STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315321	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preferred Care at Old Bridge, LLC	6989 Rt18 Old Bridge, NJ 08857

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint NJ# 420827Based on observations, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to ensure that a.) resident's call bells were within reach and could be activated for assistance with their needs, and b.) resident's needs were met in a timely manner once the call bell was answered. This deficient practice was identified for 3 out of 9 residents (Resident's #4, #6 and #7) reviewed for reasonable accommodation of needs. This deficient practice was evidenced by the following: 1. On 10/23/25 at 9:20 AM, the surveyor observed Resident #6 in bed. When the surveyor inquired about the residents call bell, they stated, I do not have a call light. The resident further stated that if they required assistance, they used their wheelchair to go to the hallway to find/alert staff. The surveyor reviewed the electronic medical record (EMR) for Resident #6. A review of the admission Record reflected that Resident #6 had diagnoses which included but were not limited to, unspecified dementia without behavioral disturbances and chronic obstructive pulmonary disease. A review of a Quarterly Minimum Data Set (MDS) dated [DATE], a tool used for the management of care, reflected a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated cognitive impairment. A review of the Care Plan Report dated 8/25/25, had a Focus for falls related to poor safety awareness, unsteady gait, and diagnosis of convulsions. Interventions included ask for assistance when attempting to transfer; and Keep call light within easy reach. On 10/23/25 at 11:30 AM, the surveyor accompanied the Licensed Practical Nurse (LPN) / Unit Manager (UM) #1 to Resident #6's room. The LPN/UM #1 confirmed the residents call bell was not accessible. In the presence of LPN/UM #1, the surveyor asked Resident #6 if they could activate the call bell. The resident stated that they did not have a call bell. The call bell was not visible nor accessible. The LPN/UM #1 traced the call bell from the wall and observed that the call bell was tied underneath the mattress on the bedframe. The surveyor then asked the LPN/UM #1 if Resident #6 could activate the call bell, the UM stated, No. The surveyor then asked the LPN/UM #1 who was responsible to ensure residents call bells were accessible and within easy reach. The LPN/UM #1 stated the Certified Nursing Assistant (CNA) and the nurses were responsible. She stated that she verbally reminded the CNAs daily to ensure residents call bells were within reach prior to exiting the room after they provided care. (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/25 at 11:50 AM, during an interview with the CNA assigned to Resident #6, she stated that she was not aware that the resident did not have their call bell within reach. 2. On 10/23/25 at 8:37AM, the surveyor observed Resident #4 lying in bed. Resident #4 was awake and alert. The call bell cord was observed coming from the wall jack and going behind a privacy curtain gathered against the wall. The resident stated they had to go to the bathroom but did not know where their call bell was. On 10/23/25 at 8:41AM, the surveyor, in the presence of a second surveyor, requested CNA #1 to accompany the surveyors to Resident #4's room. CNA #1 acknowledged that Resident #4's call bell was behind the privacy curtain and was out of sight and out of reach. CNA #1 lifted the call bell cord and guided the button end of the cord to Resident #4's bed. CNA #1 laid the call bell button on the bed on the resident's left side near their upper arm. The resident stated Where is it? I still can't reach it. I can't see it. I have a blind spot on my left side. CNA #1 then moved the call bell button to the resident's right hand. The resident told the CNA they needed to go to the bathroom. CNA #1 said OK and left the room at 8:43AM. On 10/23/25 at 8:49AM, the surveyor, in the presence of a second surveyor, returned to Resident #4's room. Resident #4 stated that nobody had taken them to the bathroom. The surveyor interviewed CNA #1 who stated that when a resident tells you they need to go to the bathroom, you take them. CNA #1 acknowledged that Resident #4 stated they needed to go to the bathroom and acknowledged he did not take the resident. CNA #1 further stated that Resident #4 was not on his assignment. The surveyor reviewed the EMR for Resident #4. A review of the admission Record reflected that Resident #4 was admitted with diagnoses that included but were not limited to unspecified sequelae of cerebral infarction, urinary tract infection, retention of urine, and muscle weakness (generalized). A review of the admission MDS dated [DATE], included a BIMS score of 13 out of 15 which indicated Resident #4 was cognitively intact. A review of the Care Plan Report reflected a Focus dated 8/21/25, which indicated the resident required assistance with ADL functions. In addition, the care plan report reflected the intervention keep call light within easy reach dated 8/21/25. 3. On 10/23/25 at 8:52AM the surveyor, in the presence of a second surveyor, observed Resident #7 in their room with the door open. Resident #7 looked in the hall, waved and told the surveyors to come in. Resident #7 stated that when staff responded to their call bell they would turn the call bell off so it stops ringing. But they leave and never come back to do what you needed. The surveyor reviewed the EMR for Resident #7. A review of the admission Record reflected that Resident #7 was admitted with diagnoses that included but were not limited to unilateral primary osteoarthritis left knee, and hereditary and idiopathic neuropathy, unspecified. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Quarterly MDS dated [DATE], included a BIMS score of 15 out of 15 which indicated Resident #7 was cognitively intact. A review of the Care Plan Report revealed a Focus dated 11/6/20, which reflected the resident required assistance with ADL functions. In addition, the care plan report reflected the intervention keep call light within easy reach dated 11/6/20. On 10/23/25 at 12:45 PM, the surveyor interviewed CNA #2 who stated that the call bell system alerts as a light above the residents room and a sound that can be heard in the hallway. She further stated that the residents room and bed number could also be seen on a monitor at the nurses' station. CNA #2 stated that upon entering the resident's room, the call bell was turned off and if it was her resident, she would see what they needed. CNA #2 also stated, If it's not my resident I go and get the aid. In addition, CNA #2 stated the CNAs should respond to the resident right away. On 10/23/25 at 12:50 PM, the surveyor interviewed LPN/UM #2 who stated that the process for answering call bells was to ask what the resident needs; then either do it or leave to get the staff that can do it. For example, if a resident needs pain medicine the CNA would get the nurse. LPN/UM #2 stated that staff should then go back to the resident to tell them someone was coming. LPN/UM #2 stated that everybody can answer a call bell. Sometimes they can do what the patient needs, but sometimes they have to get someone else. LPN/UM #2 stated that call bells needed to be in reach at all times, which meant the resident was able to press it with their dominant side or whatever's easiest. A review of the facility's policy titled, Call Bell last revised 1/2025 revealed the following: Purpose Residents will have a functioning call bell to alert staff of their needs. Procedures #1 Call bell functioning will be checked on a regular basis by Nursing and Maintenance. #7 When making beds and tidying resident rooms, call bell will be left in a standard place in all rooms: attached to a partial side rail or the top of the bed. The Nursing Assistant leaving the room must ensure that the call bell is in place regardless of the residents' ability to use it. #9 The Nursing Assistants will ensure that the call bell is within the resident's reach before leaving the room. NJAC 8:39-31.8(c)(9)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint NJ#'s 420827, 2636492Based on observation, interviews, record review and review of pertinent facility documents it was determined that the facility failed to provide appropriate assistance with toileting needs and personal hygiene care for 4 of 6 residents (Residents #5, #8, #9, and #4) reviewed for Activities of Daily Living (ADL). This deficient practice was evidenced by the following:1. On 10/23/25 at 8:45 AM, Surveyor #1 observed Resident #5 sitting in a chair by the bedside on the South Unit. Resident #5 was disheveled and unkempt. Their sneakers were heavily soiled and stained. Their facial area was covered with yellow and white flakes. Resident #5's lower extremities were swollen, covered with yellow flaky and discolored areas. The residents fitted sheet on the bed was heavily soiled and yellow stained. Resident #5 informed the Surveyor #1 that they used the sink to wash themselves daily. And further stated, that they had not had a shower. The resident stated, I make my bed, they don't do it. Surveyor #1 reviewed the Electronic Medical Record (EMR) for Resident #5. A review of the admission Record (an admission summary) reflected that Resident #5 was admitted to the facility with diagnoses which included but were not limited to, muscle weakness, major depressive disorder and anxiety disorder. A review of the Care Plan Report for Resident #5 included a Focus dated 12/2/20, for assistance with ADL functions. Interventions dated 4/27/22 included: I require staff assistance by one staff to provide bath/shower; requires one staff assistance with dressing. On 10/23/25 at 1:00 PM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) / Unit Manager (UM) regarding Resident #5's care. The LPN/UM #1 stated that Resident #5 preferred to stay in their room and staff were to assist Resident #5 with care. On 10/23/25 at 1:05 PM, Surveyor #and LPN/UM #1 went to Resident #5's room and observed the linen condition, soiled and discolored. He confirmed that the bedding had not been changed. Surveyor #1 then inquired regarding the shower schedule for Resident #5. The LPN/UM #1 stated that Resident #5 was scheduled to have a shower on Tuesday and Friday during the 7:00 AM to 3:00 PM shift. Surveyor #1 reviewed the plan of care with the Certified Nurses Aide (CNA) #1 and could not locate that the resident has had a shower or refused a shower on Tuesday 10/21/25. On 10/23/25 at 1:10 PM, Surveyor #1 interviewed LPN/UM #1 regarding the process followed when a resident refused care or a shower. The LPN/UM #1 stated that the CNA should report this to the nurse and the nurse should then document in the progress notes that the resident refused their shower. Surveyor #1 reviewed the progress notes in the EMR from 10/2/25 to 10/23/25 and could find documented evidence that Resident #5 refused a shower. On 10/23/25 at 1:20 PM, the LPN/UM #1 informed Surveyor #1 that the unit had a shower log where the nurses would document the skin assessment performed on every shower day. Surveyor #1 reviewed the shower log for October and verified that staff initialed the shower log to indicate that Resident #5 had a shower on 10/7/25, 10/14/25 and 10/28/25 (5 days from now). Surveyor #1 reviewed the shower log with LPN/UM #1, he did not have any comment. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/25 at 2:05 PM, the surveyor interviewed CNA #1 who was assigned to Resident #5. CNA #1 stated that she observed the resident in the room this morning and was informed that Resident #5 was independent with care. When asked if she changed the bed linen this morning, she stated, No. When asked if she changed the linen yesterday on 10/22/23, she stated, I was not assigned to the unit, but based on the condition of the sheet, the linen had not been changed. On10/23/25 at 9:30 AM, Surveyor #1 entered the North Unit. While approaching the nursing station a foul and strong urine odor permeated the hallway. On 10/23/25 at 9:52 AM, Surveyor #1 located the smell in the hallway of the North Unit in Resident #8's room. Surveyor #2 informed surveyor #1 that she toured the North Unit at 8:20 AM and noted a similarly strong urine smell outside of that same room (door was closed at that time). Surveyor #1 then entered Resident #8's room, along with CNA #2. Both observed Resident #8 lying in bed, the bedspread was folded, and the resident's gown was visibly soaked with urine. CNA #2 asked the resident if she could check the incontinence brief, and the resident agreed. The bedding was observed as being yellow stained, and Resident #8 was wearing an incontinence brief which was bulging from the back and was visibly soaked with urine. The surveyor observed that there was no urinal at the bedside. Resident #8 stated in the presence of CNA #2, I have not been changed since last night around 12:00 AM. On 10/23/25 at 10:00 AM, Surveyor #1 interviewed CNA #2 who stated that early this morning she was alerted by LPN/UM #2 to check on Resident #8 due to the odor in the hallway. CNA #2 further stated she was unable to attend to Resident #8 in a timely manner since she had been caring for another resident. Surveyor #1 reviewed the EMR for Resident #8. A review of the admission Record for Resident #8 reflected the resident was admitted to the facility with diagnoses which included, but were not limited to, muscle weakness, benign prostatic hyperplasia with lower tract symptoms (an enlarged prostate affecting the flow of urine). A review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/15/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident had a moderately intact cognition. It also reflected that Resident #8 required partial/moderate assist for toileting. A review of the Care Plan Report dated 05/09/25, had a Focus for I require assistance with ADL functions. Interventions dated 5/9/25 included, I require extensive assistance of one person for toilet use. On 10/23/25 at 11:37 AM, Surveyor #1 interviewed LPN/UM #2 regarding incontinence care. She stated that the nurses and the CNAs were to make rounds at the start of the shift to ensure all residents were safe. She further stated that she did not round this morning. The surveyor inquired where the CNA would document the care provided to each resident. The LPN/UM #2 stated that the care provided was documented on the Point of Care (PoC) Kiosk (computerized system) used by the CNA. On 10/23/25 at 11:45 AM, Surveyor #1 reviewed the PoC Kiosk for Resident #8 and there was no documented accountability for care provided to the resident from the 11:00 PM (10/22/25) to 7:00 AM (10/23/25) shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/25 at 11:15 AM, Surveyor #1 interviewed CNA #2 who stated she was aware of the strong urine odor when she entered the unit, but she did not know that was from Resident #8's room. On 10/23/25 at 1:45 PM, Surveyor #1 interviewed LPN/UM #2. She stated that residents were dependent on staff for incontinence care, and residents should be checked every two hours and before meals. Surveyor #1 inquired if Resident #8 was checked and provided with incontinence care on 11:00 PM (10/22/25) to 7:00 AM (10/23/25) shift. She stated, based on the observation reported by staff, incontinence care was not provided. 3. On 10/23/25 at 9:30 AM, Surveyor #1 performed an incontinence care observation with a random CNA on the South Unit. Resident #9 was soaked with urine. On 10/23/25 at 10:30 AM, Surveyor #1 interviewed CNA #3 who was assigned to Resident #9. CNA #3 stated that she was taking care of other residents and did not have time to provide incontinence care to Resident #9 prior to breakfast. Surveyor #1 reviewed the EMR for Resident #9. A review of the admission Record reflected Resident #9 was admitted to the facility with diagnoses which included but were not limited to, unspecified Atrial Fibrillation, unspecified convulsions and unspecified dementia. A review of a Quarterly MDS dated [DATE], reflected the resident had a BIMS score of 13 out of 15, which reflected the resident had an intact cognition. The MDS also reflected the resident was frequently incontinent of bowel and bladder. A review of the Care Plan Report dated 6/18/16, included the resident had a physical functioning deficit related to self-care impairment. There was a goal for staff to assist with care. Interventions included, provide personal hygiene assistance. 4. On 10/23/25 at 8:37 AM Surveyor #2, with Surveyor #1 present, observed an open door to a resident room on the South unit. Resident #4 looked out into the hallway and stated, Come in. Resident #4 was lying in bed awake and alert. Resident #4 stated, You can't get anything done around here. You have to wait for everything. Resident #4 stated they had to go to the bathroom but did not know where their call bell was. On 10/23/25 at 8:41 AM, Surveyor #1 observed CNA #4 in the hallway. Surveyor #1 requested CNA #4 join her and Surveyor #2 in Resident #4's room. CNA #4 entered Resident #4's room with the surveyors and acknowledged the resident's call bell was out of sight and out of reach. The resident then stated to CNA #4 that they needed to go to the bathroom. CNA #4 stated, OK and left the room at 8:43AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/25 at 8:49 AM, Surveyor #2 observed CNA #4 walking in the hallway. The surveyors returned to Resident #4's room. Resident #4 stated that they had not yet been taken to the bathroom. The surveyors left the room. Surveyor #1, in the presence of Surveyor #2, approached and interviewed CNA #4. He stated that when a resident tells you they need to go to the bathroom, you take them. He acknowledged that Resident #4 stated they needed to go to the bathroom. He acknowledged that he did not go back to Resident #4's room to assist them. CNA #4 stated this resident was not on their assignment and he was in the hall trying to find out which CNA was assigned to Resident #4. He acknowledged that any CNA could take any resident to the bathroom. CNA #4 acknowledged that he did not take Resident #4 to the bathroom although he should have, stating it was an error. Surveyor #2 reviewed the EMR for Resident #4. A review of the admission Record reflected that the resident was admitted with diagnoses that included but were not limited to unspecified sequelae of cerebral infarction (complications that resulted from a stroke), urinary tract infection, retention of urine, and generalized muscle weakness. A review of a Quarterly MDS dated [DATE], reflected the resident had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. The MDS also reflected that Resident #4 had an indwelling urinary catheter, and was frequently incontinent of bowels. A review of the Physicians Orders (PO) reflected a PO dated 9/25/25, to remove the indwelling urinary catheter. A review of the Care Plan Report for Resident #4 included a Focus dated 8/21/25, that the resident required assistance with ADL functions. Interventions dated 8/21/25, included, Toileting: I am totally dependent on (1) staff for toilet use. A review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, last revised 1/2025, indicated the following: Policy: Residents will be provided with care, treatment and services as appropriate to maintain their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services, necessary to maintain good nutrition, grooming and personal and oral hygiene. Procedure Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s)demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. The policy was not being followed. NJAC 8:39-27.2 (d)(h)(i)