STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315329	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Denville, The	21 Pocono Road Denville, NJ 07834

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44605 Based on observation, interview, review of medical records and review of other pertinent documentation, it was determined that the facility failed to treat all residents in a dignified manner by failing to provide a resident with respect and dignity during wound care. This deficient practice was identified 1 of 16 residents reviewed (Resident #231). The deficient practice was evidenced by the following: On 1/27/25 at 11:12 AM, the surveyor observed Resident #213 in their room. The resident was observed with a gauze (gauze wrap is a sterile material used to wrap or cover wounds) wrapped around their right elbow. During the interview the resident stated they had a skin tear prior to coming into the facility. Resident #231 was agreeable to allow the surveyor to observe the wound care treatment. A review of Resident #231 medical record revealed that the resident had diagnosis that included but were not limited unspecified fall, anemia (a deficiency of healthy red blood cells in blood), and hypertension (high pressure in the arteries). A review of the admission MDS, (an assessment tool used to facilitate the management of care) with an assessment reference date of 1/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident is cognitively intact. A review of the January 2025 Physician Orders Sheet (POS) revealed an order for wound care. The PO was dated 1/23/25, Vashe 0.033% irrigation solution (1 application) solution irrigation topical. Cleanse right elbow wound with Vashe, pat dry, apply Medihoney, cover with a non-stick gauze pad and wrap with kling daily. On 1/28/25 at 11:51 AM, the surveyor observed the Registered Nurse (RN#1) perform wound care on Resident #231's right elbow. The surveyor then observed RN #1 write a date and her initials with a pen directly on the resident's surgical tape which had already been placed on the residents wound site (right elbow). Surveyor asked RN #1 if writing the date and her initials on the tape while on the resident provided the resident dignity and respect? RN #1 stated, she should have written the date and her initials on a separate piece of tape and then place that on the resident's covered wound site. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 9:50 AM, the Director of nursing (DON) provided the surveyor with a facility policy titled, Quality of Life - Dignity with a revised date of 1/24/24. Under the procedure section of the policy it states, 1. Resident shall be always treated with dignity and respect. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .11. Demeaning practices and standards of care that compromise dignity are prohibited. On 1/29/25 at 12:32 PM, the Licensed Nursing Home Administrator (LNHA) and DON met with the survey team to review concerns found during the survey. The DON stated RN #1 did not follow the correct procedure for initialing and dating for a resident's wound and would in-service the staff. No further comments provided. On 1/30/25 at 2:00 PM, the survey team met with the LNHA and DON for the exit conference. The facility did not provide any further pertinent information. NJAC 8:39-4.1(a)(12)(28), 17.3(c), 17.4(d)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37175 Based on interview and record review, it was determined that the facility failed to issue the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) for 2 of 3 residents (Resident #8 and Resident #41) reviewed. The SNF ABN provides information to beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. If the SNF provides the beneficiary with the SNF ABN, the facility has met its obligation to inform the beneficiary of his or her potential financial liability and related standard claim appeal rights. On 1/27/25 at 10:51 AM, the facility provided the surveyor with a list of residents who were discharged from the facility within the last 6 months and should have received the SNF ABN form. The surveyor reviewed Resident #8 and Resident #41 who were listed discharged from Medicare Part A coverage stay and were documented that they remained in the facility. 1. Resident #8 was admitted to the facility on [DATE]. The last documented covered day from Medicare Part A service was 1/18/25. A review of the form titled, SNF Beneficiary Notification Review that was filled out by the facility's Director of Social Services (DSS) indicated the SNF ABN was not provided to the resident. There was no additional documentation about the communication of these forms to the resident or the resident's representative. 2. Resident #41 was admitted to the facility on [DATE]. The last documented covered day from Medicare Part A service was 12/24/24. A review of the form titled, SNF Beneficiary Notification Review that was filled out by the facility's DSS indicated the SNF ABN was not provided to the resident. There was no additional documentation about the communication of these forms to the resident or the resident's representative. On 1/30/24 at 1:31 PM, the surveyor interviewed the social worker (SW) who stated to the surveyor the SNF ABN form did not have to be issued when residents remain in the facility after Medicare A's last covered day service. The SW stated she was responsible to send the notices of Medicare non-coverage forms and the have them signed and the ABN forms. She further stated that she should have sent the ABN forms to the residents and or the families. She further stated that she was aware that there were new ABN forms, and she needed to review them. On 1/29/25 at 12:33 PM, the surveyor discussed the above concerns with the facility's Licensed Nursing Home Administrator and the Director of Nursing and Assistant Director of Nursing. There was no additional information provided. NJAC 8:39-4.1(a)(8)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on observation, interview, and record review, it was determined that the facility failed to revise the comprehensive care plans (CP) for 2 of 15 residents reviewed (Resident #35 and #13). This deficient practice was evidenced by the following: 1. On 1/27/25 at 11:00 AM, the surveyor observed Resident #35 sitting in the wheelchair inside the recreation room, unable to answer the surveyor's inquiry. On 1/27/25 at 1:25 PM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #35, which revealed the following: A review of the Face Sheet (FS; an admission summary) reflected that Resident #35 was admitted with diagnoses that included but were not limited to unspecified dementia (loss of memory), unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the recent quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care) dated 6/18/24 indicated that the facility assessed the residents' cognitive status, with a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating that the resident had severe impairment in cognition. A further review of the Q/MDS revealed that the resident received anti-anxiety and antidepressant medications on a routine basis. A review of the most recent Physician Order Sheet (POS) reflected a physician's order of the following medications: 1. Risperidone 0.5 mg. by mouth daily with an order date of 2/23/24 and discontinued on 3/16/24. 2. Xanax 0.25 mg. by mouth daily with an order date of 4/7/24 for anxiety. A review of the resident's individualized person-centered care plan (CP) with an effective date of 12/11/23 to 8/28/24 reflected under problems that I am at risk for complications related to the use of psychotropic medication. I am on Risperidone. The goal reflected that the resident would have no complications related to the use of Risperidone in the next 90 days. Further review of the CP does not reflect the discontinued use of Risperidone on 3/16/24 and the use of the anti-anxiety medication Xanax, with a start order of 4/7/24. On 1/29/25 at 11:30 AM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) regarding the above concern but did not provide further information. 2. On 1/27/25 at 11:35 AM, the surveyor observed Resident #13 lying in bed, alert and awake. The surveyor observed that the resident had a cup of water on the table. Resident #13 stated they have dialysis every Tuesday, Thursday, and Saturday pick-up at 10:00 am. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/30/25 at 09:05 AM, the surveyor observed Resident #13 awake and had just finished breakfast. The surveyor observed that the resident had a 16-ounce cup of water on the table. The resident was aware that they were under a fluid restriction and added that they were noncompliant and disagreed with the restriction. On 1/29/25 at 1:18 PM, the surveyor reviewed the hybrid medical record of Resident #13, which revealed the following: A review of the FS reflected that Resident #13 was admitted with diagnoses that included but were not limited to chronic kidney disease (CKD-kidney stopped working), Stage 4 (severe), and dependence on dialysis (a treatment for the failing kidney). A review of the recent Q/MDS, dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 14 out of 15, which indicated that the resident had intact cognition. A review of the most recent POS reflected a physician's order of fluid restrictions of 1200 ml (milliliters) in 24 hours with an order date of 12/14/24. A review of the resident's individualized person-centered CP with an effective date of 5/1/24 to present reflected under problems, Dialysis: I am on Dialysis on Tuesday, Thursday, and Saturday. Further review of the CP does not indicate that the residents are noncompliant with fluid restrictions. On 1/30/25 at 9:10 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) regarding the above concern. The CNA stated that he knew the resident was on fluid restriction and would give the resident the allowed fluids. He added that the resident would ask for more water, and he felt bad about it. The CNA revealed that the resident had been on fluid restriction since entering the facility. On 1/30/25 at 10:31 AM, the surveyor interviewed the Director of Nursing (DON) regarding the above concern. The DON stated that the resident has a history of non-compliance with the fluid restriction. A review of the facility policy titled Resident Care Plan with the revised date of October 2024 stated under Procedure: The resident care plan will reflect the resident's expressed wishes regarding care and treatment goals. The resident has the right to refuse to participate in the development of his/her care plan and medical nursing treatments. When such refusal are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies. 1. Resident care plan will be developed for all care planning issues including but not limited to: c. Resident's risk factors .d. Resident's needs . NJAC-8:39 11.1 NJAC 8:39-27.1(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on observation, interview, and record review, it was determined that the facility failed to consistently monitor, document, and evaluate the ongoing benefits of continued use of psychoactive medications for 3 of 5 residents reviewed for unnecessary medications (Resident #3, #4, and #35). This deficient practice was evidenced by the following: 1. On 1/27/25 at 10:43 AM, the surveyor observed Resident #3 out of bed to the wheelchair inside the activity room, able to answer the surveyor's inquiry. On 1/29/25 at 11:33 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #3, which revealed the following: A review of the Face Sheet (an admission summary) reflected that Resident #3 was admitted with diagnoses that included but were not limited to unspecified dementia (loss of memory), unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the admission Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care) dated 12/20/24 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident had an intact cognition. A further review of the A/MDS revealed that the resident received antipsychotic and antidepressant medications on a routine basis. A review of the most recent Physician Order Sheet (POS) with the start date of 12/13/24 reflected a physician order of the following: 1. Quetiapine 25 mg (milligram) give one tablet by mouth one time daily, and the order was discontinued on 1/17/24 and increase the dosage to Quetiapine 50 mg give one tablet by mouth one time daily for a mood disorder on 1/17/24 and 2. Sertraline 100 mg is given one tablet by mouth for depression. There was no further documentation to reflect that the resident was being monitored routinely with the use of psychotropic medications after the increase of dosage of Quetiapine 25 mg to 50 mg from December 13, 2024, to January 17, 2024. A review of the January 2025 Medication Administration Record (MAR) revealed that the nurses signed that Resident #3 was administered Quetiapine 50 mg by mouth for mood disorder at 8:00 PM and Sertraline 100 mg by mouth daily for depression at 9:00 PM. The January 2025 MAR did not reflect the target behavior and potential side effects of the psychotropic medication. A review of the recent Psychiatric Progress Note dated 1/21/25 revealed under assessment/plan to continue to monitor mood and behavior for changes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's individualized person-centered care plan (CP) with an effective date of 12/14/24 to present reflected under problems that the resident is at risk for complications related to the psychoactive medication used. The goal reflected that the resident would have no complications for 90 days. The interventions included administering the medications as ordered by the physician, monitoring for adverse reactions, and monitoring behavior every shift. The CP did not reflect specific target behaviors for the use of psychotropic medication and non-pharmacological interventions to decrease behaviors and symptoms associated with depression of the resident. On 1/29/25 at 11:30 AM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) regarding the above concern. The UM/RN revealed that the nurses documented the side effects only if the resident had a side effect but did not provide documentation of the targeted behavior monitoring. 2. On 1/27/25 at 10:01 AM, the surveyor observed Resident #4 sitting in the wheelchair inside the room, able to answer the surveyor's inquiry. On 1/27/25 at 11:29 AM, the surveyor reviewed the hybrid medical record of Resident #4, which revealed the following: A review of the FS reflected that Resident #4 was admitted with diagnoses that included but were not limited to sepsis (body response to infection) and diabetes mellitus (high sugar level). A review of the recent quarterly Minimum Data Set (Q/MDS) dated [DATE] indicated that the facility assessed the residents' cognitive status, with a BIMS score of 13 out of 15, indicating that the resident had intact cognition. A further review of the Q/MDS revealed that the resident received antidepressant medications on a routine basis. A review of the most recent POS with the start date of 7/25/24 reflected a physician's order of amitriptyline 50 mg to give one tablet by mouth daily for depression. A review of the January 2025 MAR revealed that the nurses signed that Resident #4 was administered amitriptyline 50 mg, one tablet by mouth daily for depression at 7:00 PM. The January 2025 MAR did not indicate the target behavior and potential side effects of the psychotropic medication. A review of the resident's individualized person-centered CP with an effective date of 7/18/24 to present reflected under problems that the resident is at risk for complications related to the psychoactive medication used. The goal reflected that the resident would have no complications for 90 days. The interventions included administering the medications as ordered by the physician, monitoring behavior every shift, and monitoring for adverse reactions, side effects, and changes in mental status. The CP did not reflect specific target behaviors for the use of psychotropic medication and non-pharmacological interventions to decrease symptoms associated with depression of the resident. 3. On 1/27/25 at 11:00 AM, the surveyor observed Resident #35 sitting in the wheelchair inside the recreation room, unable to answer the surveyor's inquiry. On 1/27/25 at 1:25 PM, the surveyor reviewed the hybrid medical record of Resident #35, which revealed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the FS reflected that Resident #35 was admitted with diagnoses that included but were not limited to unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the recent Q/MDS dated [DATE] indicated that the facility assessed the residents' cognitive status, with a BIMS score of 5 out of 15, indicating that the resident had severe impairment in cognition. A further review of the Q/MDS revealed that the resident received anti-anxiety and antidepressant medications on a routine basis. A review of the most recent POS reflected a physician's order of the following medications: 1. Risperidone 0.5 mg. by mouth daily with an order date of 2/23/24. 2. Xanax 0.25 mg. by mouth daily with an order date of 4/7/24. 3. Sertraline 75 mg. by mouth daily with an order date of 12/18/24. 4. Mirtazapine 15 mg by mouth daily with an order date of 1/20/25 5. Ativan 0.25 mg by mouth daily as needed with an order date of 1/21/25 The April 2024 MAR revealed that the nurses signed the above medications for Resident #35. There was no further documentation to reflect that the resident was being monitored and evaluated routinely with the use of the above psychotropic medications between the period of February 2024 and January 2025. A review of the resident's individualized person-centered CP with an effective date of 12/11/23 to 8/28/24 reflected under problems that the resident is at risk for complications related to the psychoactive medication used. The goal reflected that the resident would have no complications for 90 days. The interventions included administering the medications as ordered by the physician, monitoring behavior every shift, and monitoring for adverse reactions, side effects, and changes in mental status. The CP did not reflect specific target behaviors for the use of psychotropic medication and non-pharmacological interventions to decrease symptoms associated with the resident's behavior. A review of the Behavior/Psychotropic medication changes provided by the DON does not reflect a consistent monitoring of target behavior, potential side effects and evaluate the ongoing benefits of continued use of psychoactive medications. On 1/29/25 at 11:30 AM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) regarding the above concern. The UM/RN revealed that the nurses documented the side effects only if the resident had a side effect but did not provide further information regarding the targeted behavior monitoring. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 12:47 PM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) regarding the above concern. The DON stated that the nurses documented if there was a side effect noted to the resident with the use of psychotropic medications, and if there was no side effect, there was no documentation. The LNHA and DON did not provide further information. A review of the facility policy with the revised date 5/11/23 titled Behavioral Symptoms, under the Procedure: 11: f. iv Monitoring is necessary as long as the drug is being used to identify side effects and to identify opportunities to reduce the drug dosage or discontinue the use of the drug. NJAC 8:39-29.3(a); 29.8; 33.2(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44605 Repeat deficiency Based on observation, interview, and record review of other facility documentation, it was determined that the facility failed secure medications within the medication cart. This deficient practice was observed during wound care observation and was evidenced by the following: On 1/28/25 at 11:51 AM, the surveyor observed Registered Nurse (RN#1) provide wound care on Resident #213. RN#1 was observed gathering medication from the medication cart outside of Residents #213's room. Once RN#1 gathered all medications and supplies from the medication cart, the surveyor observed RN#1 close the drawer to the medication cart and walk away. Surveyor asked RN#1 if they had locked the medication cart. RN#1 went back to the medication cart and stated, I forgot to lock the cart. That was a mistake on my part On 1/29/25 at 9:50 AM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Storage of medications with a revised date on 5/1/2017. Under the procedure section of the policy it states, 7. Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. On 1/29/25 at 12:32 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON to review concerns found during the survey. The DON stated the medication carts should always be locked whenever the nurse is stepping away from the cart. No further comments provided. On 1/30/25 at 2:00 PM, the survey team met with the LNHA and DON for the exit conference. The facility did not provide any further pertinent information. NJAC 8:39- 29.4(a) (d)(h), 29.7(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44605 Repeat deficiency Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 1/27/25 at 9:55 AM, while on the 4th floor in the kitchenette the surveyor observed the following: in refrigerator #1 had an individual cheesecake without a cover and missing a use by date, an open jar of molasses without an open/use by label, and in freezer #2 a paper cup with a brown frozen substance not dated and without a use by label. On 1/27/25 at 10:15 AM, while on the 2nd floor in the kitchenette the surveyor observed the following in refrigerator #1: a zip lock bag of sliced pickles and red cup with oatmeal-like substance both missing labels and use by dates. On 1/27/25 at 10:20 AM, the surveyor interviewed the Unit Manager (UM), who stated all items in the refrigerator and freezers should be covered as well as have a label with an open and use by date. The UM further stated the kitchenette areas are checked by the nurses and certified nursing assistants, but unable to explain why those items had not been labeled. On 1/29/25 at 12:00 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Food Storage with reviewed date of 10/2024. Under the policy section it states, All leftovers are labeled, dated, and used within three days and then discarded. If there is any question about a product's storage or expiration, discard the product. On 1/29/25 at 12:32 PM, the survey team met with the LNHA and Director of Nursing (DON) to review concerns. The DON stated all the refrigerator and freezers in the three kitchenettes have been checked and any foods that did not have a label have been discarded. On 1/30/25 at 2:00 PM, the survey team met with the LNHA and DON for the exit conference. The facility did not provide any further pertinent information. NJAC 8:39-17.2(g)