STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315339	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Oradell	600 Kinderkamack Road Oradell, NJ 07649

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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. 46049 Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of their quality of life specifically by honoring the resident's shower schedule and preferences for 1 of 2 residents, Resident #52, reviewed for activities of daily living. This deficient practice was evidenced by the following: On 12/3/24 at 9:50 AM, the surveyor observed Resident #52 sitting in a chair in their room dressed in well-fitted clothes. The resident was alert, oriented, and verbally responsive. Resident #52 stated for the last couple of weeks they only received a shower once a week. The resident stated that previously they had received a shower twice a week although they felt that was not enough. The resident stated that they were ambulatory and independent with ADLs (activities of daily living). On 12/3/24 10:02 AM, the surveyor interviewed the Registered Nurse/Unit Manager about showers for residents. The RN/UM stated that residents were scheduled to have showers twice a week. The RN/UM showed the surveyor a shower schedule list that was on the back of the Certified Nurse Aide (CNA) assignment binder. The RN/UM provided a copy of the shower schedule to the surveyor. On 12/3/24 at 10:15 AM, the surveyor interviewed Certified Nurse Aide #1 (CNA#1) about residents receiving showers. CNA #1 stated the binder at the nurses' station had the list based on resident's bed/room for which day and shift they were scheduled for showers. CNA #1 stated residents received bed baths daily and were to have a shower at least two times per week. The CNA explained a shower meant the resident would be taken to the bathing room for a shower and the CNAs documented in the electronic medical record (EMR) section. CNA #1 stated if the resident refused a shower or was not able to get shower, the resident would be provided a bed bath, and it would be documented in the EMR. The surveyor with CNA #1 toured the bathing room which was across from the nurses' station on the unit. The bathing room had 4 shower stalls with a shower chair in 1 of the shower stalls. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 11:54 AM, the surveyor interviewed CNA #2 who was assigned to care for Resident #52. CNA #2 stated that she knew which residents were assigned for showers on the shift by checking the EMR which would have an entry for which days the resident would have a routine shower. CNA #2 was not familiar with a binder or shower schedule at the nurses' station. CNA #2 further explained residents received bed baths every day and showers were provided at least twice a week for residents. CNA #2 confirmed a shower meant the resident would shower in the bathing room. The surveyor asked if the CNA had any residents scheduled for a shower today and if she had used the bathing room today. CNA #2 replied that she had not taken any residents to shower today and stated she only had one resident (not Resident #52) scheduled for a shower. The surveyor asked about Resident #52. The CNA replied the resident was independent and was scheduled to receive showers Fridays and Tuesdays on the 7:00 AM-3:00 PM shift. The surveyor asked if the resident had received a shower as it was Tuesday. The CNA stated she may be mistaken and would have to double check the EMR. CNA #2 reviewed the EMR and showed the surveyor the resident had a scheduled entry which indicated Resident #52 was to have showers every Monday and Thursday on the evening shift and as needed. The CNA confirmed it would be documented in the EMR if a resident was provided a shower and if they refused. On 12/3/24 at 12:03 PM, the surveyor interviewed the RN/UM about the list of residents for showers and CNA documentation of showers. The RN/UM stated it was expected for staff to bring residents to the bathing room for showers and if a resident refused a bed bath would be provided. Staff would also be expected to document if a shower was refused and a bed bath given. The RN/UM confirmed besides the shower schedule on the binder it was indicated in the EMR which residents were scheduled for showers. The surveyor toured the bathing room with the RN/UM, the shower stalls and entire bathing room floor remained dry and there was no evidence of it being used. The RN/UM acknowledged that it did not appear that the bathing room was used on the shift. The RN/UM stated that he would have to follow up with nursing staff to determine if any residents were showered. On 12/3/24 at 12:17 PM, the surveyor observed Resident #52 sitting at a table in the dayroom. The surveyor asked the resident if they received a shower today. The resident replied that they had not received a shower yet. Resident #52 confirmed the previous week when they had received a shower it was on Tuesday in the morning. On 12/3/24 at 12:47 PM, the surveyor interviewed the RN/UM about Resident #52. The RN/UM stated the resident was independent and should be able to have a shower at least twice a week if not more. The surveyor informed the RN/UM about the above concerns related to showers and Resident #52 not receiving a shower at least twice a week. The RN/UM stated it was expected for residents to have a shower twice a week, that he would in-service CNAs about shower schedules and in-service CNA#2 about the shower schedule list on the binder. On 12/3/24 at 12:50 PM, the surveyor interviewed the DON about expectations for resident showers. The DON replied that residents should have showers at least two times per week. The DON stated the shower schedule with the CNA assignment at the nurses' station indicates which residents are due for shower on shift and the CNAs were to document in the EMR, including if the resident refused. The surveyor informed the DON of the above concerns. The surveyor requested the November 2024 and December 2024 EMR documentation record for Resident #52. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 1:30 PM the DON provided a copy of the November and December 2024 EMR report for Resident #52. A review of the report revealed was no documentation of the resident receiving routine showers twice a week on assigned days. The surveyor requested from the DON any policy related showers and ADL care. On 12/3/24 at 2:05 PM, the surveyor reviewed the EMR of Resident #52. The Admission Record (a summary of important information about the resident) documented that Resident #52 had diagnoses that included hypertension, anxiety, muscle weakness, and a history of fall. A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 9/17/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #52 scored a 15 out of 15, which indicated the resident was cognitively intact. Section GG for Functional Abilities and Goals indicated that the resident required supervision/touching assistance (E.g.-steadying, contact guard assistance, verbal cueing). A care plan with a focus on ADL care had an initiation date of 6/21/24. It included interventions that detailed: Assist of (1 person or supervise) with ADL's with an initiation date of 6/21/24; and supervise with daily hygiene, grooming, dressing, as needed with an initiation date of 6/21/24. On 12/4/24 at 8:33 AM, the DON provided the surveyor the ADL policy. On 12/9/24 at 11:34 AM, the DON and LNHA met with the survey team. The DON acknowledged the concern for Resident #52. A grievance was created, the DON spoke with the resident who reported they only got 1 shower. The DON further explained in-service education was provided to nursing staff and the protocol would be updated to ensure residents received showers. A review of the facility's Activities of Daily Living Policy with a last revised date of March 2018 under Policy Statement revealed: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Under Policy Interpretation and Implementation revealed: Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . hygiene (bathing, dressing, grooming, and oral care) . and mobility (transfer and ambulation, including walking). A review of the facility's Resident Rights Policy with a last revised date of 5/30/24 under Policy Interpretation and Implementation revealed: Federal and state laws guarantee certain basic rights to all residents of this facility. These resident rights included: a. a dignified existence . e. self-determination . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	N.J.A.C. 8:39-4.1

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49078 COMPLAINT# NJ178354 Based on observation, interview, and review of other facility documentation, the facility failed to ensure the facility was maintained in a safe, clean, and homelike environment. This deficient practice was identified for 2 of 2 units, (2 North and 2 South), and 1 of 22 residents, Resident #94. This deficient practice was evidenced by the following: 1. On 12/3/24 at 11:53 AM, during a tour of the 2nd floor nursing units, the surveyor observed a gray, dust or dirt like substance adhering to the air circulation vent covers on the 2 North Unit hallway. The surveyor observed 2 vent covers on the 2 North Unit. The surveyor proceeded to the 2 South unit nurses' station and observed a similar gray substance adhering to the vent cover in the ceiling over the desk area. The surveyor observed the gray dust like substance as well as stringy cobweb like material on vent covers in the hallway of the 2 South. The surveyor observed 2 vent covers on the 2 South Unit hallway. On 12/3/24 at 12:03 PM, the surveyor informed the Housekeeping Supervisor (HKS) and the Director of Maintenance (DM) of the concerns. The HKS and the DM accompanied the surveyor to the 2 North hallway, 2 South Hallway and 2 South Nurses station where the surveyor identified the air circulation vents mentioned above. The surveyor interviewed the HKS and DM. The surveyor asked if this was the normal appearance of the air vents, and the DM replied, no. The surveyor asked if this was an area that was normally cleaned, the HKS replied yes, it should be. The surveyor asked if the vents in question appeared to be clean, the HKS and DM replied, no. The surveyor asked if this could occur overnight, the HKS replied, no. The surveyor asked if this appeared to be homelike, clean, and sanitary, the HKS and DM replied no, it does not. The HKS and DM stated that the concerns would be taken care of right away. The surveyor observed housekeeping staff on ladders cleaning the air circulation vents. On 12/4/24 the surveyor interviewed the Director of Nursing (DON) and asked if there was any documentation that the air vents are cleaned regularly. The DON stated that there were no logs or documentation for cleaning of hallways or air vents by the housekeeping staff, and the only documentation that would be available was the housekeeping schedule with room assignments. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 12/5/24, the surveyor observed the shower room located on Wing 1 in the 2 South nursing unit. In the shower room, the surveyor observed vinyl type disposable gloves on the floor in 2 areas, debris near the drain in one shower stall as well as a shampoo bottle on the floor. The shower room also contained lifts used for resident transfers, a wheelchair, shower chairs and shower gurneys. The floor of the shower room was observed to be completely dry. The surveyor brought Licensed Practical Nurse #1 (LPN#1), to the shower room. The surveyor asked LPN#1 if the floor was clean and the dry. The LPN#1 stated no, it was not clean, it was dry, and there should not be anything on the floors. The surveyor asked if the above items were usually stored here. LPN#1 stated, yes. On 12/9/24 the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON and discussed the above concerns. The surveyor reviewed the hybrid (paper and electronic) medical record for Resident #147 and revealed: According to the resident's list of diagnoses, the resident was admitted to the facility with diagnoses which included but was not limited to: malignant neoplasm of prostate (prostate cancer), type 2 diabetes mellitus, and hypertension (high blood pressure). The 5 Day Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 10/5/24, Section C reflected a Brief Interview for Mental Status (BIMS), an assessment test used to monitor cognition, score of 13 of 15 which indicated that Resident #147 had intact cognition. The resident reported that there was a stain on the shower room floor when they were brought for a shower. A nursing aide cleaned the floor before assisting with shower. A physician most recent discharge summary that reflected the resident left AMA (against medical advise), signed by the attending physician. 38327 3. On 12/5/24 at 8:33 AM, the surveyor observed an Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) posted sign and personal protective equipment (PPE) hung outside the door of Resident #94. Inside the resident's room, there was a Resident Representative #1 (RR#1) at the bedside. The surveyor observed Resident # 94 lying on the bed with the head of the bed elevated, eyes open, and non-verbal. On that same date and time, the surveyor observed the floor with dried brownish substances and an accumulation of grayish substances. The heater near the window with multiple plastic covers, papers, and plastic. In between the heater a space between the windowsill with an accumulation of blackish substances. The resident's nightstand table with dried whitish substances. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 9:12 AM, the surveyor observed an EBP posted sign and PPE hung outside the door. Inside the room the surveyor observed RR#2 at the bedside. The surveyor observed the floor with dried brownish substances and an accumulation of grayish substances. The windowsill and the heater were the same with an accumulation of grayish substances, plastics, and papers. The nightstand table with dry whitish substances. At that same time, RR#2 confirmed that the brownish dry substances and whitish substances on the nightstand were there for days. RR#2 stated that they visited the resident almost every day and at times other members of the family. RR#2 further stated that the blinds in the window were hard to open and the facility staff was aware because RR#2 had to ask for help to close the blinds. On 12/9/24 at 9:16 AM, the surveyor asked LPN#2 to accompany the surveyor inside the resident's room. LPN#2 stated that the assigned nurse of Resident #94 was not at the unit at that time. Inside the resident's room, both the surveyor and LPN#2 observed the floor, nightstand table, and heater area. At that same time, LPN#2 stated that the dried brownish substances on the floor were consistent with the color of the tube feeding (TF) formula. LPN#2 further stated that the grayish substances were an accumulation of dust that was on the floor and table. LPN#2 stated that he was unsure what were the dried whitish substances on top of the nightstand table. RR#2 stated that the white dried substances were from the pistol syringe (the tube used for flushing the TF) and that RR#2 knew because they saw how the nurses used it. LPN#1 also stated that the heater had multiple plastic covers from the TF pistol syringes and confirmed that there were multiple plastics and papers. LPN#2 further stated that the floor and table should have been cleaned and that there should be no plastics and papers in the heater. He stated that he would call the Housekeeper to clean the room. On 12/9/24 at 11:34 AM, the survey team met with the LNHA and the DON. The surveyor notified the facility management of the above findings and concerns for Resident #94 regarding the environment. On 12/11/24 at 11:43 AM the survey team met with the LNHA and the DON. The LNHA stated that the blinds in the resident's window were replaced. A review of the facility's Cleaning and Disinfection of Environmental Surfaces Policy dated August 2019 that was provided by the DON revealed: The policy reflected: Policy Statement: Environmental surfaces will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) recommendations for disinfection of healthcare facilities and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. 9. Housekeeping surfaces (e.g. floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. 14. Horizontal surfaces will be wet dusted regularly (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. Spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated A review of the facility's Homelike Environment Policy dated February 2021 that was provided by the DON revealed: The policy reflected: 2. a. clean, sanitary, and orderly environment. On 12/11/24 at 01:21 PM, the survey team met with the LNHA and DON for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-31.4(a)(b)(f)

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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. 49078 REPEAT DEFICIENCY Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to adhere to professional standards of clinical practice for failing to prevent a potential medication interaction by administering two (2) potential interacting medications at the same time for one (1) of four (4) residents (Resident #55), reviewed during the medication pass observation. The deficient practices are 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 12/4/24 at 8:23 AM, the surveyor began the Medication (med) Pass Observation task. At 9:06 AM, the surveyor observed the Licensed Practial Nurse (LPN) prepare and administer medications (meds) to Resident #55. The resident had a total of 14 meds to be administered. The meds included 1 sodium bicarbonate (an antacid) 650 mg (milligram) tablet (tab) and 1 ferrous sulfate (an iron supplement) 325 mg tab. Both meds were ordered by the physician and were scheduled to be given during the 9:00 AM med pass (medpass). The surveyor observed the LPN administered these meds to Resident #55. The surveyor concluded the medpass observation. The surveyor interviewed the LPN of the results of the medpass as well as a reconciliation of the meds administered to the residents (a verification of medication doses, times, orders, and other pertinent information). The review reflected that sodium bicarbonate and ferrous sulfate may interact if given at the same time and cause a decrease in absorption of the ferrous sulfate in the body. On 12/5/24 at 10:39 AM the surveyor interviewed the LPN. The surveyor asked how the nursing staff find out if there was a potential or actual drug interaction. The LPN stated that there were notifications on the electronic med administration record (eMAR), which are usually part of the directions that can be clicked on for more information, there can be notifications from the pharmacy provider, or from the Consultant Pharmacist (CP). The pharmacy provider may not even send a med until the order was clarified sometimes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 12:25 PM The survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) and notified them of the concerns with the medpass and potential drug interaction. The surveyor reviewed the electronic medical record (eMR) for resident #55. According to the admission record (an admission summary) that reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: Hypercalcemia (high levels of calcium in the blood), chronic kidney disease stage 4 (severe loss of kidney function), and anemia (lack of healthy red blood cells to carry oxygen). A review of Resident #55's Order Summary Report reflected a physician order (PO) dated 11/28/24 for ferrous sulfate tablet 325 mg 1 tab by mouth three times daily for anemia avoid dairy products, tetracycline, etc within 2 hours, and a PO dated 11/4/24 for Sodium Bicarbonate Oral Tab 650 mg Give 1 tablet by mouth two times a day for supplement. The surveyor accessed drug interaction data for ferrous sulfate. The data revealed that administering ferrous sulfate and sodium bicarbonate together may result in the decreased absorption of ferrous sulfate (iron) by the body by up to 50%. This can be avoided by separating the dose by 2 hours. A review of an unsampled resident's medical record revealed a CP report dated 11/11/24 that reflected a recommendation to separate Iron products from sodium bicarbonate by at least 2 hours to maximize absorption. The med administration times were separated. On 12/9/24, the DON provided a CP admission review report for Resident #55. The surveyor reviewed the CP report which did not reveal any mention of separating Iron from sodium bicarbonate. A review of the facility's Administering Medications Policy dated April 2019 revealed: The policy reflected under number 5. Med administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: b. Preventing potential med or food interactions. NJAC 8:39- 29.2 (c)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39885 REPEAT DEFICIENCY Complaint #175734 46049 Based on observation, interview, record review and review of pertinent facility documents it was determined the facility failed to: a.) ensure a resident's medication was available and administered as scheduled for 1 of 5 residents, Resident #66, reviewed for unnecessary medications and b.) ensure residents received medications as scheduled for 2 of 22 residents (Residents #79, 87) reviewed for quality of care, in accordance with physicians' orders, and standards of 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. 1. On 12/3/24 at 10:01 AM, the surveyor observed Resident #66 sitting up on their bed in their room. The resident was alert, verbally responsive, and stated they had no concerns with their care in the facility. The surveyor reviewed the paper and electronic medical record (EMR) of Resident #66. The Admission Record (AR; a summary of important information about the resident) documented that the resident had diagnoses that included muscle weakness. A comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 9/25/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #66 scored a 12 out of 15, which indicated the resident had moderate cognitive impairment. Section I for Active Diagnoses indicated the resident had diagnoses that included but were not limited to Parkinson's disease and cancer. (continued on next page)

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	315339	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Oradell	600 Kinderkamack Road Oradell, NJ 07649

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order (PO) dated 9/30/2023 documented Alprazolam 0.25 mg (milligram) tablet (tab), give 1 tab by mouth at bedtime for anxiety. The medication (med) was scheduled to be administered at 9:00 PM (9 PM). A review of the December 2024 Med Administration Record (MAR) revealed the following for the Alprazolam entry order: On 12/1/24 the nurse signed the med 9, which indicated Other/See nurses notes. On 12/2/24 the nurse signed the med as administered. On 12/3/24 the nurse signed the med 9. On 12/4/24 the nurse signed the med 9. On 12/5/24 the nurse signed the med 2, which indicated Drug Refused. On 12/6/24 the nurse signed the med 9. On 12/7/24 the nurse signed the med as administered. On 12/8/24 the nurse signed the med 2. A review of progress notes (PN) revealed the following: An administration note dated 12/1/24 by the nurse for alprazolam documented script needed, MD (Medical Doctor) aware. An administration note dated 12/3/24 by the nurse for alprazolam documented pharmacy was called, they enter in the system 12/4 at 9 PM tomorrow. An administration note dated 12/4/24 by the nurse for alprazolam documented not available [backup] under profile, called pharmacy and they said it will be added. still not available as of 9:30 PM and resident appears to be resting. An administration note dated 12/3/24 by the nurse for alprazolam documented Called pharmacy as it is not showing as available in resident profile in [backup], pharmacy said they can see it on their end and do not know why [backup] is not dispensing it. Pharmacy stated they will escalate the issue and call us back. There were no additional notes related to the alprazolam med administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 11:13 AM, the surveyor interviewed the Registered Nurse (RN#1) assigned to care for Resident #66. The RN stated that she received in report at shift change that the alprazolam was not being dispensed by the pharmacy. The RN stated the nurses could remove med from the [backup] machine for the residents and medications (meds) had to be listed under the resident's profile for a med to be removed. The RN further explained there was no house stock and med could not be removed from the [backup] as house stock. The RN stated the prescription for alprazolam was already sent to the pharmacy, she was not sure when and the RN/Unit Manager (RN/UM) was to follow up. On 12/9/24 at 12:15 PM, the surveyor observed Resident #66 sitting in a chair at their bedside. The resident was alert, calm, pleasant and verbalized no concerns. The resident stated they had been receiving alprazolam for a long time to help with restlessness at night. The resident reported no issues. On 12/9/24 at 12:17 PM, the surveyor interviewed the RN/UM about Resident #66's alprazolam. The RN/UM stated he was not aware of the issues with the med delivery and would follow up with the pharmacy. On 12/9/24 at 2:39 PM, the surveyor informed the Director of Nursing (DON) of the concern regarding Resident #66's alprazolam med signed as not administered for 6 of 8 days and the med not dispensed from the [backup] machine. The DON confirmed there was no house stock in the facility and stated that stat [immediate] delivery from the pharmacy could be requested if a med was not available. The DON stated she would review to provide additional information. The surveyor requested from the DON any supportive documentation including any delivery receipts and med dispensing reports for the alprazolam med. On 12/11/24 8:32 AM, the DON provided a Drug Location Reconciliation Report from 12/1/24 to 12/8/24 for Alprazolam 0.25 mg tab, and revealed 4 entries of when the medwas dispensed on 12/5/24 and 12/8/24. The list of residents did not include Resident #66. There was no additional information provided related to Resident #66's alprazolam med. On 12/11/24 at 11:43 AM, the Licensed Nursing Home Administrator (LNHA) and the DON met with the survey team. The DON called the pharmacy who were already aware of the issue of Resident #66's Alprazolam not being dispensed from the [backup] machine and addressed the issue. The DON stated that they have not gotten back to her about what happened during the time the med was not available from the [backup] machine. The surveyor asked about the entries on 12/2/24 and 12/7/24 signed as med administered to the resident as the provided report did not include alprazolam being removed for Resident #66 on those days. The DON could not speak to those days and stated she would have to follow up. The DON acknowledged the concern of the resident not receiving the med for multiple days and protocol not being followed by the nurses. The DON stated if a med was not available, the nurses should have informed her, the physician, and could have requested a stat delivery of a small quantity of the resident's med until the issue with the [backup] machine was resolved. The DON confirmed that there was no documentation that the nurses informed the physician regarding alprazolam not being available for the resident and the resident not receiving the med. The DON provided the Med Administration. The surveyor requested any additional policy related to med availability. There was no additional information provided by the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 12/2/24 at 10:42 AM, the surveyor observed Resident #87 sitting in bed with the head of bed elevated in their room. The resident was alert, oriented, and verbally responsive. Resident #87 reported concern at times of not receiving their morning meds at the time scheduled. The resident further explained that they did not receive their meds until the early afternoon, around 1 PM. Resident #87 stated they received med to help with dizziness which was important to them to receive on time as it had a positive effect on the rest of their day. The resident stated the meds were routine meds they received. Resident #87 recalled it occurred the past week, Saturday, Sunday, and last Monday. The resident stated they discussed their concern with Resident #79, their roommate, and they could provide additional information on its occurrence. The surveyor reviewed the paper and EMR of Resident #87. The AR documented that the resident had diagnoses that included but were not limited to, acute cystitis (a bladder infection), vertigo (dizziness), and muscle weakness. A cMDS with an ARD of 9/19/24, with a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. A review of the PO, and the November and December 2024 MAR revealed the resident was scheduled to be administered the following meds on at 8:00 AM (8 AM) and 9:00 AM (9 AM): - Potassium Chloride crystals extended-release (ER) 20 milliequivalents (MEQ) tab, give 1 tab by mouth one time a day for hypokalemia (low potassium) at 8 AM, with a start date of 9/18/24. -Folic Acid 1 mg tab, give 1 tab by mouth one time a day for supplement at 9 AM, with a start date of 9/14/24. - Lexapro 10 mg tab. Give 1 tab by mouth one time a day for depression at 9 AM, with a start date of 10/31/24. - Magnesium Oxide 400 mg tab by mouth one time a day for supplement at 9 AM, with a start date of 9/14/24. - Multi-vitamin/minerals tab, give 1 tab by mouth one time a day for supplement at 9 AM, with a start date of 9/14/24. -Vitamin B-1 100 mg tab, give 1 tab by mouth one time a day for supplement at 9 AM, with a start date of 9/14/24. - Vitamin B12 1000 mcg (microgram) ER tab, give 1 tab by mouth one time a day for supplement at 9 AM, with a start date of 9/18/24. - Meclizine 25 mg tab, give 1 tab by mouth every 12 hours for dizziness at 9 AM and 9 PM, with a start date of 11/4/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/2/24 at 10:51 AM, the surveyor observed Resident #79 sitting in a wheelchair at their bedside. Resident #79 was alert, oriented, and verbally responsive. Resident #79 reported concern of occasions where morning meds were not received at their scheduled time and confirmed meds were given late on Saturday, 11/30/24 and Sunday, 12/1/24. The resident further explained they recalled it was LPN #2 and that there was no reason provided why the med was administered late and that the nurse was taking long to provide meds. Resident #79 further stated on 11/25/24 that the meds were administered late and given in the afternoon. The resident could not recall the nurse's name. In addition, Resident #79 stated on 11/29/24 their evening meds at 5:00 PM to 6:00 PM were given at 9 PM and believed LPN # 3 was the nurse. The surveyor reviewed the paper and EMR of Resident #79. The AR documented that the resident had diagnoses that included but were not limited to, peripheral vascular disease, type 2 diabetes mellitus, and hyperlipidemia (high levels of lipids or fats in the blood). A cMDS with an ARD of 9/24/24, with a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. A review of the PO, and the November and December 2024 MAR revealed the resident was scheduled to be administered the following meds at 8 AM, 9 AM, and 5:00 PM (5 PM): - Aspirin enteric coated (EC), delayed release 81 mg tab, give 1 tab by mouth one time a day for CAD [coronary artery disease] at 9 AM, with a start date of 1/24/24. -Artificial Tears Solution 1.4%, instill 1 drop to both eyes two times a day at 9 AM and 5 PM, with a start date of 11/15/24. -Active liquid protein sugar free 15 gram/30 milliliter (ml) 30 ml two times a day for supplement at 9 AM and 5 PM, with a start date of 9/10/24. -Calcium + Vitamin D3 600-200 mg, give 1 tab by mouth two times a day for supplement at 12:00 PM and 5 PM, with a start date of 6/14/24. -Gabapentin 100 mg capsule (cap), give 1 cap by mouth two times a day for neuropathy at 9 AM and 5 PM, with a start date of 1/24/24. - Metformin ER tab, give 1 tab by mouth two times a day for diabetes at 8 AM and 5 PM, with a start date of 6/14/24. - Peridex solution 0.12%, give 15 ml by mouth two times a day at 9 AM and 5 PM, with a start date of 8/23/24. - RisaQuad (Probiotic) cap, give 1 cap by mouth two times a day for supplement at 9 AM and 5 PM, with as start date of 1/24/24. - Xarelto 2.5 mg tab, give 1 tab by mouth two times a day at 9 AM and 5 PM, with a start date of 1/24/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Humalog 100 unit/ml solution, injection as per sliding scale, subcutaneously before meals for diabetes mellitus at 8 AM, 12:00 PM (12 PM), and 5 PM, with a start date of 8/15/24. - Multiple vitamins with minerals tab, give 1 tab by mouth in the evening for supplement at 5 PM, with a start date of 1/24/24. On 12/3/24 at 9:28 AM, the surveyor requested from the DON the med administration audit report (MAAR) for the November 2024 and December 2024 MAR of Residents #87 and #79. On 12/3/24 at 10:34 AM, the DON provided the MAAR for Resident #87 and #79. A review of the report for Resident #87's med administration revealed the following: On 11/25/24, Resident #87's 8 AM and 9 AM meds were documented and signed as administered by RN #1 at the times of 12:48 PM to 12:50 PM. On 11/30/24, Resident #87's 8 AM and 9 AM meds were documented and signed as administered by the Licensed Practical Nurse (LPN #4) at the times of 10:19 AM to 10:22 AM. On 12/1/24, Resident #87's 8 AM and 9 AM meds were documented and signed as administered by LPN #4 at the times of 10:27 AM to 10:28 AM. On 12/2/24, Resident #87's 8 AM and 9 AM meds were documented and signed as administered by LPN #1 at the times of 10:28 AM to 10:29 AM. A review of the report for Resident #79's med administration revealed the following: On 11/25/24, Resident #79's 8 AM and 9 AM oral meds and eye drops were documented and signed as administered by RN #1 between the times of 11:55 AM to 11:56 AM. On 11/28/24, Resident #79's 5 PM oral meds and eye drops were documented and signed as administered by LPN #3 between the times of 8:46 PM to 8:55 PM. On 11/29/24, Resident #79's 5 PM oral meds and eye drops were documented and signed as administered by LPN #5 between the times of 7:55 PM to 7:56 PM. On 12/1/24, Resident #79's 8 AM and 9 AM oral meds were documented and signed as administered by RN #1 between the times of 10:25 AM to 10:26 AM. On 12/2/24, Resident #79's 8 AM and 9 AM oral meds and eye drops were documented and signed as administered by LPN #1 between the times of 10:45 AM to 10:46 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 11:51 AM, the surveyor interviewed LPN#1, about the timeframe for med administration. LPN #1 stated routine meds could be given one hour before and one hour after the scheduled time. The LPN further explained that documentation should be completed after the med was administered to the resident. LPN #1 acknowledged there may be times meds were not administered at the scheduled time due to a resident may refuse at the time due or there was an emergency situation. The surveyor asked what would be the protocol for when a med was not administered within the scheduled timeframe. LPN #1 replied that a nurse note should be documented with the reason why the med was given late. There was no additional response from the LPN. On 12/5/24 at 11:10 AM, the surveyor interviewed LPN #3 about med administration. LPN #3 stated meds were to be administered 1 hour before or an hour after it was scheduled to be administered. LPN #3 further explained after meds were administered the MAR would be signed that the med was administered. LPN #3 acknowledged there were times meds would not be administered within the scheduled timeframe due to it being busy, other residents needing assistance or other emergent situations that could be going on. On 12/5/24 at 11:16 AM, the surveyor interviewed LPN #5 who stated meds could be administered an hour before and an hour after a med was scheduled to be administered. Additionally, the nurses were to document and sign the MAR after a med was administered. LPN #5 acknowledged there were times meds were not administered at its scheduled time. The LPN further explained, there could be heavy workload, and computer issues may occur which could contribute to delay in administering meds. On 12/5/24 at 11:22 AM, the surveyor interviewed RN #1 who stated meds should be given within an hour before and an hour after the med was scheduled. The RN stated the MAR should be signed the moment after the med was administered. RN #1 stated she tried to be timely with med administration and may be delayed due to an emergency or incidents out of the ordinary. On 12/5/24 at 12:25 PM, the survey team met with the DON and LNHA. The surveyor interviewed the DON about med administration. The DON stated it was expected meds were to be given within an hour before and an hour after a med was scheduled to be administered. Additionally, the DON stated the nurses were expected to document and sign the MAR as soon as the med was administered. The surveyor reviewed the MAAR with the DON who confirmed that the documentation time listed the time the nurses documented for a med and the administration time was the time when med was administered to a resident. The surveyor informed the DON and LNHA of the reported concerns from Resident #79 and Resident #87 and the review of the MAAR which indicated the meds were administered outside of its scheduled timeframe. On 12/9/24 at 11:34 AM, the DON and LNHA met with the survey team. The DON stated that she spoke with the residents about their concerns and completed a grievance. The DON acknowledged it was a concern that meds were being administered late. The specified nurses were provided 1:1 in-service education and education was being provided to the other nurses. There was no additional information provided by the facility. A review of the facility's Administering Medications Policy with a last revised date of April 2019 revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Under Policy Statement indicated meds were to be administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation, it revealed: 7. Meds are administered within 1 hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the med will enter the appropriate documentation code on the electronic MAR. 22. The individual administering the med initials the resident's MAR on the appropriate line after giving each med and before administering the next ones. For centers using electronic documentation, electronic signatures are utilized. N.J.A.C. 8: 39-27.1

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident received care consistent with professional standards of practice, to prevent pressure ulcers, and promote healing. This deficient practice was identified for 1 of 2 residents, (Resident #197) who was identified as having a pressure right hip injury on 11/13/24, with no description of a wound, which progressed to an unstageable wound to the right hip with 30% slough (necrotic tissue that needs to be removed from the wound for healing to take place) with serosanguinous drainage. The wound measured 3 centimeters (cm) x 4 cm x 0.1 cm and was identified during routine wound rounds by a consultant on 11/20/24. The resident developed an unstageable pressure wound to the right hip on 11/20/24, which required chemical debridement when the resident was hospitalized on [DATE]. The evidence was as follows: 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. According to the National Pressure Injury Advisory Panel (NPIAP), Pressure Injury Stages, the updated staging system includes the following definitions: Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer that may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of the soft tissue . Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to [name of immediate care company], Types of Wound Drainage and How to Tell When It is Serious, it's important to be able to identify different types of drainage in order to best care for wounds and discuss possible treatment options with the doctor. According to Disease and Condition, 4 Types of Wound Drainage: 1. Serous Drainage, a thin, watery, and clear substance exiting the wound is classified as serous drainage. When the wound is fresh and going through the inflammatory wound healing stages, it's perfectly normal to experience this type of drainage. If notice an overwhelming amount of serous drainage, it may indicate high bioburden or the presence of unsterilized bacteria living on the wound. 4. Serosanguineous is the most common type of drainage. It is thin, watery, and tends to be pink in color, but can also be shades of darker red. The pink/red coloring has to do with red blood cells in the fluid, a sign of capillary damage. 1. On 12/02/24 at 10:12 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) for an entrance conference. The DON informed the surveyor that residents with wounds including pressure ulcers, tube feeding, tracheostomy, dialysis, and an opening in their bodies were placed on EBP (Enhanced Barrier Precautions, are an infection control intervention to reduce MDRO (mutidrug resistant organism; are germs that are resistant to many antibiotics and can cause infections) transmission in nursing homes). The surveyor asked the LNHA and DON for list of residents with facility acquired wounds. On 12/2/24 at 11:09 AM, the surveyor observed a posted sign outside the door for EBP. Inside the room, Resident # 197 was lying on the geri chair. The surveyor reviewed the medical records of Resident #197. The Admission Record (an admission summary) revealed that the resident was admitted to the facility with the following medical diagnoses that were not limited to; unspecified dementia, contracture right knee and left knee, and abnormal posture. A review of the Braden scale (to measure risks of resident's developing pressure ulcers) dated 10/29/24, the resident scored 11 out of 23 which indicated high risk for developing pressure ulcers. The most recent comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 10/27/24, revealed that the resident's cognitive skills for daily decision-making were severely impaired. The cMDS indicated that the resident had no wounds. A review of the Resident Evaluation for admitted d 10/21/24, revealed sacrum, left heel, and right heel redness. There was no documented evidence of sacrum or left and right heel redness measurements. A review of the Resident Evaluation for readmitted d 11/25/24, revealed left heel blanchable skin ecchymosis, right heel blanchable skin ecchymosis, sacrum skin excoriation on a pressure point, and right trochanter (hip) suspected deep tissue injury (DTI). There was no documented evidence of measurements of the mentioned skin impairments on the left and right heels, sacrum, and right hip. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the list of residents with facility-acquired wounds provided by the LNHA on 12/02/24 at 12:10 PM, revealed two residents which included Resident #197 for sacral wound stage 2 (sore area of skin has broken through the top layer of skin (epidermis) and some of the layer below (dermis)) pressure ulcer that started on 11/20/24. A review of the wound consultation reports revealed the following: -10/23/24: recommended moisture barrier cream to bilateral buttocks and sacrum, skin prep and offload blanchable heels. There was no documented evidence that there were pressure ulcers identified for the sacrum. -11/20/24: Unstageable right hip 3 cm x 4 cm x 0.1 cm, 40% dermis, 30% slough, 30% epithelization, full thickness, serosanguineous, cleanse with saline medihoney dry dressing daily/prn (as needed), reposition side to side, monitor for changes. There was no documented evidence that there was a pressure ulcer identified for the sacrum. -11/27/24: Stage 2 right hip 3 cm x 3 cm x 0.1 cm, 100% dermis, partial thickness, cleanse with saline medihoney dry dressing daily/prn, reposition side to side, monitor for changes. There was no documented evidence that there was a pressure ulcer identified for the sacrum. A review of the physician orders (PO) revealed the following: -Calmoseptine external ointment 0.44-20.6% apply to sacrum topically every day and evening shift for redness with a start date of 10/22/24 and discontinued (d/c) on 11/22/24. -Weekly skin observations every day shift every Wed (Wednesday) 0-NO skin breakdown, 1-Previously identified wound 2-Newly identified wound with an order date of 10/22/24 and d/c order on 11/22/24. The above order for skin observations revealed that the nurse every Wed at 7:00 AM-3:00 PM (day shift) will code 0 if there was no skin impairment, code 1 if there was a previously identified wound, and code 2 if a newly identified wound was identified. -Offload heels while in bed as tolerated every shift with an order date of 10/21/24 and d/c on 11/22/24. -Optifoam to left hip every day shift for protection with a start date of 11/14/24 and d/c 11/21/24. -apply optifoam to right hip everyday shift for protection with an order date of 11/13/24 and d/c order on 11/21/24. -Cleanse Right ischium (hip) with NSS, pat dry, apply Medi-honey ointment (wound and burn gel made from honey that has antibacterial and bacterial resistant properties, meaning it prevents bacteria from building a tolerance to its beneficial effects) to the wound bed, and cover with Opti foam (is a foam dressing that has a silicone adhesive border, waterproof backing and can stay in place up to 7 days, depending on the amount of wound drainage) every day shift for Pressure with an order date of 11/21/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Weekly skin observations every evening shift every Thu (Thursday) 0-NO skin breakdown, 1-Previously identified wound 2-Newly identified wound with an order date of 11/25/24. -Offload heels while in bed every shift with a start date of 11/25/24. -Skin prep right heel every day and evening shift with a start date of 11/26/24. -Skin prep left heel every day and evening shift for protection with a start date of 11/26/24. -Cleanse right trochanter/hip wound with NSS (normal saline solution), pat dry, apply Medi-honey ointment, cover with optifoam dressing every day shift for wound care with a start date of 11/26/24. -Apply optifoam dressing to sacrum every day shift for protection with a start date of 11/27/24 and d/c 12/03/24 -Apply optifoam dressing to left hip every day shift for protection with a start date of 11/27/24 and d/c 12/03/24. The above PO were transcribed to the electronic Treatment Administration Record (eTAR) for November and December 2024 and revealed: -on 11/13/24, the Licensed Practical Nurse (LPN) signed the eTAR and coded 1 (previously identified wound) of the weekly skin observations for the day shift. A review of the Pressure Injury Documentation in the electronic medical record revealed: -11/21/24 at 3:23 PM, the first observation: right hip stage 2, measurement: 3 cm x 4 cm x 0.1 cm, 30% epithelial, 30% sloughed, 40%dermis, serosanguineous drainage, and electronically signed by the Registered Nurse (RN). -11/27/24 at 3:42 PM, the first observation: right hip stage 2, measurement 3 cm x 3 cm x 0.1 cm, 100% dermis, serous drainage, and electronically signed by the RN on 12/02/24 at 3:44 PM. Further review of the above medical records revealed that there was no documented evidence that the facility staff identified the right hip wound prior to the wound doctor identifying the pressure injury. The unstageable wound to the right hip was identified during the wound rounds. A review of the personalized care plan (CP) revealed that there was no documented evidence that the actual new pressure injury in the right hip was identified and initiated an intervention to promote healing and prevent further development of new pressure injury. Further review of the medical records revealed that there was no documented evidence that the physician was notified of the new pressure injury to the right hip. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the most recent hospitalization records revealed that Resident #197 was seen by the Advance Practice Nurse (APN) on 11/22/24, for wound evaluation. The APN documented on her assessment that the resident was dependent on mobility, and skin characteristics: right trochanter with a full-thickness wound, stage 3 pressure injury (prior to admission to the hospital) approximately 2.5 cm x 2.5 cm, wound based appeared 70% viable tissue and 30% yellow fibrinous debris, and with a scant amount of serosanguinous exudate. The APN also documented the topical care: apply collagenase to the site for enzymatic debridement and cover with a silicone dressing to promote moist wound healing and for protection, change daily. On 12/04/24 at 12:54 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) of 2 North. The RN/UM informed the surveyor that it was the responsibility of the nurses to initiate a care plan upon admission, and he was responsible for updating the care plan. The surveyor notified the RN/UM of the above concerns that there was no CP initiated for the right hip pressure ulcer when it was first identified by the wound doctor on 11/20/24. The RN/UM stated, I missed it. He also confirmed that there was no stage 2 pressure injury to the sacrum and the facility-acquired wound was the right hip. At that same time, the surveyor notified the RN/UM of the concern that there was no documented evidence in the 10/21/24, admission that there was right hip skin impairment and 11/25/24, readmission resident's evaluations (assessment) that the skin impairment in the right hip was measured. The RN/UM responded that the nurse should have documented wound measurements. The RN/UM stated that the right hip had a previously healed wound which was why on 11/13/24, optifoam dressing was ordered as protection. The RN/UM further stated that he would get back to the surveyor as to why there was no documented evidence that there was a previously identified wound to the right hip. On 12/04/24 at 02:27 PM, the surveyor notified the DON of the concern that the resident's unstageable right hip wound was identified on 11/20/24, by the wound doctor during the routine wound rounds. The surveyor asked the DON why there was an order for optifoam dressing on 11/13/24, and the DON responded that there was no wound or redness on the right hip on 11/13/24, it was ordered for protection. At that same time, the DON stated that she understood the concern of the surveyor as to why the facility did not see the right hip wound, and it was the wound doctor who identified it, when the wound doctor saw the wound, it was unstageable with slough and drainage. The DON stated that she would get back to the surveyor. On 12/05/24 at 10:46 AM, the surveyor interviewed the RN regarding skin and wound assessment. The RN stated that she knew that for an open wound, the nurse should measure the wound, but she was unsure if she had to measure intact skin or intact skin impairment like redness or bruise. She further stated that it was the responsibility of the wound doctor to stage the wound every Wednesday during wound rounds. The surveyor asked the RN, what would happen for residents who developed new wounds, new admission, and readmission with wounds, who would stage the wound and document appropriate wound description to obtain the correct treatment if the wound doctor came on Wednesday only. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At that same time, the RN acknowledged that she was the nurse who documented pressure injury documentation for the dates 11/21/24 and 11/27/24, for the right hip. She stated that the 11/21/24, right hip documentation was based on the 11/20/24 wound consult notes documentation. The surveyor then asked if she copied the wound documentation from the wound doctor, and why she documented stage 2 as not unstageable considering that there were no changes from the description of the wound doctor, and the RN did not respond. On 12/05/24 at 10:54 AM, the surveyor observed the wound treatment of Resident # 197 done by RN/UM and was assisted by the RN. The RN/UM read the order: to cleanse the right hip wound with NSS (normal saline solution), pat dry, apply medihoney ointment, and cover with optifoam dressing everyday shift for wound care (start date 11/26/24). The RN/UM removed the right hip dressing and informed the surveyor that the wound was beefy red, and the measurement was 0.5 cm x 0.5 cm. The RN did not perform hand hygiene in between gloves use, after direct contact to resident's environment (garbage receptacle), and prior to exiting the resident's room. The RN/UM did not disinfect the marker used to sign the dressing applied to the resident before and after use, and did not disinfect the container of medihoney that was brought inside the resident's room prior to returning inside the treatment cart. On 12/05/24 at 11:26 AM, the surveyor interviewed the LPN. The LPN confirmed that she was the nurse on 11/13/24 and 11/20/24 who signed the eTAR for a weekly skin evaluation. She stated that she coded 1 which meant that there was a previously identified wound. The LPN further stated that the previously identified wound was the right hip and she remembered it was definitely not a redness, it was more than that, it was worse and open. She further stated that on 11/13/24, she remembered that was the time the resident was moved to her side and assignment, and she did the skin evaluation and signed the eTAR. The surveyor asked why she coded it a previously identified wound that was not identified in the admission, and the LPN responded that when she notified the RN/UM at that time, the RN/UM told her that they knew about it, and they had been monitoring it and the RN/UM took care of it that was why she coded 1 as previously identified wound for the right hip. Further review of the EMR revealed the following: -The Late Entry Progress Notes (PN) with an effective date of 11/30/24, created on 12/08/24 at 4:23 PM, that was electronically signed by the Medical Doctor (MD) revealed that the right hip wound was covered with a dressing. -The PN with an effective date of 12/08/24, that was electronically signed by the MD revealed that the MD was called by the nurses on 11/13/24, that the resident had right hip pressure noted, optifoam dressing daily was ordered, the staff was advised to monitor for worsening changed of the area, wound care consult advised, and monitor for fever. -The Late Entry PN with an effective date of 11/20/24, created on 12/03/24 at 12:47 PM, that was electronically signed by the DON revealed that the RN/UM reported to her that during wound rounds with the wound team, the resident was noted with right hip pressure ulcer, 3 cm x 4 cm x 0.1 cm with small amount of serosanguineous drainage, 40% dermis, 30% slough, 30% epithelialization. Further review of the above EMR revealed that the advice of the MD on 11/13/24, to consult the wound doctor was not followed for the right hip pressure wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/05/24 at 12:25 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the concerns with Resident #197's right hip facility-acquired wound. On 12/09/24 at 11:34 AM, the survey team met with the LNHA and DON. The DON informed the surveyor that she asked the RN/UM to create another wound timeline that would include more information on Resident #197's right hip facility-acquired wound. The DON stated that the nurses should be able to assess, describe a wound, stage a wound, and relay to the doctor the wound to obtain an appropriate treatment order promptly. She further stated that the nurse should measure any skin impairment either a bruise, pressure ulcer, or skin tear as part of the assessment. At that same time, the DON stated that there was no documentation from the nurse why the order for optifoam dressing was obtained and it was missed by the nurse. The DON further stated that there was no documentation from the facility before the wound doctor identified the facility-acquired unstageable pressure injury to the right hip. The DON stated that there was a knowledge deficit on the part of the nurse on how to describe and assess the appearance of the wound, because if the nurse had seen that it should have been documented and notified the doctor to obtain a proper treatment for that skin impairment. Furthermore, the surveyor asked the LNHA and the DON if they were able to verify with the LPN that she was able to identify the right hip wound on 11/13/24, during weekly skin observation, why it was not investigated, and why the LPN did not notify the physician of the observation that the right hip was an open wound and non-intact skin. The DON stated that she would get back to the surveyor. On 12/09/24 at 01:29 PM, the surveyor interviewed the DON regarding the Pressure Injury Investigation Form (PIIF) dated 11/13/24, the PIIF revealed an investigation for right hip pressure injury with no description of the pressure injury, no measurements, and did not include what stage the wound was. In the summary, it was documented that the pressure injury was unavoidable. The PIIF instruction included in the summary was if unavoidable, a box should be checked off for a yes or a no if the physician has completed the physician documentation form or written a progress note, and it was not checked off. The DON stated that she had to ask the RN/UM who did the PIIF because she did not have a copy of the PIIF. The surveyor also notified the DON of the concern that the PIIF investigation on 11/13/24, did not match what was previously provided information of the DON and the RN/UM about the right hip and that no wound was why the order for optifoam the physician was for protection. On 12/09/24 at 01:33 PM, the DON provided a copy of the Pressure Injury investigation dated 11/20/24, which was prepared by the DON for the right hip that was identified during wound rounds, that the incident was unwitnessed, and that no statements were found. Attached to the investigation were the Pain Evaluation and Braden Scale assessment with an effective date of 11/20/24, which was electronically signed by the DON on 12/03/24. The surveyor asked the DON why the pressure injury investigation on 11/20/24, was incomplete, with no staff statements, and was not completed until 12/03/24, after the surveyor's inquiry. The DON stated that she had to get back to the surveyor. On 12/11/24 at 8:49 AM, the surveyor called and left a message for the Wound Doctor (WD#1), and the doctor did not return the call. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/11/24 at 10:50 AM, the surveyor interviewed WD#2 and notified that WD#1 did not return the call of the surveyor. WD#2 informed the surveyor that she was the covering wound doctor of the facility and acknowledged that WD#1 was the other doctor who was caring for the resident. WD#2 stated that she was familiar with the resident and had seen the resident since last week. She further stated that the wound team rounds were every Wednesday between 7:00 AM-9:00 AM. On that same date and time, the surveyor asked WD#2 about the identified unstageable pressure injury to the right hip on 11/20/24, and WD#2 stated that a resident would be possible to develop an unstageable open wound or intact DTI if the resident was immobilized for 6 hours that was why it was important to turn and reposition the resident. A review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol Policy with a revision date of March 2014 that was provided by the DON revealed: Assessment and Recognition: 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; 3. Staff will examine the skin of a new admission for ulcerations or alterations in skin . On 12/11/24 at 01:21 PM, the survey team met with the LNHA and DON for an exit conference. The facility management did not provide additional information. NJAC 8:39-27.1 (a,e)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49078 REPEAT DEFICIENCY Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services of residents that were receiving oxygen, according to the standard of clinical practice and the facility's policy and procedure. Specifically, a.) administer oxygen therapy according to the physician's order, b.) obtain a valid order for continuous oxygen use, c.) clarify the physician's order for as needed (PRN) oxygen, and d.) document the use of PRN oxygen therapy for 1 of 3 residents, Resident #19. 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 12/2/24 at 11:17 AM, during initial tour, the surveyor observed Resident #19 in bed, awake, with oxygen (O2) being administered by nasal cannula (N/C) (tubing that fits around the face and provides O2 into the nostrils). The rate of O2 delivery reflected on the supply gauge was 2 liters per minute (LPM). The N/C was displaced from the resident's nostrils and located on the bridge of the nose. On 12/3/24 at 10:52 AM, the surveyor observed the resident in bed, sleeping. The resident was observed with O2 in use at 2 LPM via N/C. On 12/5/24 at 10:50 AM, the surveyor observed the resident in bed, sleeping. The resident was observed with O2 in use at 2 LPM via N/C. The surveyor reviewed the hybrid (electronic and paper) medical record for Resident #19. According to the resident's list of diagnoses, the resident was admitted to the facility with diagnoses which included but was not limited to: chronic obstructive pulmonary disease [COPD] (an ongoing lung condition caused by damage to the lungs), type 2 diabetes mellitus, and anxiety disorder. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/24/24, Section C reflected a Brief Interview for Mental Status (BIMS), an assessment test used to monitor cognition, score of 03 of 15 which indicated that Resident #19 had severe cognitive impairment. Further review of the MDS, Section O, revealed the resident was not using O2. A review of the resident's Care Plan (CP), dated 9/27/24, reflected, that the resident was at risk for respiratory impairment related to COPD with an intervention of administer O2 per physician order (PO). A review of Resident #19's Order Summary Report (OSR) reflected a PO dated 5/24/24 for O2 at 2 LPM via: N/C PRN for O2 less than less than 92. The above PO was transcribed in the electronic Treatment Administration Record (eTAR). A review of Resident #19's November 2024 eTAR revealed no documentation of the resident using O2 use for the month. Further review of December 2024 eTAR reflected no documentation of the resident using O2 as of December 5th, 2024. A review of Resident #19's O2 saturation (sats) levels, (saturation - a measure of how much O2 is in your blood) summary, from Weights and Vitals Summary, for November and December 2024 did not reveal any saturation levels less than 92. The sats reflected if the resident was on either O2 or room air. On 12/5/24 at 2:27 PM, the surveyor interviewed the Licensed Practical Nurse (LPN). The surveyor asked if Resident #19 uses O2 continuously and was there an order for it. The LPN replied yes, the O2 was continuous and proceeded to check the resident's electronic medical record (eMR) for the order. The LPN stated that there was an order for O2 2 LPM PRN sat less than 92. The LPN stated that Resident #19's family member who was involved with the resident's care wanted it on all the time. On 12/11/24 at 11:30 AM, the surveyor notified the Director of Nursing (DON) about the concern with Resident #19. On 12/11/24 at 11:45 AM, the DON provided a copy of Physician Order Sheet (POS) with a handwritten order dated 12/9/24, (after surveyor inquiry), by the attending physician (MD) that reflected instructions to increase O2 to 3 LPM at bedtime and to put back to 2 LPM during the day. The surveyor notified the DON that no order for 2 LPM routine was observed in the resident's eMR. The DON stated that the order needed to be clarified. The facility did not provide any further pertinent documentation. A review of the facility's Oxygen Administration Policy dated October 2010 revealed: The policy reflected, under Preparation, 1. Verify that there is a PO for this procedure. Review the PO or facility protocol for O2 administration. Documentation, .the following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 5. The reason for PRN administration. NJAC 8:39-11.2(a,b); 27.1(a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39885 REPEAT DEFICIENCY Complaint # 175734 48781 Based on observation, interviews, and record reviews it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to: a.) provide nursing assistance care to resident in accordance with the resident care plans for 1 of 22 residents, Resident #22, reviewed and b.) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey . This deficient practice was evidenced by the following: 1. On 12/2/24 at 11:20 AM, the Resident Representative of Resident #27 requested to talk to the surveyor, who stated, They have a huge staffing issue, on Saturday 11/30/24, they had one aide on the floor, I got from a source that it was a scheduling issue and it was a common thing, these girls are working hard. On 12/3/24 at 11:11 AM, the surveyor observed Resident #22 sitting on the wheelchair in the resident's room. The surveyor interviewed the resident who stated that they attended resident council meeting every month and held a position in the council. The resident further stated that there was a problem with the number of aides and the resident was left on the toilet for about half an hour about a month ago. The resident was unable to state the exact date. The resident also stated that the aides on board were spread too thin and the weekend was terrible. The surveyor reviewed Resident #22's medical records and other documents and revealed: A review of the Resident Council minutes held on 11/22/24 at 2:00 PM under resident concerns revealed [Name Redacted] waited on toilet calling for aide for 10 minutes. Resident's #22's Admission Record (admission summary) reflected diagnoses included but not limited to type 2 diabetes mellitus without complications, non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 10/11/24, reflected the resident had a brief interview for mental status (BIMS) score of 13 out of 15, indicating that the resident had an intact cognition. The MDS also revealed that the resident required substantial/maximal assistance for toileting. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 12:25 PM, the surveyor interviewed the Certified Nursing Aide (CNA) on the 2 North Wing. The CNA stated that the staffing depends on the census, the aides work short in the weekends. The CNA further stated that she got 10 residents when aides call out and they were give 1 to 2 extra residents. The CNA also stated that the facility management attempted to call people at home but they do not come and the facility did not offer any bonuses. The CNA informed the surveyor that last Saturday, 1 CNA called out, we worked with 4 CNAs, the census was like 58, Sunday we had six CNAs. The CNA further stated that last Saturday and Sunday she had 11 residents each day. On 12/4/24 at 11:34 AM, the surveyor interviewed the Staffing Coordinator (SC), regarding staffing for CNAs. The SC stated, Our CNA staffing, we can be challenged more on Saturdays and Sundays, during the week it was pretty good. I know that the ratio on days 1:8, evenings 1:10 and night shifts 1:14. The SC further stated that she was short as far as the aides and unable to meet the mandated staffing law because she did not have enough staff. The SC added that we lost 7 to 8 aides and had not replaced them. She further stated that the facility had a program for Hospitality Aides to get more CNAs, but most will go somewhere after graduation because they said they can go elsewhere and make more. On that same date and time, the SC informed the surveyor that it had been going on over time, a little less than a year the problem with short staff and that the SC spoke to Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) about it. The SC stated that the facility do not utilized agencies, have not used bonuses and the SC did not know why. The SC further stated that I was told by other employees that families will complain that my relative was not changed, and that the SC knew because of short staff. On 12/4/24 at 12:12 PM, the surveyor interviewed the DON and the LNHA. The DON stated, We are aware of the state ratio regulations. I am aware of the shortage of CNAs for the last 3 months, during the week it was manageable even though we are not compliant with the regulations, the weekend is more challenging, we try to come in and help. We do not employ agencies, maybe in the beginning. So right now, the recent graduates of CNA class, the class is free, they get an increase once they are hired. I reviewed the staffing at least twice a day, communicate to staffing coordinator, about the staffing. The LNHA stated, We give a class that we offer free to CNAs. We do our best. I have given bonuses and used agencies in the beginning. We do have a referral bonus too. The surveyor notified the LNHA and the DON of the above concerns. 2. For the 8 weeks of AAS-11 staffing, the facility was deficient in CNA staffing as follows: For the 2 weeks of staffing prior to survey from 11/17/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/17/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -11/18/24 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -11/19/24 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -11/20/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -11/21/24 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. (continued on next page)

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	315339	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Oradell	600 Kinderkamack Road Oradell, NJ 07649

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/22/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -11/23/24 had 7 CNAs for 104 residents on the day shift, required at least 13 CNAs. -11/24/24 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/25/24 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -11/26/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -11/27/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -11/28/24 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -11/29/24 had 7 CNAs for 104 residents on the day shift, required at least 13 CNAs. -11/30/24 had 6 CNAs for 104 residents on the day shift, required at least 13 CNAs. A review of the facility's Staffing, Sufficient and Competent Nursing Policy dated August 2022. The policy statement revealed, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. NJAC 8:39-25.2(b), 27.1(a)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48781 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure the accurate daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for 2 of 6 days during the annual re-certification survey. This deficient practice was evidenced by the following: On 12/2/24 at 9:00 AM, upon entry to the facility, the surveyor observed a Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the main entrance. The NHRCSR posted was dated 11/30/24 with a census of 107, for the [7:00 AM to 3:00 PM] day shift. There was no NHRCSR for 12/2/24 posted. On 12/4/24 at 11:21 AM, the surveyor interviewed the covering Receptionist on the main entrance, who was also the Unit 2 South Unit Clerk (UC), regarding the posting of the NHRCSR. The UC stated, The Staffing Coordinator (SC), will print it out and give it to the receptionist to put it up. She will also print out the weekend and Monday schedules and give it to the receptionist every Friday. On 12/4/24 11:26 AM, the surveyor interviewed the SC. The SC stated, I leave it every night with the updated census in the receptionist desk and she will post it on the front desk. If there are any changes, she will manually change census. When I come in the morning, I will update the call outs for staff. Usually if I am not here, the supervisor will update, or the receptionist will update it manually then I will update it in the system when I come in. Usually on the weekends, I will leave the Saturday, Sunday and Monday NHRCSR reports. The SC acknowledged that the NHRCSR posted on Monday 12/2/24 was incorrect. What happened on Monday 12/2/24 that the staffing posted was dated 11/30/24, the receptionist that was working over the weekend forgot to put it in, but they had the forms, and when the fulltime receptionist came in on Monday morning 12/2/24, she posted the correct one on Monday, with the corrected census of 108, after the surveyors entered. On 12/4/24 at 12:12 PM, the surveyor interviewed the Director of Nursing (DON), and the License Nursing Home Administrator (LNHA). The DON stated that the Receptionist over the weekend will post the staffing report and that the Receptionist told her that she should have posted the right information for the posted staffing on 12/02/24. The DON and LNHA and both acknowledged the concerns. On 12/5/24 at 8:10 AM, the surveyor reviewed the 2 copies of posted NHRCSR and census list that were provided, the NHRCSR census was 112 and 113 while the Nursing Census Sheet and assignments for the 2 units total census was 111. On 12/5/24 at 9:30 AM, the surveyor interviewed the SC regarding, the census discrepancy on the NHRCSR for 12/5/24, and she stated, I usually will make corrections when I come in the morning, I don't know why the census was incorrect this morning, usually the night shift will make the corrections as well. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 12:24 PM, the surveyor met with the DON and LNHA regarding the inaccurate census posted on the NHRCSR for 12/5/24. A review of the facility's Staffing, Sufficient and Competent Nursing Policy dated August 2022, revealed under Competent Staff #6, Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift. NJAC 8:39-41.2

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication for 1 of 2 medication storage areas and 2 of 3 medication carts inspected according to facility's 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 [DATE] at 11:56 AM, the surveyor began to inspect selected medication (med) storage areas in the facility. The surveyor observed the following: The surveyor in the presence of the med nurse on duty, inspected the med cart labeled Cart 4 located on the 2 South wing. The surveyor observed a vial of blood glucose testing strips (strips used with a portable meter that obtains a blood sugar value with a small blood sample) in the top drawer. The vial did not reflect a date when it was originally opened. The surveyor asked the med nurse if the vial should have a date when opened. The med nurse stated, yes, it should have one. The surveyor in the presence of the med nurse on duty, inspected the med car labeled Cart 3 located on the 2 South wing. The surveyor observed a vial of blood glucose testing strips in the top drawer. The vial did not reflect a date when it was originally opened. The surveyor asked the med nurse if the vial should have a date when opened. The med nurse stated, yes, there should be one written on it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:30 PM the surveyor, in the presence of the Director of Nursing (DON), accessed the central supply stock room located on the 1st floor. The surveyor observed that the door to this room was not locked. The surveyor accessed a metal cabinet, also unlocked, containing the facility stock medications (meds). Upon inspection of the stock meds, the surveyor observed 5 bottles of 100 count Folic Acid 1 mg (milligram) with an expiration date of ,d+[DATE], 1 bottle of 100 count Folic Acid 1 mg with an expiration date of , d+[DATE], and 1 bottle of 100 count Aspirin 325 mg with an expiration date of ,d+[DATE]. The surveyor asked the DON if those meds were expired and should not be in stock. The DON agreed that those meds were expired and proceeded to remove them from the storage area to be disposed. The surveyor asked the DON if any room that contains meds or medical supplied should be secured. The DON stated yes, the door should have been locked. On [DATE], the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON and notified them of the concerns with med storage and labeling. On [DATE] at 12:36 PM, the surveyor attempted to contact the facility Consultant Pharmacist (CP) by telephone. The surveyor left a voice mail message. No return call was received as of [DATE]. The facility did not provide any further pertinent information. A review of the manufacturer package inserts for blood glucose test strips, reflected For vial test strips, record the date on the bottle when you open a new bottle of test strips. Discard any unused test strips six months after opening. Vial test strips are good six months after opening or until the expiration date on the vial, whichever comes first. A review of the facility policy titled Medication Labeling and Storage, dated February 2023, reflected under Policy Statement, The facility stores all meds and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. It also reflected under Policy Interpretation and Implementation, Med Storage, 3. If the facility has discontinued, outdated, or deteriorated meds or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing meds and biologicals are locked when not in use. And trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. NJAC 8:,d+[DATE].4(d)(g)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Based on observation, interviews, and a review of facility documentation, it was determined that the facility failed to ensure that a facility wide assessment was reviewed and updated to identify the required services and procedures necessary to protect the health, safety, and welfare of all residents to ensure adequate facility resources to provide resident care and services. These failures had the potential to affect all 109 residents who currently live in the facility during the time of the survey. This deficient practice was evidenced by the following: During the entrance conference on 12/02/24 at 10:12 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) documents to complete the survey process which included but were not limited to Facility Assessment (FA). Both the LNHA and DON stated that the facility's census (the number of residents currently under the care of a specific facility) was 109. On 12/03/2024 at 8:40 AM, the surveyor followed up with the DON regarding the requested documents during the entrance conference, and the DON responded that she would get back to the surveyor. On 12/04/24 at 10:58 AM, the surveyor met with 4 residents for the resident council meeting. Resident #79 stated that sometimes the gowns were not enough. Resident #72 stated that the facility maybe needed to order a little bit more and have the incontinence pads, the green, because at times staff was unable to find one when needed. All four residents confirmed and acknowledged the need for more supplies. On 12/05/24 at 8:39 AM, the surveyor interviewed Certified Nursing Aide #1 (CNA#1) who was in room [ROOM NUMBER] with a linen cart in front of the room. The CNA informed the surveyor that usually we have our linen cart for each CNA. She stated that today she had 9 residents and she received supplies that included but were not limited to a total of 4 towels and 5 sheets. She further stated that she had not received incontinence pads yet, because they would be delivered later, and was using the leftover from last night. She added that linen was delivered usually around 7:15 AM-7:30 AM and the incontinence pads delivered around 7:30 AM. She further stated that the green incontinence pads were the extra-large (XL), blue was the large, and white was the pull-ups. On that same date and time, CNA#1 stated that the supplies were not enough and that we could have more. She further stated that sometimes the aides go down to the laundry area to get more around 10:30 AM-11:00 AM because that was the time the laundry was finished washing and there would be available supplies. The surveyor asked the CNA how she could provide care if she had 4 towels and 5 sheets, and the CNA had no answer. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/05/24 at 8:45 AM, the surveyor interviewed CNA#2 from 2 South. The CNA stated that she had 8 residents today and her linen cart included but were not limited to 4 towels and 4 linens. The CNA accompanied the surveyor to the clean utility room where the CNA informed the surveyor that the incontinence pads were just delivered for 2 South and 2 North. Both the surveyor and the CNA counted the delivered incontinence pads as follows: -Large=31 pieces -XL=31 pieces -pull-ups=22 pieces There was a total of 6 packs of washcloths. At that same time, the surveyor asked the CNA how she was able to provide morning care specifically incontinence care and showers to the residents assigned to her if she only had 4 towels and 4 linens, the CNA had no response. On 12/05/24 at 8:51 AM, the surveyor interviewed CNA#3 from 2 North. The CNA informed the surveyor that she had 15 residents in her assignment today and her linen cart included but was not limited to 3 towels, 3 pieces of washcloths, 5 sheets, and 1 pad. The surveyor asked the CNA how she was able to provide morning care, showers, and incontinence care if she only had those supplies, and the CNA responded, Good question. The CNA acknowledged that it had been the same every day as what she receives for supplies. She further stated that the 2 North was a long-term care unit. The surveyor also asked was the facility management aware of the concern with supplies, the CNA responded Yes. The surveyor asked how the facility management responded to the concerns, the CNA responded that the facility management told them We are working on it. The CNA did not respond when the surveyor asked CNA#3 whom they mentioned the concerns with supplies. On 12/05/24 at 9:02 AM, the surveyor went to the laundry area and interviewed the Laundry Aide (LA) who informed the surveyor that she had been working as the LA for 7 years for 7:00 AM-3:00 PM (7-3) shift and there was another laundry person for the afternoon. The LA stated that there was a big linen cart for each shift, the one I brought for the 7-3 shift linen cart was the prepared one from last night, and that they followed the posted par level. The LA showed and provided the 7-3 shift carts and 3:00 PM-11:00 PM (3-11) shift carts for par level. The surveyor then asked the LA why there was no par level for the 11:00 PM-7:00 AM (11-7) shift and she responded that they followed the 3-11 par level for the 11-7 shift. The LA further stated that she prepared the 3-11 shift linen carts after she did the laundry. At that time, the surveyor observed the washing machines were in use and there were towels, and linens being laundered. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The LA and the surveyor went to the next room (connected room) where the LA stated that was where the backup supplies were. The LA showed the big linen cart with extra pillows and clean heel booties. The LA showed the other big linen cart with 6 blankets, 18 gowns, and 27 yellow gowns. The LA informed the surveyor that the blankets and gowns were clean. She further stated that the 27 yellow gowns were being used by staff as PPE (personal protective equipment) when providing care to the residents. The LA confirmed that there were backup supplies and there was another room for emergency supplies next room. There was another blue linen cart (medium size) with supplies next to the empty big linen cart which the LA stated that the blue linen cart was for the rehabilitation (rehab) department. There were two big empty linen cart trucks in the laundry area, one had a marker for 3-11 and the other one for 11-7. Later, the surveyor and the LA went to the emergency supplies room and there were: 3 boxes of washcloths (1 box=10 dozen) 3 boxes of bath towels (1 box=5 dozen) 2 boxes of flat sheets (1 box=2 dozen) 1 box of fitted sheet (1 box=2 dozen) Furthermore, the LA informed the surveyor that the emergency supplies were only being used if in case the laundry staff filling out the big carts to be delivered in the unit did not meet the required number of supplies items in the par level. The LA confirmed the par level list below for 7-3 and 3-11 and stated that the 3-11 par will be the same for the 11-7 shift, and revealed: 7-3 shift carts par level: Items: Amount: towels 25 flats 40 fitted 12 gowns 25 blankets 140 pillowcase 20 3-11 shift carts par level: Items: Amount: towels 25 (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	flats 40 fitted 12 gowns 10 blankets 16 washcloth 30 pillowcase 15 A review of the provided FA by the LNHA on 12/03/24 at 10:10 AM revealed that the date of assessment was 8/05/24, the reason for the assessment was for an annual review and change requiring a plan update. The FA also included the facility management who attended the meeting which were the LNHA, DON, Medical Director, Director of Social Services, and Director of Rehab. The FA review was based on the average daily census of 106. Part 3 of the FA included the facility resources needed to provide competent support and care for the resident population every day and during emergencies were based on the information and programming goals to meet the needs of the residents. In 3.9 Physical environment and building/plant included the physical resources category for non-medical supplies for soaps, cleansing products, incontinence supplies, waste baskets, bed/bath linens, communication devices, and computers that the planned changes this planning period for par levels reviewed on 8/01/24. Further review of the provided FA did not include attachments or information for par levels as specified on the 3.9 resources. A review of the provided 2 South 7-3 shift schedule for 12/05/24 by the Unit Clerk revealed that the census was 52, CNA#1 had 9 residents and CNA#2 had 8 residents. A review of the provided 2 North 7-3 shift schedule for 12/05/24 by the Registered Nurse/Unit Manager (RN/UM) revealed that the census was 61 and CNA#3 had 15 residents. A review of the provided incontinence list of the DON revealed: -CNA#1=1 resident incontinent both bladder and bowel (B & B) elimination. -CNA#2=5 residents incontinent of B & B. -CNA#3=9 residents incontinent of B & B. On 12/05/24 at 12:25 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the concerns with supplies for linens, towels, incontinence pads, and laundry area supplies that could affect the care of residents. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/05/24 at 01:18 PM, the LNHA, Director of Maintenance (DM), and Housekeeping Director (HD) came to meet with the surveyor, the LNHA stated that he was concerned with the surveyor's findings with care issues related to not enough supplies of the facility as reported during a team meeting with the facility. The DM confirmed the par level copies that were provided to the surveyor by the LA. The facility management confirmed that the LA was assigned to laundry and distribution of the linen supplies to the units by following the par level posted in the laundry room for 7-3 shifts. On 12/05/24 at 01:31 PM, the surveyor interviewed the LNHA regarding the FA. The surveyor asked the LNHA while presenting the FA copy that LNHA previously provided on 12/03/24, if the copy was the facility's most updated FA, and the LNHA responded that he had to check his records again. The surveyor asked where the attached information about the par level was reviewed on 8/01/24 as part of the FA, and the LNHA responded that he had to check. The surveyor then asked the LNHA why he was unsure if what he had provided on 12/03/24 was the most updated one if the documents were requested at the entrance conference on 12/02/24 and today was the 4th day of the survey already, and the LNHA had no response. Both the surveyor and the LNHA went to his office and the LNHA was unable to provide the par level copy and stated that it was probably with the DM. On that same date at 01:34 PM, the LNHA provided another copy of FA, the same copy as what was provided on 12/03/24 at 10:10 AM with no attached par level and no information about the par level. The surveyor asked the LNHA again where the par level information and he said it was probably with the DM. On 12/05/24 at 01:39 PM, the DM confirmed with the LNHA that the information that should be in the FA was the same information that was posted in the laundry area that was provided by the LA to the surveyor. On 12/05/24 at 01:42 PM, the LNHA stated that the DON would be the one to discuss further the FA. On 12/05/24 at 01:46 PM, the surveyor interviewed the DON in the presence of the Director of Quality Assurance (DQA). The surveyor asked the DON if the two provided FA (12/03/24 and 12/05/24 at 01:34 PM) were the facility's FA, and the DON stated that she had to check again will have to be back. On 12/05/24 at 02:17 PM, the DON asked for another 10 minutes to be able to provide the requested attachments for the FA. On 12/05/24 at 02:44 PM, the surveyor followed up with the DON regarding the interview and the requested documents for the FA. The DON confirmed that the 8/05/24 FA was the facility's most updated FA. The DON informed the surveyor that the facility management met on 8/05/24 because both the LNHA and the DON were new, and they wanted to discuss updates and review the FA that required changes. The DON stated that as per protocol, the facility management meets at least annually, and if there were any changes or disasters that happened that needed modification in the FA to meet the needs of the residents in the facility. At that same time, the surveyor asked the DON if the par level of the supplies met the requirements. The DON stated No, and that the FA should have updated the par level for linen supplies to meet the needs of the residents. (continued on next page)

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	315339	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Oradell	600 Kinderkamack Road Oradell, NJ 07649

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/09/24 at 11:34 AM, the survey team met with the LNHA and DON. The DON stated they were able to obtain more supplies that included towels, the par level reviewed, and should be according to the census. The DON further stated that the facility management needs to do another meeting to revise and address their FA tool based on the needs of the resident to address the par level of the linen supplies. A review of the facility's Facility Assessment Policy with a revision date of June 2024 that was provided by the LNHA revealed: An FA is conducted annually to determine and update the capacity to meet the needs of and competently care for residents during day-to-day operations and emergencies. Policy Interpretation and Implementation: 2. The team responsible for conducting, reviewing, and updating the FA includes but is not limited to LNHA, DON, and other department heads . Review of Available Resources: 1. The FA also includes a detailed review of the resources and personnel available to meet the needs of the resident population. This part of the assessment includes the following: beguilement and supplies (medical and non-medical) . Facility Assessment: 2. The FA is used to identify current or potential gaps in care or services due to misalignment or lack of appropriate resources. 3. The FA is also used to help the facility plan and respond to changes in the needs of the resident population, and determine budget, staffing, equipment, and supplies needed . On 12/11/24 at 01:21 PM, the survey team met with the LNHA and DON for an exit conference. There was no additional information provided and the facility management did not refute the findings. NJAC 8:39-5.1(a); 27.1

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48781 Based on interview, review of medical record, and review of other pertinent facility documents, it was determined that the facility failed to offer residents a pneumococcal and influenza vaccines or document the refusal and reason for ineligibility for the vaccines for 4 of 22 residents reviewed for immunizations (Resident #42, #66, #94 and #197). The deficient practice was evidenced by the following: Reference: According to the Centers for Disease Control (CDC) and Prevention, recommends pneumococcal vaccination (PCV) for many adults based on age, having certain risk conditions, and pneumococcal vaccines already received . CDC recommends PCV15, PCV20, or PCV21 for adults who never received a PCV and are Ages [AGE] years or older Ages 19 through [AGE] years with certain risk conditions. Chronic conditions and other factors that increase someone's risk for pneumococcal disease include Chronic heart, kidney, liver, or lung disease (Chronic lung disease includes chronic obstructive pulmonary disorder (COPD), emphysema, and asthma); Diabetes; Immunocompromising condition (having a weakened immune system). According to CDC 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. 1. The surveyor reviewed the Resident's #42 medical record which revealed the following information: The admission record (AR; an admission summary) revealed that Resident #42 had been admitted to the facility with diagnoses which included but not limited to encounter for orthopedic aftercare following surgical amputation; acquired absence of right leg above knee. The Admission/5Day Medicare Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/7/24, reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. The Electronic Health Record (EHR) Nursing Admission Resident Evaluation immunization status and admission notes which revealed Influenza vaccination as Not assessed/no information. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 11:07 AM, the surveyor interviewed the License Practical Nurse (LPN) in the Unit 2 North, who had been working at facility for [AGE] years. The LPN stated, We seldom get admission/re-admission but when we do, we usually look at hospital records or ask resident/families for information on Flu shot, Pneumonia and COVID vaccines. If they don't have it, we offer it and if they refuse, we ask them to sign a consent form and let them know about vaccines. The surveyor and the LPN reviewed Resident's #42 vaccine information in the medical records, and the LPN acknowledged that the Flu shot information was missing. On 12/5/24 at 11:32 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) of Unit 2 North, who had been working in the facility for [AGE] years regarding immunizations. The RN/UM stated, On initial assessment we ask patient information if alert, if they don't have vaccines we ask family. Infection Preventionist (IP) also follows up, we offer vaccines, if they refuse, we put it on admission assessment and refusal consent signed and educated. I don't know why the resident does not have the Flu shot. On 12/5/24 at 12:51 PM, the survey team discussed immunization concerns with the Director of Nursing (DON), and the License Nursing Home Administrator (LNHA). The DON acknowledged and stated, It's part of our admission process, that admission nurse will ask about immunizations and if no information, we offer Pneumonia, FLU shot and COVID, we'll re-offer on the future time. We also ask the families for information. It depends on the information we gather; it should be documented. On 12/5/24 at 1:30 PM, the surveyor interviewed the RN/UM for Unit 2 North regarding Flu shot consent form for the Resident #42. The surveyor and the RN/UM reviewed the resident's chart and the RN/UM confirmed, If I have the consents for the vaccines, it's under the admission record tab or in the [electronic record] but I see that it was not here in the chart. On 12/5/24 at 1:40 PM, the surveyor observed the Resident #42 lying in bed. The Resident #42 stated regarding immunizations, I don't recall if I had the Flu vaccine but if they offered it, I would take it. I'm not an anti-vaccine. A review of the facility's Influenza Vaccine Policy with the revision date of March 2022, revealed, Residents admitted between October 1st and March 31st shall be offered the vaccine within 5 days of the resident's admission to the facility. 46049 2. On 12/5/24 at 1:05 PM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #66. The AR documented that the resident had diagnoses that included muscle weakness. A comprehensive MDS (cMDS) with an ARD of 9/25/24, had a BIMS score of 12 out of 15, which indicated the resident had moderate cognitive impairment. Section I for Active Diagnoses indicated the resident had diagnoses that included but were not limited to Parkinson's disease and cancer. A review of immunizations listed in the EMR revealed for the flu vaccine, the last documented administration was on 11/3/23. Additional review of the EMR revealed no documentation of the resident being offered a flu vaccine for 2024. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the paper chart revealed there was no documentation to indicate Resident #66 was offered or declined the flu vaccine. On 12/5/24 at 1:30 PM, the surveyor interviewed the RN/UM about flu vaccine consent. The RN/UM stated consent forms for flu vaccine would be under the Admission Record tab of the paper chart or in the EMR. The RN/UM reviewed the Resident #66's paper chart and confirmed that there was no consent form for the flu vaccine. On 12/9/24 at 9:20 AM, the surveyor reviewed the facility provided resident immunization binder, which included consent forms for residents' vaccinations. A review of the binder revealed flagged consent forms which included one flu vaccination consent form for Resident #66 and was dated 12/8/24. The surveyor requested a copy from the DON and confirmed it was dated 12/8/24. On 12/9/24 9:41 AM, the DON provided a copy of the signed flu vaccine consent for Resident #66 dated 12/8/24. Review of EHR, resident administered flu vaccine on 12/8/24 and monitoring for 3 days post vaccine. On 12/9/24 at 2:25 PM, the surveyor informed the DON of the concern regarding Resident #66 not being previously screened for or offered the flu vaccine for the 2024-2025 season until after surveyor inquiry. On 12/11/24 at 11:43 AM, the DON and LNHA met with the survey team. There was no additional information provided for Resident #66's flu vaccination concern. The DON stated the previous IP initiated flu vaccination for residents in the facility, had to take leave and current IP who started at end of October is trying to pick up all the previous IP's work. DON further stated .I know that's not excuse . for why residents' immunization records were not complete, and vaccinations not offered. 38327 3. On 12/05/24 at 8:33 AM, the surveyor observed an Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) posted sign and personal protective equipment (PPE) hung outside the door of Resident #94. Inside the resident's room, there was a Resident Representative (RR) at the bedside. The surveyor observed Resident # 94 lying on the bed with the head of the bed elevated, eyes open, and non-verbal. The surveyor reviewed Resident #94's hybrid (combination of paper and electronic) medical record and revealed: Resident #94's AR indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to anoxic brain damage (a serious condition that occurs when the brain is deprived of oxygen) not elsewhere classified, other seizures, encounter for attention to gastrostomy (the creation of an artificial external opening into the stomach for nutritional support or gastric decompression), anemia (low blood count), and quadriplegia (a form of paralysis that affects 4 limbs) unspecified. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the most recent cMDS with an ARD of 10/28/24, Section C Cognitive Patterns, the decisions regarding tasks of daily life were coded 3 which reflected that the resident's cognitive status was severely impaired. Section O Special Treatments, Procedures, and Programs reflected that the resident did not receive an influenza vaccine in the facility for the flu season and the reason was not provided, the pneumococcal vaccine was not up to date and it was not offered. A review of the immunizations tab in the EMR revealed there was no documentation to indicate the administration, declination, or not eligible status of the influenza and pneumococcal vaccines. An additional review of Resident #94's hybrid medical record revealed no documentation of the resident's vaccination status being assessed or the influenza nor the pneumococcal vaccines being offered. On 12/05/24 at 8:57 AM, the Infection Preventionist Nurse (IPN) confirmed that the resident had no consent forms and no documented evidence in the medical records that the resident was offered flu and pneumonia vaccines. 4. On 12/02/24 at 11:09 AM, the surveyor observed a posted sign outside the door for EBP. Inside the room, Resident # 197 lying on the geri chair. The surveyor reviewed the hybrid medical records of Resident #197 and revealed: The AR revealed that the resident was admitted to the facility with the following medical diagnoses that were not limited to unspecified dementia, contracture right knee and left knee, and abnormal posture. The most recent cMDS with an ARD of 10/27/24 revealed that the resident's cognitive skills for daily decision-making were severely impaired. Section O reflected that the resident did not receive influenza vaccine in the facility for this year's influenza vaccination season and there was no reason specified as to why the resident did not receive, the pneumococcal vaccination was not up to date and was not offered. On 12/04/24 at 01:16 PM, the surveyor interviewed the MDS Director. The MDS Director confirmed that the flu and pneumococcal vaccines were being offered at the facility. The surveyor notified the MDS Director of the concern that the MDS reflected that the resident had not offered the vaccines, and she responded that because at the time of assessment probably, there was no documented evidence that it was offered. On 12/04/24 at 01:50 PM, the RN/UM confirmed in the 2 North nursing station after reviewing the resident's medical records that there was no documented evidence that the resident had consent or was offered vaccines. The RN/UM stated that the surveyor and the RN/UM can go to the IPN to check if they have a record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/24 at 01:54 PM, the surveyor interviewed the IPN who informed the surveyor that she started working at the facility on 10/21/24 and was responsible for tracking and offering the vaccines to the residents according to the nurses and I think that was the policy of the facility. She further stated that the vaccines that the facility offered were flu, pneumonia, and COVID-19. The IPN also stated that the process was the IPN would offer vaccines, the resident or resident representative would sign the consent, and the vaccines would be administered. She further stated that once it was administered, she would enter it in the tracking and the consent would be then put in the chart of the resident and EMR. At that same time, the IPN stated that she was in the process of completing the tracking record for immunization for the residents in the facility. The surveyor notified the IPN of the concern that the resident had no documented evidence that the vaccines were offered as confirmed by the RN/UM. The IPN provided a copy of the tracking. A review of the tracking that was provided by the IPN revealed that Residents #94 and #197 information for influenza and pneumococcal vaccines were blank. On 12/05/24 at 12:25 PM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the concerns with Resident #94 and Resident #197's immunizations. The DON stated that on admission we should know what vaccines and if they were eligible to receive vaccines. The DON further stated that immunizations were part of the admission packet process to offer vaccines, and it was the admission nurse or any nurse's responsibility to offer the vaccines on the day of admission or even on other days. She also stated that if the information was not available about the resident's vaccination status, the nurse should reach out to the family, there should be some documentation if it was declined and will be offered in future times. On 12/11/24 at 01:21 PM, the survey team met with the LNHA and DON for exit conference and there was no additional information provided by the facility. NJAC 8:39-19.4 (a,3,4)(d)(h)(i)