STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Gardens of Edison	1801 Oaktree Road Edison, NJ 08820

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48964 Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to complete reference checks on employees before their start date. The deficient practice was identified for 5 of 6 employees reference checks reviewed under Sufficient and Competent Nurse Staffing task. The deficient practice was evidenced by the following: On 10/15//24, the surveyor reviewed six employee files of employees hired since the last standard survey which revealed that five of the six did not have reference checks done prior to the start of employment. RN #1, date of hire 12/4/23 LPN (Licensed Practical Nurse) #1, date of hire 9/5/23 LPN #2, date of hire 8/17/23 LPN #3, date of hire 1/30/24 Housekeeper#1, date of hire 11/20/23 On 10/15/24, the surveyor requested the reference checks on the above employees. On 10/16/24 at 12:30 PM, the surveyor interviewed the Director of Nursing (DON) who stated that he was unable to provide the reference checks at this time. He further stated that they used to be handwritten but now are on an electronic system. He acknowledged that the reference checks should be readily available. On 10/16/24 at 12:32 PM, the surveyor interviewed the Human Resources Director and the Administrator, who stated that they do reference checks on newly hired employees. They use a software program that requests electronically references from the previous places of employment. They were stored in one software program but were moved to another software program. They stated that was why they couldn't retrieve the reference checks. The Administrator further stated that she understood and stated we should be able to print them out. (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy Employment Verifications and Backround checks reviewed 5/16/24, revealed: 4.1 Background Check Components: .Prior Employment Verificaition confirms applicant's employment with the provided companies, includeing dates of employments, position held .performance ratings, reason for departure and eligibility for rehire. This generally will be run on past two employers or past five years, which ever is most recent. N.J.A.C. S 8:39-9.3(b)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48964 Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to notify the resident and or resident representative in writing of the reason for transfer or discharge to the hospital for 2 of 2 residents (Resident #8 and Resident #173) reviewed for hospitalization . This deficient practice was evidenced by the following: 1.) On 10/11/24 at 9:52 AM, the surveyor observed Resident #8 out of bed in a high back wheelchair in the common area with activities. On 10/11/24, the surveyor reviewed the Electronic Medical Record (EMR) which indicated that Resident #8 was admitted to the facility for long term care. Further review showed there was a Discharge/Return Anticipated MDS completed on 5/16/24 following a transfer to the hospital for treatment of a sacral wound. The surveyor review of the Admission Record indicated Resident #8 had medical diagnosis which included but were not limited to; stage 4 pressure ulcer of the sacral region and osteomyelitis (an infection of the bone). A review of the annual Minimum Data Set (MDS), an assessment tool, dated 8/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 9 out 15, indicating moderate cognitive impairment. The surveyor reviewed the progress notes which revealed that on 5/16/24 at 7:30PM, Resident #8 was transferred to the Hospital. On 10/15/24 at 10:13AM, the surveyor asked the Director of Nursing (DON) for the location of the family and ombudsman notification of hospitalization . He stated the family notification is in the progress notes. On 10/16/24 at 9:17AM, the surveyor was unable to locate written notifications to the resident or family for the reason of transfer in the medical records. On 10/16/24 at 9:51 AM, in the presence of the survey team, the Social Service Coordinator, and the Licensed Nursing Home Administrator (LNHA), the LNHA stated when a resident was hospitalized , a written notice goes to the hospital with the resident's transfer paperwork. The LNHA further stated in most cases the facility retains a copy; however, in this case they did not have a copy to provide to the surveyor. 2. On 10/10/24 at 11:19 AM, during the initial tour, the surveyor observed Resident #173 in bed with their eyes closed. The resident's family member was at the bedside and stated the resident had just been readmitted to the facility. The surveyor reviewed the electronic medical record (EMR) for Resident #173. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; end stage renal disease (the kidneys can no longer function properly) and dependence on renal dialysis (a renal replacement therapy that removes waste and excess fluids from the blood). A review of the progress notes revealed: 10/4/2024 08:01 COMMUNICATION - with Physician - Narrative Note Text: Nephrologist called at 7:30 AM 10/04/2024 .requested that [identifier redacted] be sent to hospital for evaluation .Dr. (doctor) and Son [name redacted] were both notified of the situation. Further review of the medical record, did not revealed written notification of reason for transfer to the resident or family. On 10/16/24 at 11:52 AM, the Director of Nursing (DON) provided a copy of Skilled Nursing Facility Notice of Transfer for Resident # 173. The letter dated was 10/4/24. The DON stated the letter was sent with the resident to the hospital. He was unable to verify if a copy was sent to the family/representative or if a copy was given to the resident. On 10/16/24 at 12:31 PM, in the presence of the survey team, the DON confirmed a written copy of the notification of hospitalization was not sent to the family or given to Resident #173. Review of facility provided policy Transfer, Discharge & Bed-Hold Notices reviewed 5/16/24,included: 4. The Social Service Coordinator/designee will complete the following steps before the community transfers or discharges a resident (voluntary or involuntary): a. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move, in writing and in a language and manner they understand. NJAC 8:39-4.1(a) 31 41858

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41858 Based on observation, interview, and record review, it was determined that the facility failed to obtain an admission weight for 1 of 3 residents, Resident # 173, reviewed for nutrition. This deficient practice was evidenced by the following: On 10/10/24 at 11:19 AM, during the initial tour, the surveyor observed Resident #173 in bed with their eyes closed. The resident's family member was at the bedside and stated the resident had just been readmitted to the facility. The surveyor reviewed the electronic medical record (EMR) for Resident #173. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; end stage renal disease (the kidneys can no longer function properly) and dependence on renal dialysis (a renal replacement therapy that removes waste and excess fluids from the blood). A review of the admission Minimum Data Set, an assessment tool, dated 10/8/24, revealed it was in progress. A review of the individual comprehensive care plan (ICCP) revealed: FOCUS: .resident has nutritional problem or potential nutritional problem r/t (related to) wound and current dx. (diagnosis) Date Initiated: 10/10/2024. Goal: [name redacted] will consume at least 75-100% of meals and supplements offered resulting in stable weight and wound improvement over next 30 days. Date Initiated: 10/10/2024. The surveyor reviewed both the EMR and paper chart for the resident's admission weight. There was no documented readmission weight taken by the facility in the resident's medical record. The last weight entry was 9/26/2024 at 12:28 PM. A review of the progress notes revealed the Registered Dietician's (RD) progress note: 10/10/2024 12:01 PM Type: Nutrition/Dietary Note . Resident known from previous admission .Updated weight pending . RD from dialysis center to be in contact with community dietitian .RD will continue to follow up. On 10/15/24 at 10:32 AM, the surveyor interviewed the RD, who stated a resident's weight should be obtained within 24 hours of admission. He stated he completes the nutrition section on the Service Evaluation and Health Assessment (SEHA) for all new admissions. He stated the purpose of the admission weights was for a baseline weight. The RD reviewed the SEHA for Resident #173 in the presence of the surveyor and acknowledged a new admission weight was not used. He acknowledged the weight from 9/26/24 was used. He further reviewed the EMR and confirmed he was unable to find a new admission weight for the resident. He stated if there was not an admission weight, he would ask the nurse. He stated he had told the nurse but was unable to say when or who he told. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 10:50 AM, the surveyor interviewed Resident #173's assigned Certified Nursing Assistant (CNA), who stated the residents should have been weighed yesterday (Monday) but the resident did not want to get out of bed. On 10/15/24 at 10:53 AM, the surveyor interviewed Resident #173's assigned Licensed Practical Nurse (LPN), who stated new admission should be weighed upon admission and then in 3 days. She stated weights should be done usually within 24 hours so you know the parameters. The LPN reviewed the EMR in the presence of the surveyor and acknowledged the last entered weight was 9/26/24. On 10/15/24 at 11:10 AM, the surveyor interviewed the Director of Nursing (DON) and the Assistant DON (ADON). The DON stated new admissions should be weighed within 24 hours, and then weekly x 4 weeks. He then stated all weights would be in the EMR. The DON reviewed the EMR for Resident #173 in the presence of the surveyor. He acknowledged that a new admission weight was not entered. He reviewed the SEHA, effective date 10/8/24, completed by the RD and acknowledged the RD should not have used the weight from 9/26/24. He then stated, We missed the admission weight. He stated our policy is to weigh them (the residents) ourselves and if a weight was not obtained the reason should be documented. On 10/15/24 at 1:18 PM, in the presence of the survey team, the Licensed Nursing Home Administrator and the DON were made aware of the above concerns. A review of the facility's policy Nutrition & Weight Management Program reviewed 5/16/24, revealed: Goal: The Goal of this program is to evaluate residents .prevent unanticipated weight gain or loss .Section 2: . Weight Monitoring: Ongoing weight is integral to the plan to manage the resident's weight: Residents are upon admission, weekly for 4 weeks, then monthly to evaluate trends or in accordance with physician's orders .All weights are recorded int the resident's electronic health record. NJAC 8:39-11.2(e), 17.1(c), 27.1(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34033 Based on observations, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation performed on 10/11/24, the surveyor observed two (2) nurses administer medications to four (4) residents. There were 27 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.41 %. This deficient practice was identified for two (2) of four (4) residents, (Resident #12 and #13), that were administered medications by one (1) of two (2) nurses (Licensed Practial Nurse (LPN #1). The deficient practice was evidenced by the following: 1. On 10/11/24 at 9:27 AM, during the medication pass, the surveyor observed LPN #1 preparing to administer five (5) medications to Resident #12 which included one 81 milligram (MG) chewable tablet of Aspirin. LPN #1 stated that the resident had a physician's order (PO) for Aspirin 81 MG according to the electronic medication administration record (eMAR). LPN #1 also stated that the Aspirin 81 MG tablets were a house stock over the counter (HS/OTC) medication, meaning that the facility purchased a bottle to be used for any resident that had a PO. LPN #1 stated that the Aspirin was a chewable tablet and was the only formulation of Aspirin 81 MG in the medication cart. On 10/11/24 at 9:32 AM, the surveyor observed LPN #1 administer the Aspirin chewable tablet to Resident #12 and told the resident to chew the tablet. On 10/11/24 at 9:46 AM, after the surveyor observed LPN #1 administer an Aspirin EC (enteric coated) 81 MG tablet to Resident #13, LPN #1, with the surveyor, reviewed the eMAR for Resident #12 which revealed a PO for Aspirin EC 81 MG which was the same PO for Resident #13. LPN #1 explained that Resident #13 had their Aspirin EC 81 MG tablets packaged by the provider pharmacy and labeled for them and had not had to use the HS/OTC. LPN #1 acknowledged that the PO for Resident #12 was for Aspirin EC 81 MG tablets and that he had administered Aspirin 81 MG chewable tablets. (ERROR #1) On 10/11/24 at 10:33 AM, the surveyor interviewed LPN #1, in the presence of the Assistant Director of nursing (ADON). LPN #1 stated that there were no bottles of Aspirin EC 81 MG in the medication room where the backup supply of HS/OTC medications were stored. The ADON stated that if the PO was for Aspirin EC 81 MG and there was not any available, then the physician had to be called and the order changed to chewable. LPN #1 stated, It was already administered. The surveyor reviewed the medical record for Resident #12. A review of the Admission Record revealed diagnoses which included but not limited to; dementia and acute ischemic heart disease (heart problems caused by narrowed heart (coronary) arteries that supply blood to the heart muscle). A review of the October 2024 Order Summary Report revealed a PO with an order date of 10/1/24 for Aspirin EC tablet delayed release 81 MG (Aspirin) Give 1 tablet by mouth one time a day for CAD (coronary artery disease)(a narrowing or blockage of the coronary arteries). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the October 2024 electronic medication administration record (eMAR) revealed a PO with a start date of 10/2/24 for Aspirin EC tablet delayed release 81 MG (Aspirin) Give 1 tablet by mouth one time a day for CAD. On 10/11/24 at 11:53 AM, the surveyor interviewed the Health Information Coordinator (HIC), who stated she was responsible for ordering the HS/OTC medications. The HIC stated that she was aware of what had happened this morning, meaning that there were no Aspirin EC 81 MG tablets available. The HIC stated that she usually ordered by visualizing what was low in the medication room where the HS/OTC medications were stored or what she was told by the nurses. The HIC added that she was just given a list of what HS/OTC medications the facility were to keep on hand and would now check the list against what was on hand. A review of the facility Stock List provided by the Director of Nursing (DON) reflected that Aspirin EC 81 MG 100 ct (count) was on the list as a HS/OTC medication. On 10/11/24 at 2:00 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone, who stated that Aspirin EC and Aspirin chewable were the same drug but not the same formulation and that one could not be substituted for the other. The CP added that the chewable formulation is absorbed in the stomach and that the EC formulation was absorbed in the intestine. The CP also stated that he had completed medication observations but had not completed an inservice on medication pass. On 10/15/24 at 9:08 AM, the surveyor interviewed the DON, who stated that he had completed a Medication Skill Capability Evaluation Checklist on 12/27/23 for LPN #1 which was a comprehensive medication pass observation. The DON also stated that Aspirin EC 81 MG was a HS/OTC medication but was not available on 10/11/24 and was obtained after the surveyor performed the medication administration observation. The DON acknowledged that if the Aspirin EC was not available then the physician was to be called and asked to switch to what was on hand. The DON added that the nurses were inserviced on the specific issue of what to do if a medication was not available and to make sure the correct HS/OTC was available. On 10/15/24 at 1:29 PM, the survey team met with the Licensed Nursing Home Administrator and the DON. The DON stated that the Aspirin EC 81 MG tablets were obtained on 10/11/24 after the surveyor performed the medication administration observation. A review of the manufacturer specifications for Aspirin included, but was not limited to, Aspirin is available in different formulations such as film-coated, enteric coated and chewable. In addition, the specifications reflected that Film-coated, extended-release, or enteric-coated may be associated with less GI irritation and/or symptomatic GI disturbances than uncoated tablets. 2. On 10/11/24 at 9:34 AM, during the medication pass, the surveyor observed LPN #1 preparing to administer nine (9) medications to Resident #13 which included Polyethylene Glycol 3350 (PEG3350) (a medication used to relieve constipation). LPN #1 stated that according to the eMAR the dose of PEG3350 was 17 grams (GM). LPN #1 added that sometimes the provider pharmacy sent 17 GM packets, but that Resident #13 had a labeled bulk powder bottle that was sent by the provider pharmacy and that he had to measure the 17 GM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the surveyor observed LPN #1 pour the PEG3350 powder into a 30 milliliter (ML) medication cup. LPN #1 stated that he was filling the medication cup up to 17 ML, which was an estimate between the 15 ML mark and the 20 ML mark on the medication cup. On 10/11/24 at 10:16 AM, the surveyor interviewed LPN #1, who stated that he thought 17 GM was the same as 17 ML. LPN #1 added that it was easier to use the 17 GM premade packets. LPN #1, in the presence of the surveyor, removed the resident's bulk bottle of PEG3350 from the medication cart and reviewed the label which revealed the instructions for use were to Use the measuring line on the bottle cap to measure a single dose (about 1 heaping tablespoon). (ERROR #2) At that time, LPN #1 removed the cap of the PEG3350 bottle and stated that there was a designation for 17 GM to be measured in the cap. LPN #1 then stated that he was unsure if the 17 ML that he had measured in the medication cup would be the same as the 17 GM measurement indicated on the cap of the PEG3350 bottle. On 10/11/24 at 10:19 AM, the surveyor observed LPN #1 measure 17 GM of PEG3350 from the resident's bulk bottle in a 30 ML medication cup as he had previously done by estimating 17 ML, and poured the measured 17 ML powder into a clear plastic 8-ounce cup. Then, LPN #1 poured a 17 GM packet of PEG3350 powder into another clear 8-ounce cup and put the two cups side by side. LPN #1 stated that he was unsure if they were the same but thought the two cups were close to the same amount. On 10/11/24 at 10:26 AM, the surveyor, in the presence of another surveyor, with LPN #1, showed the two clear cups of PEG3350 that were measured by LPN #1 to the ADON. The ADON stated that the plastic cup with the 17 GM packet measured a little more than the plastic cup with the 17 ML measured PEG3350 powder. LPN #1 explained that he had measured 17 GM of the bulk PEG3350 powder in a medication cup and had to make an estimation of 17 ML between the 15 ML mark and the 20 ML mark. At that time, the surveyor with the ADON reviewed the label on the PEG3350 bulk powder bottle which revealed Use the measuring line on the bottle cap to measure a single dose (about 1 heaping tablespoon). The ADON stated that the manufacturer instructions for measuring were to be followed for an accurate dose. The surveyor reviewed the medical record for Resident #13. A review of the Admission Record revealed diagnoses which included but were not limited to; gastro-esophageal reflux disease without esophagitis (stomach acid rises into the esophagus chronically), muscle weakness and difficulty in walking. A review of the October 2024 Order Summary Report reflected a PO with an order date of 10/3/24 Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 GM by mouth in the morning for constipation. A review of the October 2024 eMAR revealed a PO with a start date of 10/4/24 Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 GM by mouth in the morning for constipation. On 10/11/24 at 2:00 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone, who stated that the manufacturer instructions should be followed for measuring PEG3350 powder from the bulk bottle for an accurate dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 9:08 AM, the surveyor interviewed the DON, who stated that he had completed a Medication Skill Capability Evaluation Checklist on 12/27/23 for LPN #1 which was a comprehensive medication pass observation. The DON also stated he was aware that the PEG3350 was inaccurately measured using a 30 ML medication cup. A review of the manufacturers' specifications for PEG3350 reflected to Follow all directions on your prescription label. In addition, the specifications reflected to use the powder form of this medicine, measure your dose with the medicine cap on the bottle. This cap should contain dose marks on the inside of it. A review of the facility policy titled Medication Administration dated January 2023 provided by the DON revealed that Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing and principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Also, the policy revealed for the medication administration procedure that Medications are administered in accordance with written orders of the prescriber. In addition, the policy revealed for the medication administration procedure that Verify medication is correct three (3) times before administering the medication. a. When pulling medication package from med cart b. When dose is pulled c. Before dose is administered. NJAC 8:39-11.2(b), 29.2(d), 29.4(c)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40042 Based on observation, interviews, and review of facility documentation it was determined that the facility failed to a.) handle, clean and sanitize dishware in a manner to prevent microbial growth and cross contamination, and b.) wear hair restraints to maintain proper kitchen sanitation. This deficient practice was evidenced by the following: On 10/10/24 at 9:22 AM, the surveyor entered the kitchen with a second surveyor. The surveyors observed a staff member at the dish machine without a hair restraint. At 9:35 AM, the surveyors began the kitchen tour with the Dining Director. The surveyors observed the same staff member (now with a hair restraint worn) load the dish machine with soiled dishware and bare hands. He then removed clean bowls from the clean side of the dish machine without performing hand hygiene and glove application. The Dining Director acknowledged that the staff member should have washed his hands and applied gloves prior to removing clean dishware from the dish machine to prevent cross contamination. She stated that there was usually one dishwasher that worked the soiled side and one dishwasher on the clean side of the dish machine. A review of the facility's policy Food Safety and Seniors - Additional Food Safety Tips dated 2015, included Restrain hair in food preparation areas. A review of the facility's policy Dishwashing Procedure dated 11/19/2019, included Objective: Participants will understand the correct dishwashing procedures .; Either two people are in the dish room, one on the dirty side, one on the clean side. If one person does both, they must wash their hands between dirty and clean areas . A review of the facility's policy Proper Handwashing dated 8/16/23, included Hands must be washed: . After contact with unsanitary surfaces i.e. soiled dishes . A review of the facility's policy Food Safety and Seniors - Facts About Handwashing dated 2015, included When to Wash Your Hands . After washing dirty dishes. A review of the facility's policy Food Safety and Seniors - Four Steps to Food Safety dated 2015, included Wash and sanitize . to prevent cross contamination. A review of the facility's policy Food Safety and Seniors dated 2015, included Objective: to recognize the consequences of unsafe food practices and identify ways to prevent foodborne illness. Be sure to: . Avoid cross contamination. A review of the Dishwasher Job Description, dated November 2023, included The Dishwasher is responsible for cleaning and janitorial duties . while adhering to all food safety and sanitation requirements and maintaining a safe and orderly kitchen. Performs dishwashing tasks to properly wash and sanitize all dishes and china, silverware, glassware, utensils and cookware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Gardens of Edison	1801 Oaktree Road Edison, NJ 08820

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	N.J.A.C 18:39-17.2(g)