and the behavior monitoring was not reinstated when she returned. The LNHA did not provide any additional information. A review of the facility's Psychotropic Medication Use Policy with a revised date of February 2025, included the following Policy Statement, Residents do not<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | receive psychotropic meds that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Policy Interpretation and Implementation .2. Med in the following categories are considered psychotropic (affecting the brain and nervous system, altering mood, thoughts, perception, and behavior) meds and are subject to prescribing, monitoring, and review requirements.;a. Anti-psychotics;.5. Psychotropic meds are never used to sedate or alter a resident's behavior for discipline or for the convenience of the staff .Monitoring and Adverse Consequences. 2. Residents receiving psychotropic med are monitored and the response to treatment is documented. A review of the facility's Behavioral Assessment, Intervention, and Monitoring Policy with a revised date of February 2025, included the following Interventions and Management 1. The IDT evaluates behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develops a plan of care accordingly.3. The CP includes, as a minimum: a. a description of the behavioral symptoms.b. targeted and individualized interventions for the behavioral and/or psychosocial symptoms; c. the rationale for the interventions and approaches; d. specific and measurable goals for targeted behaviors; and e. how the staff will monitor the effectiveness of the interventions.9. Non-pharmacologic approaches are used to the extent possible to avoid or reduce the use of psychotropic meds to manage behavioral symptoms. 10. If psychotropic meds are prescribed for behavioral symptoms, documentation includes: a. rationale for use; b. potential underlying causes of the behavior; e, specific target behaviors and expected outcomes; h. monitoring for efficacy and adverse consequences; and i. plans (if applicable) for gradual dose reduction.NJAC 8:39-4.1(a)6 |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on interviews and record review, it was determined that the facility failed to complete and transmit the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within 14 days as required, for 1 of 22 residents, (Resident #80), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following:According to the Resident Assessment (RAI) Manual, dated October 2025, RAI-required Assessment Summary, The Discharge MDS assessment return not anticipated, the MDS completion date is the discharge date + 14 calendar days. The Transmission date is MDS Completion date + 14 calendar days. On 3/16/26 at 11:55 AM, the surveyor reviewed the MDS of Resident #80, revealed that the DRNA (Discharge Return Not Anticipated) MDS with an assessment reference date (ARD) of 10/30/25, was completed but was not accepted (or transmitted). On 3/16/26 at 12:40 PM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC) who informed the surveyor that the facility followed the RAI Manual when doing MDS including when to complete and transmit MDS. The surveyor showed to the RN/MDSC the printed information that the DRNA MDS with an ARD of 10/30/25, and she stated that it was completed but was not transmitted. She further stated that the 10/30/25 MDS should have been transmitted. She also stated that she was unsure if it was within seven or 14 days that the completed MDS should have been transmitted. On 3/16/26 at 2:00 PM, the RN/MDSC stated that there was no transmission reports for Resident #80 because the DRNA MDS was not transmitted. On 3/17/26 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns regarding Resident #80's MDS that was not transmitted. On 3/19/26 at 10:49 AM, the survey team met with the DON and LNHA stated that Resident #80's MDS was transmitted after surveyor's inquiry. A review of the facility's Electronic Transmission of the MDS Policy that was provided by the RN/MDSC, with a revision date of October 2023, revealed under Policy Statement, all MDS assessments (e.g. admission, annual, significant change, quarterly review, etc.) and discharge and reentry records are completed and electronically encoded into the facility's MDS information system and transmitted to the CMS' Internet Quality Improvement and Evaluation System (iQIES) system in accordance with current OBRA (Omnibus Budget Reconciliation Act of 1987, in MDS refers to federal nursing home regulations establishing mandatory, standardized assessment schedules for all residents in certified facilities, regardless of payer type) regulations governing the transmission of MDS data. Policy Interpretation and Implementation.8. The MDSC is responsible for ensuring appropriate edits are made prior to transmitting MDS data and feedback and validation reports from each transmission are maintained for historical purposes and for tracking. NJAC 8:39 - 11.1 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on interview and record review, it was determined that the facility failed to accurately complete portions of the Minimum Data Set (MDS), an assessment tool to facilitate the plan of care, to accurately reflect the residents' status as of the Assessment Reference Date (ARD) for 4 of 22 residents reviewed (Resident #7, # 33, #54 and #99). The deficient practice was evidenced by the following:<br><br>1. On 3/12/26 at 11:12 AM, Surveyor #1 (S #1) observed Resident #7 asleep on an air mattress bed in their room.<br><br>On 3/16/26 at 3:38 PM, S #1 reviewed the electronic Medical Records (eMR) which revealed diagnoses which included but were not limited to metabolic encephalopathy (brain dysfunction caused by metabolic disturbances) and fracture of the right femur.<br><br>A review of the Admission/Medicare 5 Day MDS with an ARD of 10/6/25 and the Quarterly MDS with an ARD of 1/6/26, revealed a Brief Interview of Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment. Furthermore, the MDSs under section N (Medications) revealed the resident was on antidepressant and antipsychotic medications (meds); under section I (Active Diagnoses) there were no diagnoses captured for the antipsychotic and antidepressant meds.<br><br>A review of the Care Plans (CP) revealed: At risk for adverse effects related to (r/t) use of antidepression medication (med), use of antipsychotic med, date initiated on 9/30/25; At risk for behavior symptoms related to anxiety, mood disorder and depression, date initiated on 11/5/25; At risk for changes in mood related to anxiety, depression, mood disorder, date initiated on 11/5/25; [Name Redacted] has indicators of depression/sadness related to cognitive loss, date initiated on 10/9/25.<br><br>A review of the physician orders (PO):<br><br>-ordered on 9/30/25 Olanzapine Oral Tablet (tab) 2.5 mg (milligram) (brand name Zyprexa-antipsychotic), give 1 tab by mouth at bedtime (HS) for agitation;<br><br>-ordered on 10/9/25 Olanzapine Oral Tab 2.5 mg, give 1 tab by mouth at bedtime for mood disorder; and<br><br>-an order on 10/2/25 Paroxetine HCl Oral Tab 10 mg, give 2 tablets (tabs) by mouth one time a day for depression, give 2 tabs to equal 20 mg.<br><br>A review of the Psychiatric consult dated 10/2/25 and 1/22/26, revealed, to continue Paxil for depression / anxiety; continue Zyprexa for mood disorder, target symptoms were restlessness, agitation, symptoms are mild and episodic, worse at night.<br><br>2. On 3/12/26 at 11:33 AM, S #1 observed isolation signage, on the door of Resident #33's room. The door was closed. S #1 interviewed the Unit Manager (UM), who stated the door was closed due to the resident on isolation for COVID-19.<br><br>On 3/17/26 at 10:08 AM, a review of the medical records revealed diagnoses which included but were not limited to orthopedic aftercare, and unspecified fracture of upper end of right humerus.<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the Significant Change MDS with an ARD of 1/22/26, revealed a BIMS score of 15 out of 15 indicating intact cognition. The MDS reflected in section N for an antidepressant; section I reflected no diagnosis captured for depression.<br><br>A review of the CP revealed: At risk for adverse effects r/t use of anti-depression med, date initiated 11/5/25; At risk for changes in mood related to adjustment to subacute rehab, date initiated 9/5/25.<br><br>A review of the PO revealed: an order on 1/15/26, for Trazodone HCl (antidepressant), oral tab 50 mg, give 1 tab by mouth at HS for depression.<br><br>A review of the Psychiatric consult dated 12/4/25, revealed a follow-up visit to Resident #33 for adjustment with depression; Diagnoses and Plan: Adjustment disorder with depression & anxiety; Continue Trazodone for depression, may help with sleep.<br><br>3. On 3/12/26 at 11:37 AM, S #1 observed Resident #54 lying in bed, with a right arm sling and stated, they were admitted in January 2026 and therapy was going fine.<br><br>On 3/17/26 at 4:00, a review of the medical records reflected diagnoses which included but not limited to encounter for surgical aftercare following surgery on the digestive system, diverticulitis of intestine, unspecified, with perforation and abscess without bleeding.<br><br>A review of the Admission/Medicare 5 Day MDS with an ARD of 1/23/26, revealed BIMS score of 15 out of 15 indicating intact cognition. The MDS reflected in Section N antidepressant medication was captured; Section I revealed no diagnoses for the antidepressant med.<br><br>A review of the CP reflected: At risk for adverse effects r/t use of anti-depression med, date initiated 1/17/2026; At risk for changes in mood r/t symptoms of depression, date initiated 2/11/26.<br><br>A review of the PO revealed:<br><br>-Escitalopram Oxalate (brand name Lexapro-antidepressant) oral tab 5 mg, give 1 tab by mouth one time a day for depression for 1 week -start date 1/23/26.<br><br>-an order on 1/22/26 for Mirtazapine (brand name Remeron-antidepressant) oral tab 15 mg, give 1 tab by mouth at HS for depression.<br><br>A review of the Psychiatric consult dated 1/22/26, revealed a diagnosis and plan: Adjustment disorder with depression; Decrease Lexapro to 5 mg oral daily for one week, then discontinue; Remeron increase to 15 mg oral every night for depression, may help with sleep and appetite.<br><br>4. On 3/12/26 at 11:37 AM, Surveyor #2 (S #2) observed Resident #99 lying in a bed that was low to ground. S #2 interviewed the RR (resident representative) of Resident #99 about the low bed and she stated that the resident fell two times.<br><br>A review of Resident #99's admission Record or face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to type 2 diabetes mellitus (a chronic metabolic disorder characterized by high blood glucose resulting from insulin resistance and relative insulin deficiency) and abnormalities of gait and mobility (irregular, walking, or movement patterns often caused by pain, neurological diseases, or musculoskeletal (continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | issues like arthritis).<br><br>A review of Resident #99's most recent comprehensive MDS (cMDS), with an ARD of 1/15/26, reflected that the resident had a BIMS score of 00 out of 15, which indicated that Resident #99's cognition was severely impaired. Further review of the MDS reflected that the resident received an antipsychotic med. The cMDS did not indicate in Section I any active diagnosis that the antipsychotic med was ordered for.<br><br>On 3/18/26 at 11:22 AM, S #1 interviewed the Registered Nurse/MDS Coordinator (RN/MDSC) regarding the process for capturing psychotropic meds and diagnoses in the MDS assessments. The RN/MDSC stated that she reviewed psychiatry notes, meds, and checks the medical records for diagnoses. She stated she would capture the meds in Section N and the diagnoses in section I of the MDS assessment. The RN/MDSC reviewed the eMAR (electronic Medication Administration Record) and the MDSs for all the four residents and stated, Yes the MDSs were completed in error and diagnoses for antidepressants and antipsychotics should have been coded in the MDS assessments.<br><br>On 3/18/26 at 1:05 PM, the survey team met with the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and S #1 notified them of the concerns regarding Residents #7, #33, #54, and #99 diagnoses not coded in the MDS assessments for Psychotropics meds.<br><br>On 3/19/26 at 10:49 AM, the survey team met with the LNHA and the DON stated that they had no response regarding MDS inaccuracy.<br><br>On 3/19/26 at 11:46 AM, the DON stated that the facility had no policy for MDS accuracy. She further stated that the RN/MDSC told her that they follow the Resident Assessment Instrument (RAI-standardized tool used to assess resident's health, functional status and care needs) Manual.<br><br>On 3/19/26 at 11:52 AM, the LNHA did not provide additional information.<br><br>A review of the facility's Electronic Transmission of the MDS Policy, revision date October 2023, revealed under Policy Interpretation and Implementation #1. All staff members responsible for completion of the MDS receive training on the assessment, data entry .in accordance with the RAI User's Manual<br><br>NJAC 8:39-33.2(d) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview, record review, and review of other pertinent facility provided documentation, the facility failed to, a.) complete thoroughly the psychoactive medication monthly note and b.) accurately document the target behavior that was being monitored for 1 of 5 residents (Resident #81) reviewed for unnecessary medications in accordance with facility policy and standard of clinical practice.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 3/12/26 at 11:20 AM, the surveyor observed Resident #81 in their room was seated in a specialized wheelchair while watching a movie on their tablet. Afterward, in the nursing station, the surveyor interviewed the Licensed Practical Nurse (LPN) who claimed that she was the assigned nurse of the resident. The LPN further stated that the resident was able to make needs known to the staff. The surveyor reviewed the medical record for Resident #81.A review of the admission Record or face sheet (admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; hydrocephalus unspecified (excessive accumulation of cerebrospinal fluid (CSF) within the brain's ventricles, causing increased pressure, tissue damage, and potential neurological impairment), nontraumatic subarachnoid hemorrhage unspecified (bleeding in the area between your brain and the thin tissues that cover and protect it), other lack of coordination, and dysphagia oropharyngeal phase (difficulty moving food or liquid from the mouth to the throat and into the esophagus). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/3/26, revealed in Section C-Cognitive Patterns with a brief interview for mental status (BIMS) score of 10 out of 15, which reflected that resident had moderately impaired cognition. A review of the psychiatric follow up consult note dated 11/28/25 and 2/5/26, revealed that Resident #81 to continue Depakote for mood disorder NOS (not otherwise specified). Increased restlessness was noted with prior dose reduction on 6/28/23; nighttime restlessness improved after dose increase on 8/22/23. Prior GDR (gradual drug reduction) failed; persistent target symptoms present, and GDR not advised. A review of the Psychoactive Medication Monthly Note (PMMN) revealed the following:-With an effective date of 2/8/26, for month of January 2026, electronically signed by Registered Nurse #1 (RN #1), Depakote sprinkles oral capsule delayed release sprinkle 125 mg (milligram), give 2 capsules (caps) by mouth at bedtime (HS) for mood stabilizer (2 caps=250 mg). The documented targeted behavior and number of episodes for the month review was depressed mood. There was no corresponding number of episodes for the month review was documented. Date of last psychiatry consult was 11/28/25. -With an effective date of 3/10/26, for month of March 2026, electronically signed by Registered Nurse #2 (RN #2), divalproex (also known as Depakote) 250 mg by mouth at HS for mood stabilizer daily. The documented targeted behavior and number of episodes for the month review was psychosis. There was no corresponding number of episodes for the month review was documented. Date of last psychiatry consult was blank. On 3/17/26 at 11:53 AM, the Director of Nursing (DON) stated that it was the nurses who were responsible for documenting the monthly psychotropic notes in the electronic medical record. The (continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | surveyor notified the concerns regarding the PMMN that did not match the eMAR (electronic Medication Administration Record) and the psychiatric consult note targeted behavior of restlessness. The DON stated that it should match, and the effective date was the date it was done the PMMN by the nurse and the month being reviewed was the last month and not the current month. Further review of the above PMMN, the effective date 3/10/26, was for the month of March 2026, and should have been for February 2026 as per DON's information above. On 3/17/26 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON, and the surveyor notified them of the above findings and concerns regarding the resident's PMMN. On 3/19/26 at 10:49 AM, the survey team met with the LNHA and the DON who stated that with regard to Resident #81, we will tie up the loose ends to address the concerns with the PMMN. A review of the facility's Psychotropic Medication Use Policy that was provided by the DON, with a revision date of February 2025, revealed that the residents do not receive psychotropic medications that are not clinically indicated and necessary to treat specific condition documented in the medical record. Policy Interpretation and Implementation.Monitoring and Adverse Consequences: 3. Monitoring may include.behavior flow sheets, medication administration records. On 3/19/26 at 12:31 PM, the survey team met with the LNHA, Regional Nurse, and the DON for an exit conference. The LNHA and the DON did not provide additional information and did not refute the findings. NJAC 8:39-11.2(b) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>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 received necessary treatment and services, deliver a clean technique for wound treatment, and develop a care plan consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 1 resident reviewed for pressure ulcer (Resident #4).The 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 3/12/26 at 11:23 AM, the surveyor observed Resident #4 lying on air mattress bed, asleep with bilateral heel boots on. The surveyor interviewed License Practical Nurse #1 (LPN #1), who stated that the resident currently had no open wounds, but getting wound treatment on the left heel for a facility acquired wound that just recently closed.On 3/12/26 at 12:33 PM, the License Nursing Home Administrator (LNHA) provided the list of residents with a facility acquired (FA) wound. Resident #4 was listed with FA wound.A review of the electronic Medical Record (eMR) revealed diagnoses which included but were not limited to; displaced intertrochanteric fracture of left femur, orthopedic aftercare, unspecified fracture of the lower end of left radius, history of falling, Alzheimer's disease, muscle weakness (generalized), and other abnormalities of gait and mobility.A review of the Significant Change Minimum Data Set (MDS), an assessment tool, with an assessment refence date (ARD) of 12/31/25, revealed a Brief Interview of Mental Status (BIMS) score of 00 out of 15 indicating severely impaired cognition. The MDS also reflected that the resident had one Stage 3 (full thickness skin injury) and one DTI (deep tissue injury) pressure ulcers. A review of the wound consultation note revealed:-dated 12/15/25, revealed no pressure ulcer (PU).-dated 12/19/25, the pressure ulcers: left heel DTI (damaged to soft underlying tissue) and right buttock unstageable wound. T-dated 1/5/26, revealed right buttock PU resolved and left heel not healed.-dated 3/9/26 revealed, left heel chronic PU 1 cm (centimeter) x 1 cm x 0 cm, DTI non-blanchable deep red, maroon or purple discoloration, no exudate, 100% subcutaneous ecchymotic discoloration, full thickness. A review of the nursing progress note (PN) Created by the Registered Nurse (RN-wound nurse) dated 12/17/25, revealed in the note text: On observation noted stage 2 (partial thickness) pressure injury to right buttock 3 cm x 2 cm x 0.1 cm and pressure injury to left heel 4 cm x 2 cm x 0 cm. The note further stated that the physician and resident representative (RR) were notified and new orders for PU were received. A review of the physician orders (PO) revealed:-an order dated 12/15/25, air mattress and turn patient every 2 hours side to side;-an order dated 12/17/25, for skin prep dry dressing daily to left heel every-day shift for wound care;-an order dated 12/17/25, Silver Sulfadiazine external cream 1 % apply to buttocks topically every day and evening shift for wound care cleanse buttock wound with normal saline (NS), apply Silvadene, dry dressing twice a day; -an order 12/18/25, cleanse right buttock wound with NS, apply Medi honey and dry dressing daily every day shift for wound care.A review of December 2025, electronic Treatment Administration (eTAR) and nursing PN revealed no signed treatment on the eTAR for left heel PU on 12/17/25. The PN of the RN dated 12/17/25, indicated treatment rendered to left heel and heels<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | boots were applied. The eTAR revealed no signed treatment for right buttock on 12/18/25, and no PN indicating it was rendered.A review of the Care Plan (CP) revealed: Actual skin breakdown to left heel related to pressure injury, date initiated on 12/29/25, (initiated 12 days after the wound was identified). Furthermore, there was no CP initiated for the right buttock PU.On 3/16/26 at 11:22 AM, the surveyor interviewed the RN, and the Unit Manager (UM), regarding FA wound treatments and CP (including resolved care plans). The surveyor reviewed with them the eTAR for both wounds and inquired why there was no signed treatment for the left heel on 12/17/25, and right buttock no treatment administered for 12/18/25. The UM confirmed the eTAR should have been signed, and treatments should have been administered for both wounds. The UM also confirmed the CP should have been initiated earlier and stated she did not know why there was no CP for the right buttock. On 3/17/26 at 10:55 AM, the surveyor observed the wound treatment to the left heel, in attendance was Licensed Practical Nurse #2 (LPN #2) assisted by the Certified Nursing Assistant (CNA). LPN #2 stated that the left heel was not open, it was a DTI, and the right buttock wound had been healed. The surveyor observed the CNA brought two boxes of gloves, a container of disinfectant and ABHR (alcohol base hand rub) container in the resident's room and placed it on the disinfected over bed, bedside table. The surveyor observed during the treatment preparation LPN #2 performed hand washing. LPN #2 applied soap on both hands first before wetting both hands, rubbed hands together in the sink, and observed both hands with minimal soap suds. The surveyor observed the CNA at the conclusion of the wound treatment, removed the disinfectant container, two boxes of gloves and ABHR container from the over bed table and proceeded to place the items on top of the treatment cart, outside the resident's room without disinfecting them. On 3/17/26 at 11:39 AM, the surveyor reviewed the hand-washing process and wound treatment with LPN #2 and she confirmed, she did not know the process for handwashing was to wet her hands first before applying soap. LPN #2 also stated during wound treatment, what comes in the resident's room should not come out. LPN #2 confirmed the box of gloves, container of disinfectant and ABHR bottle were not disinfected before returning them to the treatment cart.On 3/17/26 at 11:47 AM, the UM responded regarding the late and missing CP. The UM stated that she did not know why the right buttock CP was not done. The UM stated regarding the late CP for the left heel, according to the nursing administration, You have leeway and time to do the CP. On 3/17/26 at 1:30 PM, the UM provided a resolved CP of the sacrum but not for the right buttock. The surveyor asked the UM what the expectation for services-wound treatments that were rendered, and she replied Yes it should be signed by the nurse. The surveyor reviewed with the UM the discrepancy of the timeline that was provided regarding the resident's wounds which indicated the left heel was identified on 12/19/25. According to the wound nurse PN, it was identified on 12/17/25. The UM had no response.On 3/18/26 at 1:05 PM, the survey team met with the LNHA and Director of Nursing (DON), and the surveyor notified them of the above concerns regarding wound treatment, hand washing procedure, documentations, and CP.On 3/19/26 at 10:49 AM, survey team met with the LNHA and the DON confirmed that the timeline did not coincide with the date of the incident which the report indicated both wounds were identified on 12/17/25. The DON further stated regarding the missing signatures in the eTAR, according to her conversation with the nurse who stated she did not know what happened, but patient did not have a delay in treatment. On 3/19/26 at 11:52 AM, in presence of survey team, the LNHA and DON provided no additional information.A review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol Policy, with revision date April 2018, revealed under Assessment and Recognition #2 . the nurse shall document d.) Current treatments .A review of the facility's Handwashing/Hand Hygiene Policy, revised in December 2025, revealed under Procedure, Washing Hands #1. Wet hands first with warm (not hot) water, then apply the amount of soap product recommended by the manufacturer to hands .A review of the facility's Care Plans, Comprehensive Person-Centered Policy, with revision date March 2022, revealed under Policy Interpretation and Implementation #7. The comprehensive, person-centered CP b.) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical well-being. #11. CP are<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revised as information about the residents and the residents' conditions change. #12. The interdisciplinary team reviews and updates the CP .NJAC 8:39-25.2(c), 27.1(a)(c) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure that a new intervention was implemented and documented in the resident's care plan, in a timely matter, after a resident's fall, in order to prevent any additional falls for 1 of 1 resident reviewed for falls (Resident #99).This deficient practice was evidenced by the following: On 3/12/26 at 11:37 AM, the surveyor observed Resident #99 lying in a bed that was low to ground. The surveyor interviewed Resident Representative (RR) about the low bed and she stated that the resident fell two times. On 3/12/26 at 1:43 PM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for any incidents/investigations that Resident #99 had since admission. A review of Resident #99's admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to type 2 diabetes mellitus (a chronic metabolic disorder characterized by high blood glucose resulting from insulin resistance and relative insulin deficiency) and abnormalities of gait and mobility (irregular, walking, or movement patterns often caused by pain, neurological diseases, or musculoskeletal issues like arthritis). A review of Resident #99's most recent comprehensive Minimum Data Set (cMDS), with an Assessment Reference Date (ARD) of 1/15/26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated that Resident #99's cognition was severely impaired. On 3/16/26 at 10:25 AM, the surveyor reviewed the facility provided five fall incidents which included the following: 1. 1/11/26, Resident #99 observed laying on floor in lounge area. Attached was a Progress Note (PN) dated 1/20/26, IDCP team met care plan (CP) updated with intervention of medication (med) review. The intervention was implemented nine days after the fall. 2. 1/15/26, Resident #99 observed sitting on floor in shower was left in front of door to retrieve shower items. Attached was a PN dated 1/20/26, IDCP team met CP updated with intervention of not be left unattended in the shower. The intervention was implemented five days after the fall. 3. 1/23/26, Resident #99 found sitting on floor. Attached was a PN dated 1/27/26, IDCP team met plan of care was appropriate and will continue with plan of care. There was no new intervention implemented. 4. 2/9/26, Resident #99 seen walking and fell down. Attached was a PN dated 2/10/26, IDCP team met and CP updated with intervention of psych (psychiatric) consult. 5. 2/13/26, Resident #99's chair alarm sounding pt (patient) slid from the chair to floor. Attached was a PN dated 2/20/26, IDCP team met and CP updated with intervention of dycem (a non slip mat) to wc (wheelchair). The intervention was implemented seven days after the fall. A review of Resident #99's individualized CP included a focus area of at risk for falls due to unsteady gait with an initiated date of 1/9/26, which included the following interventions initiated on that date:Therapy evaluation and treatment as ordered; Encourage to transfer and change positions slowly; Have commonly used articles within easy reach; Provide assistance to transfer and ambulate as needed.The following interventions were initiated 1/19/26, (Resident #99 had a fall on 1/11/26 and 1/15/26): Reinforce the need to call for assistance; Report development of pain, bruises, change in mental status/ADL (activities of daily living) function, appetite, or neurological status per facility guidelines; Bed alarm-tab; Chair alarm-tab.The following intervention was initiated 1/20/26: Med review.The following intervention was initiated 2/10/26: Psych eval.The following intervention was initiated 2/20/26 (Resident #99 had the 5th fall on 2/13/26): dycem to wc.The CP did not indicate that the resident had any actual falls. The intervention of not to be left unattended was not included on the CP. The interventions added were not implemented until several days after each fall. On 3/16/26 at 11:44 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that when a resident had a fall, the nurse did an incident/risk management in the computer and that she thought the unit manager updated the CP. On 3/16/26 at 11:54 AM, the surveyor interviewed the Unit Manager (UM) who stated that after a fall the nurse documented a nurse note and risk management. She added<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that the multidisciplinary team met and decided on an intervention. The UM stated that an intervention was done immediately to try to prevent any further falls and added to the CP. The UM stated that a discussion was done with supervisor, Assistant Director of Nursing (ADON) and Director of Nursing (DON) to come up with an initial intervention usually the next morning. On 3/17/26 at 1:40 PM, the surveyor interviewed the DON regarding the process for falls. The DON stated that the resident was assessed and if there was no injury transferred to the bed or chair. She added that if an injury, they would call 911. The DON stated that the physician and RR were notified. The DON stated that the nurse documented the fall in an incident report and that linked into a PN. The DON stated that an investigation and root cause analysis was done and that a new intervention was put in place, to prevent further falls, after the team met which was usually the following day. The DON stated that the CP was updated. On 3/18/26 at 1:12 PM, the surveyor notified the LNHA and DON the concern that Resident #99 had 5 falls and that for three of the falls the intervention was not implemented until several days later and the 3rd fall did not have a new intervention implemented to prevent further falls. On 3/19/26 at 11:03 AM, in the presence of the LNHA, the DON stated that the interventions were delayed along with CP being updated and that they initiated a QAPI (quality assurance performance and improvement) and risk management will be reviewed daily. The LNHA stated that the facility did not have a policy related to actual fall. The LNHA did not provide any additional information. A review of the facility's Fall Risk Assessment Policy with a revised date of March 2018, included the following Policy Statement, the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff and others, will seek to identify and document resident risk factors for falls and establish a resident-centered prevention plan based on relevant assessment information.Policy Interpretation and Implementation .3. The nursing staff, attending physician, and consultant pharmacist will review for medications or med combinations that could relate to falls or fall risk, such as those that have side effects or dizziness, ataxia, or hypotension.9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. A review of the facility's Accidents and Incidents-Investigating and Reporting Policy with a revised date of July 2017, included the following Policy Statement, all accidents or incidents involving residents,.occurring on our premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation 1. The nurse supervisor/charge nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following date, as applicable, shall be included on the Report of Incident/Accident form: k. Any corrective action taken: l. Follow-up information; m. Other pertinent data as necessary or required. N.J.A.C. 8:39-27.1 (a) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure residents who received enteral feeding received care in accordance to standard of practice by failing to document the actual total volume infused, plotted an order for flush accurately, and clarified a continuous order for enteral feed for 1 of 1 resident (Resident #12) reviewed for enteral feeding.This deficient practice was evidenced by the following:On 3/12/26 at 10:46 AM, the surveyor observed Resident #12 in bed with their head of bed elevated receiving enteral feed via pump at 50 ml/hr (milliliters/hour). The pump indicated that the total enteral feed received was 877 ml and there was 323 ml left to be infused. On 3/18/26 at 9:28 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #12's enteral feed was hung in the evening and that it was finished when the total volume (TV) of 1200 ml was finished. The LPN stated that there was an order for TV each shift. On 3/19/26 at 10:54 AM, the surveyor reviewed Resident #12's medical record.A review of Resident #12's admission Record or face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to gastrostomy (a feeding tube placed through the abdomen into the stomach, used to deliver nutrition, fluids, or medication, or for stomach decompression) and down syndrome (a genetic condition caused by an extra copy of chromosome 21 (Trisomy 21), leading to mild-to-moderate intellectual disabilities, delayed development, and distinct physical traits like a flattened face). A review of Resident #12's most recent comprehensive MDS (cMDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated that Resident #99's cognition was severely impaired. Further review of the cMDS reflected that the resident had a feeding tube. A review of Resident #12's March 2026 electronic Medication Administration Record (eMAR) included the following orders:Enteral Feed Order every shift Flush enteral tube q (every) 6 hours with 125 of ml with a start date of 1/24/26. The order did not indicate what fluid was to be used. The administration was plotted for three times a day and not q 6 hours. Enteral Feed Order every shift Formula Type: Jevity 1.2 Rate: 50 ml/hr Total Nutrient: 1200 ml Total Calories : 1440 CAL (calorie) Start at 4 PM (4:00 PM) and run until 1200 ml has infused Tube Type: Peg tube with a start date of 1/24/26. The nurses signed as administered, but did not indicate the TV that was infused each shift. On 3/19/26 at 11:18 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), the concern that Resident #12's orders were not clarified, the TV was not documented each shift, that the resident was not able to receive the TV of 1200 ml in a 24 hour period, and that the flush order was not plotted q 6 hours. On 3/19/26 at 11:55 AM, in the presence of the LNHA, the DON stated that the nurses signed off that 1200 ml were infused in 24 hours. The DON stated that she amended the flush order after surveyor inquiry and that the flush was not manual and that it was programmed in the pump. The surveyor asked how the resident received 1200 ml in 24 hours when the enteral feed would have to be stopped for two hours when the resident received care. The LNHA stated that they understood. The LNHA did not provide any additional information. A review of the facility's Enteral Nutrition Policy with a revised date of November 2018, included the following Policy Statement, adequate nutritional support through enteral nutrition is provided to residents as ordered. Policy Interpretation and Implementation .3. Enteral nutrition is ordered by the provider based on the recommendations of the dietician.8. The dietician monitors residents who are receiving enteral nutrition, and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. 9. The nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition, altered hydration, hypo-or hyperglycemia, and altered electrolytes. The nursing staff and provider also monitor the resident for worsening of conditions that place the resident at risk for the above.The policy did not contain information about documenting amount infused. N.J.A.C. 8:39-17.4(a)1 |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily for 2 of 5 days. This failure could affect the knowledge of the availability of staff to care for the residents, resident representative, and visitors.This deficient practice was evidenced by the following: On 3/12/26 at 8:19 AM, upon entry into the facility, the surveyor observed a posted Nursing Home Resident Care Staffing Report (NHRCSR) that was posted in the reception area of the lobby, dated 3/11/26, for Day Shift 7:00 AM (7 AM)-3:00 PM (3 PM), for Evening Shift 3 PM-11:00 PM (11 PM), and for night shift 11 PM-7 AM. The NHRCSR reflected current census (total number of residents) of 74 in all shifts. The ratio of Certified Nursing Aide to Residents for 7 AM-3 PM shift was 1:8.2. On that same date and time, the Receptionist informed the surveyor that the visiting hours was from 8:00 AM to 8:00 PM. On 3/12/26 at 8:45 AM, the Director of Nursing (DON) confirmed that the facility's census was 74. On 3/16/26 at 9:25 AM, the surveyor entered the facility and observed the posted sign for NHRCSR dated 3/16/26, Day Shift, Evening Shift, and Night Shift with census of 75. On 3/16/26 at 12:51 PM, the surveyor reviewed the Midnight Census report provided for 3/16/26, revealed that the census was 74, and the Regional Nurse confirmed that the census was 74. The 3/16/26 posted census of 75 did not match the midnight census reported by the Regional Nurse. On 3/17/26 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON, and the surveyor notified them of the above findings and concerns regarding the posted NHRCSR for two days observations. On 3/19/26 at 10:49 AM, the survey team met with the DON and the LNHA who stated, regarding the posting, it would be posted according to the regulation. The LNHA further stated that I was reconciling the census and the posted NHRCSR, yes it should be posted as 74 not 75 on 3/16/26. A review of the facility's Posting Direct Care Daily Staffing Numbers Policy that was provided by the DON, with a revision date of August 2022, revealed under policy statement that the facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementations, 1. Within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care is posted in a prominent location and in a clear and readable format. 2.The information recorded on the form shall include the following: a. The name of the facility; b. the current date; c. The resident census at the beginning of the shift for which the information is posted. On 3/19/26 at 12:31 PM, the survey team met with the LNHA, Regional Nurse, and the DON for an exit conference. The LNHA and the DON did not provide additional information and did not refute the findings. N.J.A.C. 8:39-41.2 (a)(b)(c) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to ensure that a resident received a monthly medication review (MMR) from a pharmacy consultant (PC) for 1 of 5 residents reviewed for unnecessary medication (Resident #99). This deficient practice was evidenced by the following:On 3/12/26 at 11:37 AM, the surveyor observed Resident #99 lying in a bed that was low to ground. The surveyor interviewed the Resident Representative (RR) about the low bed and she stated that the resident fell two times. A review of Resident #99's admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to type 2 diabetes mellitus (a chronic metabolic disorder characterized by high blood glucose resulting from insulin resistance and relative insulin deficiency) and abnormalities of gait and mobility (irregular, walking, or movement patterns often caused by pain, neurological diseases, or musculoskeletal issues like arthritis). A review of Resident #99's most recent comprehensive Minimum Data Set (cMDS), with an Assessment Reference Date (ARD) of 1/15/26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated that Resident #99's cognition was severely impaired. Further review of the MDS reflected that the resident received an antipsychotic medication (med). A review of the PC binder for 2026 reflected that an Electronic Pharmacist Information Consultant (EPIC) review was done on 1/9/26, for the initial admission review of med orders. Further review of the binder did not reflect any other MMR done during the resident's stay. A review of Resident #99's medical record reflected a Progress Note dated 3/9/26 that the PC completed an MRR. There was no documented evidence that the PC completed a MRR for the month of February 2026. On 3/17/26 at 1:52 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the PC reviewed residents on 1 unit on 1 day and that would return another day to do the other unit. The DON stated that when the PC was on Resident #99's unit in February, the resident was in the hospital and returned to the unit after the PC left. On 3/18/26 at 1:11 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON, the concern that Resident #99 did not have a MMR for the month of February 2026. On 3/19/26 at 11:00 AM, in the presence of the LNHA, the DON stated that Resident #99 did not have a MMR in February because the resident was in the hospital on the day that the PC was here. The DON stated that she would have a conversation with the PC. The LNHA did not provide any additional information. N.J.A.C. 8:39-29.3 |

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| | 315313 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Careone at Cresskill | 221 County Road<br>Cresskill, NJ 07626 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that all medications (meds) were administered without error of 5% or more during medication (med) administration, 3 nurses administered meds to 3 residents. There were 25 opportunities for error, 2 errors were observed which calculated to a med administration error rate of 8%. This deficient practice was identified for 1 of 3 residents, (Resident #79), that was administered meds by 1 of 3 nurses that were observed.The 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 3/12/26 at 8:56 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare meds for Resident #79. The meds included active physician's orders (PO) for PreserVision capsule (cap) 1 cap by mouth twice daily for supplement (a specialized vitamin supplement) and Probiotic oral cap (Saccharomyces boulardii) 1 cap by mouth once daily for GI (gastrointestinal) PPX (prophylaxis). (a strain of beneficial bacteria used for gut health). The surveyor observed the LPN select and prepare from a bottle labeled multivitamin with minerals tablets (tabs) and a bottle labeled Probiotic Acidophilus capsules (caps). The surveyor asked the LPN if the multivitamin with minerals was the same as PreserVision cap. The LPN stated, oh, these are tabs. The surveyor asked the LPN if the Probiotic Acidophilus matched what the order on the electronic medication administration record (eMAR) displayed. The LPN stated that it looked like they may be different. The surveyor concluded the observation. The surveyor reviewed the electronic medical record (EMR) for Resident #79. The EMR revealed the following:A review of the admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to osteoarthritis (a chronic degenerative joint disease) and osteoporosis (a chronic bone disease characterized by weak, fragile bones). A review of Resident #79's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 1/27/26, had a Brief Interview Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the Order Summary Report (OSR), for active orders as of 3/13/26, which reflected orders for Acidophilus Probiotic oral tablet (tab) and PreserVision oral tab. A review of Resident #79's eMAR revealed orders for Acidophilus probiotic oral tab and PreserVision oral tab administered on 3/12/26. On 3/16/26 at 1:42 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. On 3/16/26 at 3:38 PM, the surveyor interviewed the facility Consultant Pharmacist (CP) by phone. The surveyor asked the CP if PreserVision were equivalent to regular multivitamins with minerals. The CP stated that they were unsure if they were interchangeable. The surveyor asked if Saccharomyces boulardii was the same as Acidophilus. The CP stated that they were both probiotics, but they were different types. On 3/17/26 at 1:28 PM, the DON stated that both orders were corrected and clarified, and the staff were educated with regard to surveyor's concerns during med pass. The LNHA provided no further pertinent information. A review of the facility's Administering Medications Policy, dated<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4/2019, reflected, under 4. Medications are administered in accordance with prescriber orders. Under 10.verify.right med.before giving the med. N.J.A.C 8:39-29.2 (d) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication (med) per manufacturer specifications and standards of practice. This deficient practice was identified in 2 of 4 med carts observed in the facility.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 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 3/12/26 at 11:40 AM, the surveyor began to inspect selected med storage areas in the facility. The surveyor observed the following: The surveyor in the presence of Licensed Practical Nurse (LPN) inspected the northwest med cart. The surveyor observed a sealed foil package containing the med albuterol/ipratropium inhalation solution vials (a med used to treat wheezing and shortness of breath). The foil package did not contain a label from the dispensing pharmacy. Other identical foil packages were contained in a box with a label. The surveyor did not observe any box that the med would normally be in. The surveyor asked the LPN if the med should have a label. The LPN stated yes, it should have one or a box it came in. The surveyor asked the LPN if there was a box in the med cart. The LPN stated they could not locate one. The LPN removed the foil pouch from the med cart and disposed. On 3/12/26 at 12:08 PM, the surveyor in the presence of the Registered Nurse (RN) inspected the northeast med cart. The surveyor observed a plastic bag with a Humalog insulin pen (insulin pen) (a disposable device containing a drug that is used to treat diabetes or high blood sugar) inside. The surveyor did not observe a date of first use or disposal date written on the bag or the label on the device. The label on the device reflected that it was dispensed by the pharmacy on 1/27/26. The surveyor asked the RN if the insulin pen should have a date it was placed in the med cart. The RN stated yes it should have. The RN removed the insulin pen from the med cart and disposed of it. The RN stated they would order a new one. The surveyor concluded the observation. On 3/16/26 at 1:42 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. On 3/16/26 at 3:38 PM, the surveyor interviewed the facility Consultant Pharmacist (CP) by phone. The surveyor asked the CP if all medications (meds) should have a pharmacy label. The CP stated yes. The surveyor asked if insulin pens should be dated when put in the med cart. The CP stated yes, the facility has an informational sheet with the dating procedure. On 3/17/26 at 1:28 PM, the DON provided responses for the med storage and labeling concerns. The DON stated the meds were immediately removed and staff education provided. The LNHA did not provide any further pertinent information. A review of the facility's Medication Labeling and Storage Policy, dated 2/2023, reflected under Medication Storage 1. Meds.are stored in the packaging.in which they are received. Under Medication Labeling 5. Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. NJAC 8:39-29.4(a)(h) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Complaint #2632945Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain medical records that were accurate for 1 of 22 residents (Resident #96) reviewed. This deficient practice was evidenced by the following: On 3/16/26 at 11:00 AM, the surveyor reviewed the closed hybrid (electronic and paper) medical record of Resident #96. A review of Resident #99's admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to hypertensive heart disease (heart damage caused by long-term high blood pressure, leading to structural changes like left ventricular hypertrophy, coronary artery disease, and heart failure) and acute myeloblastic leukemia (an aggressive, fast-growing cancer of the blood and bone marrow that produces abnormal, immature white blood cells). A review of the facility grievance binder included the following grievance:-9/27/25, the Resident Representative (RR) complained that 1 to 1 was late on Friday night (9/26/25).Attached to a different grievance dated 9/26/25, which complained that the call bell was unplugged and folded neatly on the residents chair when the RR arrived, was a schedule dated 9/26/25, 9/27/25, and 9/28/25. The schedule had one CNA (Certified Nursing Aide) name listed on for 8:00 PM-10:00 PM (10 PM) and another CNA listed on 10 PM-8:00 AM.A review of the North Station CNA assignment sheet for 9/26/25 to 9/28/25, did not indicate any resident having a 1 to 1. A review of Resident #96's comprehensive care plan (CP) did not reflect that the resident was on a 1 to 1. A review of Resident #96's progress notes (PN) did not reflect any documentation that the resident was on a 1 to 1. On 3/16/26 at 11:49 AM, the surveyor interviewed the Licensed Practical Nurse who stated that if a resident was not safe, getting up and tried to leave that they would do a 1 to 1 and that they would take turns. She added that she was not sure if it would be in the CP. On 3/18/26 at 10:34 AM, the surveyor interviewed the Unit Manager (UM) who stated that 1 to 1 was only in an acute situation if suicidal and usually the resident was transferred to the hospital. She added that it would be documented somewhere, it would be in the PN. The surveyor asked if would be in the CP. The UM stated that it should be. On 3/18/26 at 10:54 AM, the surveyor interviewed the Director of Nursing (DON) regarding 1 to 1. The DON stated that a 1 to 1 would be provided if a resident had suicidal ideation or hurt themself. She added that if someone needed it that the RR would provide it. The DON stated that they asked us who they could get. The DON stated that if someone was on 1 to 1 for safety that it would be documented. The DON stated that if 1 to 1 was physically needed then it should be in the CP. On 3/18/26 at 11:20 AM, the surveyor interviewed the UM regarding the grievance of Resident #96's 1 to 1. The UM stated that she could not remember but that it looked like the RR was going to provide the 1 to 1 to the resident and that the facility assisted with the 1 to 1 very temporarily. The surveyor asked the UM why the resident needed 1 to 1. The UM stated that she thought it was just the RR's request. The surveyor asked the UM why it was not documented in the medical record. The UM stated that the documentation was schedule of the 1 to 1. The surveyor asked if a schedule was part of the medical record. The UM stated that it might be but that she was not sure. On 3/18/26 at 1:16 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #96 did not have any documentation in the medical record or a CP for the 1 to 1 that was provided by the facility and the concern that if the 1 to 1 was for safety reasons that it was not provided for a short period time. The surveyor asked the LNHA for a policy regarding 1 to 1. The LNHA stated that they did not have a policy. On 3/19/26 at 11:04 AM, in the presence of the LNHA, the DON stated that that they contacted the previous administration who told them that the 1 to 1 that was provided was a matter of customer service, and that it had nothing to do with the resident's safety. The surveyor asked if they consider that part of the care of the resident and if it should have been in the CP. The DON stated that she would have to find out and stated that it was just a companion for the resident to adjust to the new room. The LNHA stated that (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | we understood the surveyor's concern and that what they could gather from the previous staff was that they did not have their documentation tied up. The LNHA did not provide any additional information.NJAC 8:39-35.2(a),(e),(f) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on interview, review of medical record, and review of other pertinent facility documents, it was determined that the facility failed to offer residents an influenza vaccine or document the refusal and reason for ineligibility for the vaccine for 1 of 5 residents reviewed for unnecessary medications (Resident #81).The deficient practice was evidenced by the following:Reference:According to the Centers for Disease Control (CDC) and Prevention, Public Law, dated 5/16/24, Influenza Vaccination Laws for State Long-Term Care Facilities, Flu vaccination laws for patients in long-term care facilities, All long-term care facilities.In New Jersey, long-term care facilities must document evidence of annual vaccination against influenza for each resident. On 3/12/26 at 11:20 AM, the surveyor observed Resident #81 in their room was seated in a specialized wheelchair while watching a movie on their tablet. The surveyor reviewed the medical record for Resident #81.A review of the admission Record or face sheet (admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; hydrocephalus unspecified (excessive accumulation of cerebrospinal fluid (CSF) within the brain's ventricles, causing increased pressure, tissue damage, and potential neurological impairment), nontraumatic subarachnoid hemorrhage unspecified (bleeding in the area between your brain and the thin tissues that cover and protect it), other lack of coordination, and dysphagia oropharyngeal phase (difficulty moving food or liquid from the mouth to the throat and into the esophagus). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/3/26, revealed in Section C-Cognitive Patterns with a brief interview for mental status (BIMS) score of 10 out of 15, which reflected that resident had moderately impaired cognition. A review of the Immunizations tab in the electronic medical records (EMR) revealed that the last influenza vaccine was administered and completed was on 10/26/23. A review of the Influenza and Pneumococcal Vaccine Consent and Tracking Form that was in the resident's paper chart included previous years consent forms, with the most recent dated 10/24/23, which it was a telephone consent received from the Resident Representative (RR). The consent form also included information of the influenza vaccine date administered on 10/26/23, manufacturer, lot number, expiration date, site administered, and nurse signature. There was no consent form for 2024, 2025, and 2026 to show that the RR was notified to obtain consent to either accept or decline the influenza vaccine. Further review of the medical records revealed that there was no documented evidence that the resident received or declined the influenza vaccine. On 3/19/26 at 8:34 AM, the surveyor reviewed the paper chart of the resident in the presence of the Licensed Practical Nurse (LPN) in the nursing station, and both did not see Influenza and Pneumococcal Vaccine Consent and Tracking Form for 2024, 2025, and 2026. Both the surveyor and the LPN saw the last consent was on 10/24/23. The LPN confirmed after reviewing the EMR, and stated that the immunization record in the EMR and paper consent both matched the information which last consent obtained on 10/24/23. At that same time, the LPN informed the surveyor it was the responsibility of the IPN (Infection Preventionist Nurse) to obtain consent and should be in the chart. On 3/19/26 at 8:37 AM, the surveyor notified the Director of Nursing (DON) of the above findings and concerns that there was no consent forms signed by the RR for flu vaccine and there was no documented evidence that the resident received and/or declined the vaccine. The surveyor asked for the IPN, and she stated that she would get back to the surveyor. On 3/19/26 at 8:50 AM, the surveyor interviewed the Registered Nurse/IPN (RN/IPN) who stated that she started working at the facility in December 2026. The RN/IPN further stated that the flu season started October 1st and ends March 31st, and flu vaccine to be given at that time. She also stated that it was the responsibility of the nurses and me to acquire consents for flu and other vaccines. She added that the consent should be in the resident's chart, and I document in the EMR if I obtain consent and or attempted consent. She informed the surveyor that she pulled out information from the EMR when tracking the immunization records of the residents in the facility. At that same time, the surveyor<br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | notified the RN/IPN of the concern that Resident #81 did not have consent signed either decline or accepted the flu vaccine and the last consent was obtained on 10/24/23. She responded that she remembered attempting to call the RR and was unable to reach them. The surveyor then asked if she documented it, and she stated she would get back to the surveyor. She confirmed also that she was responsible for the 2025 consent, and not the 2024, because she started here in December 2025. She further stated that she was unsure what had happened on 2024 consent. On 3/19/26 at 9:12 AM, the RN/IPN provided a copy of the printed immunization report with date range of 9/1/25-3/31/26, of all residents, and she stated that Resident #81 was not included on the list. She further stated that she was unable to locate documentation that she contacted the RR for consent. The surveyor asked for 2024 immunization report for the resident and if there were documentation that the RR was contacted to obtain consent for flu vaccine and she responded that she would get back to the surveyor. On 3/19/26 at 9:41 AM, the RN/IPN informed the surveyor that she could not find any documents or records that the RR was contacted to obtain consent for flu vaccine, and there was no information that the resident had flu vaccine received in 2024 and 2025. On 3/19/26 at 10:49 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON, and the surveyor notified the LNHA and DON concern with Resident #81's flu vaccine consent was not obtained and not administered. A review of the facility's Influenza Vaccine Policy that was provided by the Regional Nurse, with a revision date of August 2025, revealed under Policy Statement, between October 1st and March 31st each year, the influenza vaccine is offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. Policy Interpretation and Implementation.6. Before receiving the influenza vaccine, the individual (or their representative) receives information and education regarding the risks, benefits, and potential side effects of the vaccine.10. The resident (or representative) has the right to refuse vaccines. If refused, the date of and stated reason for the refusal of the vaccine are documented in the resident's medical record.12. Administration of the influenza vaccine is made in accordance with current Advisory Committee on Immunization Practices (ACIP) and CDC recommendations at the time of the vaccination.15. Residents and staff may obtain their influenza vaccines from their personal physicians. Documentation of influenza vaccination must be provided to the facility. 16. The infection preventionist maintains surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff. On 3/19/26 at 11:52 AM, the survey team met with the DON and the LNHA stated that they were unable to locate Resident #81's immunization consents for 2024 and 2025. Both the LNHA and DON stated that there was no additional information to provide. NJAC 8:39-19.4 (a)(d)(h) |