STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315336	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens at Monroe Healthcare and Rehabilitation, T	189 Applegarth Road Monroe Township, NJ 08831

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code a resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 1 of 21 residents (Resident #87) reviewed for accurately coding the MDS according to the Resident Asessment Instrument (RAI-used to assess and care plan residents). The deficient practice was evidenced by the following: On 04/07/25 at 10:30 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #87. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified intracapsular fracture of right femur (a broken thigh bone), subsequent encounter for closed fracture with routine healing and lobar pneumonia, unspecified organism (a bacterial lung infection). A review of the MDS dated [DATE], revealed section A0310, F Entry/discharge reporting: revealed a code 10, discharge assessment-return not anticipated. Further review revealed section A2105 Discharge status code 04: Short-term General Hospital. A review of the physician order's (PO) revealed a PO: patient okay for discharge home today with family, dated 1/17/2025. On 04/08/25 at10:21 AM, the surveyor interviewed the MDS Coordinator, who stated when a resident was discharged from the facility, she would be alerted of the discharge, she would review the nursing notes and social services would make her aware of the discharge plan. The MDS coordinator reviewed Resident #87's MDS dated [DATE], in the presence of the surveyor and verified the discharge was coded discharge return not anticipated; discharge to the hospital. She reviewed the nursing notes and confirmed the resident was discharged home. She acknowledged the MDS was coded wrong. She stated, I will modify it as we speak as per the RAI manual. On 04/08/25 at 1:13 PM, the Licensed Nursing Home Administrator, the Director of Nursing, and the Infection Preventionist were made aware of the above concerns. (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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	A review of the CMS's RAI Version 3.0 Manual revealed section A2105: Discharge Status; Steps for Assessment:1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location; Coding Instructions: Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. NJAC 8:39-11.1

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 51500 Based on observation, interviews, record review and review of pertinent facility documents, it was determined that the facility failed ensure that a Registered Nurse (RN) documented a resident's assessment after a fall occurred. This deficient practice was identified for 1 of 2 residents reviewed for falls (Resident #10). 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 or 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 regimes 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 4/03/25 at 10:26 AM, the surveyor observed Resident #10 in bed. The resident stated they fell yesterday. The surveyor reviewed the medical record for Resident #10. A review of the Admission Record (an admission summary) reflected the resident had diagnoses which included but not limited to; age related osteoporosis and mild cognitive impairment. A review of a comprehensive Minimum Data Set, an assessment tool used to facilitate the management of care, reflected the resident had a Brief Interview for Mental Status of 7 out of 15, which indicated the resident had a severely impaired cognition. A review of the Nursing Note dated 2/23/2025 at 7:02 PM, reflected that Resident #10 sustained a fall on 2/23/2025 at 6:30 PM. This note was entered by Licensed Practical Nurse (LPN) #1. There was no documented evidence in the Electronic Medical Record (EMR) that a Registered Nurse (RN) assessed the resident after Resident #10 sustained a fall. A review of the facility's Incident/Accident Report including the facility's Incident Investigation Worksheet, both dated 2/23/2025, were completed and signed by LPN #1. On 4/07/25 at 1:50 PM, LPN #1 stated the nurse assigned to a resident who sustained a fall completed all incident documentation. He further stated, when the Unit Manger/RN assessed the resident, they don't document the assessment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/07/25 at 2:04 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team. She stated when the RN assessed the resident, the RN and or supervisor would not document anything on the incident/accident report or in the EMR regarding their assessment. She stated, They must do the assessment, but they do not document on any separate form. She further added that residents who sustained a fall should be assessed by the RN to determine if there was any complication or injury from the fall. A review of the facility's policy Fall Assessment and Management with a revised date of 10/2024, did not reflect that a RN was required to document resident's assessments after sustaining a fall. A review of an undated facility Job Description titled Registered Nurse, included duties and responsibilities for supervision of direct care provided to residents by CNAs and LPNs. NJAC-8:39-5.1(a)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34033 Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by not ensuring a.) an apical heart rate (pulse heard on the chest) was obtained before the medication Digoxin (a medication used to treat heart failure or rhythm problems) was administered by one (1) of three (3) nurses and b.) required vital sign parameters for a medication were obtained in a timely manner by one (1) of three (3) nurses who administered medications to two (2) of five (5) residents, (unsampled Residents #2 and #140), during the medication administration observation. The deficient practices were 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. 1. On 4/4/25 at 8:47 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) preparing medications for unsampled Resident #2. LPN #1 stated that there was a physician's order (PO) for Digoxin and would have to obtain an apical pulse. On 4/4/25 at 9:04 AM, LPN #1 stated that she was going to the nursing station to get a stethoscope to perform the apical pulse. On 4/4/25 at 9:06 AM, the surveyor observed LPN #1 return to the medication cart, enter unsampled Resident #2's room and hold the resident's wrist for 60 seconds. LPN #1 then stated that the pulse was 76 and was able to administer the Digoxin. The surveyor had not observed LPN #1 return with a stethoscope or use a stethoscope on unsampled Resident #2 to obtain the heart rate. On 4/4/25 at 9:19 AM, the surveyor interviewed LPN #1, at the medication cart, who stated she did not have her stethoscope with her. LPN #1 acknowledged that an apical pulse was obtained by using a stethoscope and listening to the heartbeats for 60 seconds. LPN #1 also acknowledged that what she had done with unsampled Resident #2 was a radial (arm) pulse. LPN #1 stated I should have taken an apical pulse for Digoxin. (continued on next page)

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	315336	A. Building B. Wing	04/09/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/25 at 11:46 AM, the surveyor interviewed the Unit Manager (UM)/Registered Nurse (RN) who stated that Digoxin requires a pulse to be taken before administering the medication. UM/RN #1 added the pulse required for Digoxin was to be obtained by using a stethoscope on the chest to listen to the heartbeats for 60 seconds, which was an apical pulse. On 4/7/25 at 8:48 AM, the surveyor interviewed the Director of Nursing (DON) who stated that it was mainly her responsibility for staff education. The DON stated that the nurses were to take an apical pulse prior to Digoxin administration and that required using a stethoscope. The DON also stated that the Consultant Pharmacist (CP) has done inservices on medication administration and agency nurses may not attend if they were not working. On 4/8/25 at 8:58 AM, the surveyor interviewed the CP via telephone who stated the nursing standard of practice was to take an apical pulse with a stethoscope for 60 seconds before administering Digoxin. The CP added that he thought that was a national standard and that recommendation should be on the electronic medication administration record (EMAR). A review of an inservice dated 10/4/24 for Pharmacy: Medpass provided by the DON, who stated the CP had performed the inservice, reflected Be prepared- Stethoscope, blood pressure machine, glucometer -clean and operational. In addition, the inservice indicated Examples of meds (medications)with specific timing parameters included, but not limited to HOLD Digoxin (Lanoxin) Full 60 second apical pulse. Further review of the sign-in sheet revealed that LPN #1 had not attended the inservice. The surveyor reviewed the medical record for unsampled Resident #2. A review of the EMAR revealed a PO dated 1/9/2019, for Digoxin tablet 125 MCG (micrograms) Give 1 tablet by mouth in the morning every Mon (Monday), Wed (Wednesday), Fri (Friday) for A.Fib (atrial fibrillation- an abnormal heart rhythm) DAILY A/P (apical pulse)-HOLD IF A/P = 60 or below. On 4/9/25 at 9:28 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON and Infection Preventionist (IP)/Registered Nurse (RN). The DON acknowledged that a radial pulse cannot be taken for Digoxin. The DON added that agency nurses received an orientation packet the first time they were scheduled to work at the facility which included medication administration instructions and guidelines to follow. The DON acknowledged that LPN #1 should have obtained an apical pulse. A review of manufacturer specifications indicates for an assessment of Digoxin by a healthcare professional Monitor apical pulse for 1 full minute before administering. 2. On 4/4/25 at 9:30 AM, the surveyor observed LPN #2 preparing to administer medications to unsampled Resident #140. LPN #2 stated that the resident's blood pressure (BP) was 169/80 and was allowed to administer the resident's Doxazosin (a medication used to treat high BP) according to the PO. LPN #2 explained that the PO indicated to hold Doxazosin if the systolic BP (SBP) was less than 100 and unsampled Resident #140's SBP was 169 so she could administer the medication. The surveyor had not observed LPN #2 obtain a BP. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/25 at 9:39 AM, the surveyor interviewed LPN #2, who stated unsampled Resident #140's BP was taken earlier. LPN #2 showed the surveyor the electronic profile for unsampled Resident #140 which indicated an entry dated 4/4/25 at 7:07 AM of a BP of 169/80. LPN #2 further explained that her usual routine was to take BPs when she did her rounds when she came onto her shift which was 7 AM. LPN #2 added BP results were electronically recorded and she would use those during the medication pass. In addition, LPN #2 stated that unsampled Resident #140 was at the facility as a sub-acute resident, meaning that the resident would not be staying for long term care and would be going home. The surveyor reviewed the medical record for unsampled Resident #140. A review of the EMAR revealed a PO dated 3/28/25 for Doxazosin Mesylate Tablet 2 MG (milligrams) Give 1 tablet by mouth every 12 hours for htn (hypertension-high BP) HOLD BP BELOW 100. May cause dizziness or lightheadedness. On 4/4/25 at 12:07 PM, the surveyor interviewed UM/RN #2, who stated that usually the nurses checked BP results between 7 AM and 9 AM, before going out on a medication pass. The UM/RN #2 added that a BP taken at 7 AM could be used to determine if a medication had instructions to be held with specific parameters and was being administered at 9 AM as long as the BP that was taken at 7 AM was within range. UM/RN #2 further explained that if a BP was taken at 7 AM and was low, then the nurse should recheck before administering the medication but if the BP was normal then the nurse does not need to recheck. On 4/7/25 at 8:48 AM, the surveyor interviewed the DON, who stated that it was mainly her responsibility for staff education. The DON stated the nurses could take parameters such as BP for all their residents during rounds and then start the medication pass or could take the parameters before they were preparing the medications for administration. The DON explained that it was the nurse's preference and further explained if the nurse were to take parameters such as a BP and a medication had a hold order then the BP would have had to be taken within an hour. The DON further explained that when there was a PO to hold a medication according to specified BP parameters, she did not want the nurses to put the medication in a cup ready to administer until the BP was taken. The DON added that a BP taken within an hour of being administered was reasonable for a hold order. On 4/8/25 at 8:58 AM, the surveyor interviewed the CP, via telephone, who stated when a medication had specific hold orders then ideally the parameters should be taken just before administering the medication. The CP added it would be reasonable to allow 30 minutes to 1 hour before a medication was administered to be acceptable to determine if the medication was to be administered according to the hold order. The CP added that if a nurse took a BP at 7 AM for a resident and then was administering a medication that had a hold order at 9AM for the resident, the 7 AM BP should not be used to determine whether the medication should be administered. A review of an inservice dated 10/4/24 for Pharmacy: Medpass provided by the DON, who stated that the CP had performed the inservice, reflected Timing of medication Administration -HOLD -take BP or pulse immediately before pouring medication. Further review of the sign-in sheet revealed that LPN #2 had attended the inservice. NJAC 8:39-11.2 (b); 27.1(a)

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	315336	A. Building B. Wing	04/09/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51500 Based on observations, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to ensure that a.) two Certified Nurse Aides (CNA) on 2 of 4 Units ([NAME] and [NAME]) caring for Residents #54 and #340, removed (doffed) personal protective equipment (PPE) appropriately, and b.) 1 of 3 nurses wore their facemask properly on 1 of 4 units ([NAME]) caring for Resident #2, and in accordance with the Center for Disease Control (CDC) Guidance. This deficient practice was evidenced by the following: 1. On 4/03/25 at 11:57 AM, the surveyor observed CNA #1 enter Resident #340's room who was on transmission-based precautions (TBP) [process that is implemented to prevent the spread of infections]. CNA #1 was wearing a surgical mask and donned (put on) a gown, gloves and face shield prior to entering the room. She carried the food tray in the room and assisted the resident with setting up the lunch tray. CNA #1 removed and discarded her gloves in the room and exited the resident's room into the hallway with the gown and face shield on. She removed her gown and face shield in the hallway and placed the gown and face shield in the trash can located in the hallway labeled PPE trash. On 4/03/25 at 12:03 PM, the surveyor interviewed CNA #1 who stated the resident was on TBP for the flu and acknowledged the signage posted at the doorway. In the presence of CNA #1, the surveyor observed two signs posted at the resident's doorway. One sign indicated the type of TBP, which was contact and droplet precautions. The second sign described the required and appropriate procedure to don and doff PPE. CNA #1 stated the PPE trash bin was outside in the hall and that was why she removed and discarded her gown and face shield in the hallway. The surveyor reviewed the medical record for Resident #340. A review of the Admission Record (AR) [an admission summary] reflected that the resident had diagnoses which included but was not limited to; Influenza, asthma, and malignant neoplasm (cancer) of the ovary, peritoneum (lining of the abdominal cavity), lung and large intestine (history of). A review of the Order Summary Report (OSR), reflected a physician's order (PO) dated 4/02/2025, for Influenza (Seasonal Influenza) . Observe Contact & Droplet Precautions every shift for 7 days. On 4/07/25 at 10:46 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) related to TBP. She stated that when staff exited a TBP room, they should remove their PPE outside the room in the hallway and discard the contaminated PPE into the designated PPE trash bin located outside of the room in the hallway. The IP/RN further stated, Staff is supposed to remove their PPE outside of the residents room. On 04/08/25 at 1:13 PM, the Licensed Nursing Home Administrator (LNHA), the DON, and the IP/RN were made aware of the above concerns. 41858 (continued on next page)

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	315336	A. Building B. Wing	04/09/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 04/08/25 at 10:31 AM, the surveyor observed CNA #2 don PPE, which included a gown, gloves, a N95 respirator mask, and a face shield, enter Resident #54's room. The surveyor observed signage on the door for TBP: Contact Precaution/ Droplet Precautions: STAFF PLEASE USE PPE: N 95, eye shield, gown and gloves. The surveyor observed a trach can located in the hallway labeled PPE trash. At 10:37 AM, CNA #2 exited the resident's room and entered the hallway wearing the above mentioned PPE. He removed his gloves and discarded them into the PPE trash can. He removed his gown and face shield in the hallway and placed them into the PPE trash can in the hallway. On 04/08/25 at10:40 AM, the surveyor interviewed CNA #2, who stated the resident was on TBP for COVID (a highly contagious disease caused by the coronavirus SARS-CoV-2) and acknowledged the signage posted at the doorway. CNA #2 stated the PPE trash bin was outside in the hall and that was why he removed and discarded his gown and face shield in the hallway. The surveyor reviewed the medical record for Resident #54. A review of the AR revealed the resident had diagnoses which included but was not limited to; Multiple Sclerosis (a chronic autoimmune disease that affects the central nervous system (brain and spinal cord) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities). A review of the OSR revealed a PO dated 4/02/2025, for COVID Transmission Based Precaution (CONTACT & DROPLET PRECAUTIONS). On 04/08/25 at 1:13 PM, in the presence of the survey team, the LNHA, the DON, and the IP/RN were made aware of the above concerns. A review of the facility policy Donning and Doffing date revised 10/2024, included The facility will follow the CDC guidelines on proper donning and doffing of appropriate PPE to prevent the spread of infection. The policy further included, Discard all PPE in the waste receptacle situated outside of the room. The DON also provided the surveyor the CDC guidance on how to safely remove PPE as an attachment to the facility policy, which reflected the following Remove all PPE before exiting the patient room . 34033 3. On 4/3/25 at approximately 9:00 AM, upon entry into the building, the DON informed the survey team that the facility was currently in an outbreak and recommended all visitors wear a mask covering. The DON offered surgical masks that were at the receptionist desk. In addition, the DON offered the surveyors a different style of mask covering that she was wearing. The DON added that all staff were to wear a mask covering in patient care areas. At that time, the surveyor observed at the entry doorway on a wall, near the visitor electronic sign-in machine, posted signage All Visitors: The facility is currently on a COVID (coronavirus disease) outbreak investigation. We are performing contact tracing and testing per CDC/NJDOH (New Jersey Department of Health). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/25 at 8:47 AM, during the morning medication administration pass, the surveyor observed Licensed Practical Nurse (LPN #1) at the medication cart who stated that she was performing her morning medication pass. The surveyor observed LPN #1 wearing a surgical mask with her nose exposed, the top of the surgical mask was below her nose and over her mouth. On 4/4/25 from approximately 8:47 AM to 9:19 AM, the surveyor observed LPN #1 prepare and administer 11 medications to unsampled Resident #2, which included obtaining a blood pressure, pulse, administering an inhaler and eye drops. On 4/4/25 at 9:45 AM, the surveyor interviewed LPN #1, who stated she was an agency nurse and worked at the facility approximately once or twice a month. LPN #1 also stated that she was aware that the facility currently had a requirement that all staff wear masks. She stated she wore a surgical mask every time she worked anyway. LPN #1 added that she always wore her mask with her nose exposed because I have a big nose. LPN #1 added that it was difficult to fit her nose in the mask. A review of signage Facemask Do's and Don'ts for Healthcare Personnel that was placed on walls throughout the facility indicated When wearing a facemask, don't do the following: Don't wear your facemask under your nose or mouth. On 4/9/25 at 9:28 AM, the survey team met with the LNHA, the DON and the IP/RN. The DON stated that the nurses should be wearing a mask covering which was tight fitting. The DON acknowledged that the staff were required to wear mask coverings over their nose and that a surgical mask could be pulled above the nose and had an area that could be pinched to adjust covering the nose. The DON added the facility provided different styles of mask coverings, in addition to surgical masks, which may feel more comfortable in accommodating covering the nose area. The DON referenced her mask that she was wearing which was a KN95 (a mask that filters at least 95% of particles of size down to 3 microns in diameter) mask which had a different angle of nose covering. On 4/9/25 at 11:30 AM, the surveyor interviewed the DON, who stated the local health department had advised her to institute facility wide masking as source control when she had reported a case of COVID at the facility. The DON added she had a checklist that was reviewed when they report to the local health department. A review of the Outbreak Management Checklist for COVID-19 (coronavirus disease of 2019) in Nursing Homes and Other Post-acute Care Settings dated 4/2/25 provided by DON reflected that source control measures were implemented on 4/2/25. The checklist indicated CDC recommends implementing source control for persons residing or working on a unit or area of the facility experiencing a SARS (severe acute respiratory syndrome)-CoV-2 (coronavirus that caused COVID-19) or other outbreak of respiratory infection; . N.J.A.C. 8:39-19.4(a)