STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at St Mary's	135 South Center Street Orange, NJ 07050

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observations, interviews, record reviews, and review of pertinent documentation, it was determined that the facility failed to provide residents with a dignified environment by not providing bed linens, and not consistently emptying multiple urinals. This deficient practice was identified for 2 of 2 residents (Resident #113 and Resident #91) reviewed for dignity and was evidenced by the following: a. On 01/15/25 at 10:10 AM, Surveyor #1 observed Resident #113 in their room and in their bed, wearing a hospital type gown. There were no linens, pillows, or blankets on the bed and crumbs were observed in the bed. On 01/15/25 at 10:49 AM, Surveyor #1 and Surveyor #2 went to Resident #113's room. Both surveyors observed the resident was still sitting on the bed with no linens, pillows, or blankets on the bed as observed by the surveyor approximately 40 minutes prior. On 01/16/25 at 8:19 AM, Surveyor #1 observed Resident #113 sitting in a wheelchair in the room. There were no linens, pillows, or blankets on the resident's bed. On 01/16/25 at 8:19 AM, Surveyor #1 and the Registered Nurse Unit Manager (RN/UM) went to Resident #133's Room. Both the RN/UM and Surveyor #1 observed the bed without linens, blankets, or pillows. The RN/UM was made aware of the two prior similar observations by two surveyors on 01/15/25. The RN/UM stated that was not acceptable and it was a dignity issue. On 01/16/25 at 10:26 AM, Surveyor #1 reviewed the Admission Record (an admission summary) which revealed that Resident #113 had diagnoses which included, but were not limited to; unspecified Dementia, Anxiety, and muscle weakness. A review of the annual Minimum Data Set (MDS), an assessment tool, dated 10/18/24, included but was not limited to; a Brief Interview for Mental Status of 01 out of 15 which indicated Resident #113 had a severely impaired cognition; and needed substantial/maximal assistance to transfer to and from the bed to a chair or wheelchair. A review of the individual Care Plan included a Focus area initiated 04/22/24, for self-care/mobility performance deficit with interventions which included required staff participation with transfers. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/25 at 10:11 AM, the RN/UM informed Surveyor #1 that the CNA informed the RN/UM that on 01/15/25, Resident #113's bed was soiled so the CNA stripped the bed and the CNA went to assist another resident, however, the RN/UM did not address the address if leaving a resident in that condition for almost 40 minutes was acceptable and the RN/UM had no comment on the 01/16/25 observation. A review of the facility provided, Position Title: Certified Nurse Aide undated, included but was not limited to; Summary . performs various resident care activities . essential to caring for personal needs and comfort of residents. 25. Obtains clean linens and supplies . 29. Ensures that residents and families receive the highest quality of service. A review of the facility provided policy, Quality of Life: Dignity revised 1/25, included but was not limited to; Policy: each resident . shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Procedure: 1 residents shall be treated with dignity and respect at all times. On 01/23/25 at 11:32 AM, the above concerns were presented to the facility administration. 27193 b. On 1/15/25 at 11:15 AM, while touring the 400 Unit, the surveyor observed Resident #91 sitting in the room, the resident was awake and alert. The resident informed Surveyor #2 that he /she had some concerns that he/she would like to address. Surveyor #2 observed 4 urinals hung on the footboard all almost full with urine. The resident informed the surveyor that the 11:00 PM - 7:00 AM shift did not empty the urinals. According to the resident the staff delivered the breakfast tray and did not empty the urinals. Surveyor #2 returned to the room around 11:30 AM to meet with the resident. The resident told the surveyor that they had some concerns regarding the call light mostly on the 11 PM - 7 AM shift. When they activated the call light, the staff will not show up and some had attitude. The 11:00 PM - 7:00 AM staff were to empty the urinal, they do not pay attention. The resident told the surveyor that the CNA did not come to the room and they will turn the light off. On 1/16/25 at 10:46 AM, the surveyor interview the Quality Assurance (QA) /CNA who revealed that in the morning she would check the schedule, make the make the assignment, make rounds either alone or with the Unit Manager, and assist with care. The QA/CNA further stated that the norm was to check the residents, make rounds, and provide incontinence care prior to breakfast. On 1/16/25 at 11:50 AM, Surveyor #2 reviewed Resident #91's medical record with revealed diagnoses which included; unspecified osteoarthritis, respiratory failure, difficulty in walking and muscle weakness. The Quarterly Minimum Data Set Assessment (MDS) dated [DATE], revealed Resident #91 was awake, alert, oriented and able to make his/her needs known. Resident #91 received a score of 15 out of 15 on the Brief Interview for Mental Status indicative of intact cognition. On 1/18/25 at 9:30 AM, Surveyor #2 interviewed the CNA who cared for the resident. The CNA revealed that the resident was awake, alert and oriented and able to make their needs known. The CNA also revealed that the resident used the urinal and would activate the call bell when assistance was needed. When inquired regarding the urinals with urine in the room, the CNA stated that she would empty them. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/27 at 12:45 PM, Surveyor #2 visited Resident #91 in the room while the resident was eating lunch. The surveyor observed the urinal was full of urine and was hung on the footboard. The resident stated that the night shift forgot to empty the urinals. On 1/21/25 at 1:15 PM, Surveyor #2 reviewed Resident #91's Care Plan (CP). The CP Focus dated 08/06/21, indicated that Resident #91 had limited mobility on bilateral lower extremities, and needed assistance with toileting . The plan of care further indicated to provide prompt response to all requests for assistance. On 1/22/25 at 10:00 AM, the surveyor interviewed the Unit Manager regarding the urinals observed at the bedside while meals were being served. The UM stated that the staff were to make rounds and ensure that the residents were being cared for. When the surveyor showed her the urinals full of urine while the resident was eating their meals, the UM then stated, not on my floor. The UM stated that the QA/CNA was to make rounds in the morning and that the staff should have emptied the urinal prior to the resident being served the breakfast meal. On 1/23/25 at 11:30 PM, the above concerns were discussed with the administrative staff, no further information was provided. NJAC 8:39-4.1(a, 11, 12), 27.1(a)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 48423 Complaint # NJ 168201, # NJ 179357 Based on observations, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure that a resident call light was readily accessible and within reach on 01/15/25, 01/16/25, and 01/21/25. The deficient practice was identified for 1 of 1 resident (Resident #43) reviewed for accommodation of needs and was evidenced by the following: On 01/15/25 at 10:45 AM, during an initial tour, the surveyor observed Resident #43 watching television (TV) in the bed. The resident stated, I am paralyzed (unable to move) from a stroke and not able to move my right arm. The surveyor observed resident's left hand elevated on a pillow. The surveyor observed the resident's call bell (a round disk-shaped flat device with a red cross in the middle) was placed close to their right shoulder. Resident #43 stated, I am not able to use my call bell and have asked them (staff) to place it on more towards left side. On 01/16/25 at 11:57 AM, the surveyor observed Resident #43 watching TV in the bed and the call bell was placed by resident's right shoulder in the same location as the previous observation. While the surveyor was in the room, the resident called the attention of the Certified Nursing Assistant (CNA) to help lower their head. The surveyor observed that the resident was not able to reach and/or use the call bell with their left hand. On 01/21/25 at 10:08 AM, the surveyor observed Resident #43 in bed. The resident's call bell was placed on the right side by their pillow and the resident was not able to reach the call bell. On 01/16/25 at 1:08 PM, the surveyor reviewed the electronic medical record for Resident #43 which revealed: According to the Admission Record (admission summary), Resident #43 was admitted to the facility with diagnoses which included, but were not limited to; paraplegia (a form of paralysis that mostly affects the movement of lower body), and muscle weakness. A review of the Quarterly Minimum Data Set Assessment (MDS), an assessment tool, dated 11/02/24, revealed that the resident scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated that the resident had a moderately impaired cognition. Further review of the MDS revealed that resident had impairment on both sides on Upper Extremities (UE) (arms). A review of the Order Summary Report (OSR) for Resident #43 revealed a Physician Order (PO) for- Call Bell Within Reach Every Shift; Start Date: 12/30/23. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Care Plan (CP) dated 1/12/24, with a focus that reflected that the resident has an ADL (activities of daily living) Selfcare performance deficit related to activity intolerance, hemiplegia (complete or severe paralysis on one side of the body) limited UE mobility, b/l (bilateral) (both) hand contractures. The interventions reflected encourage to use call bell to call for assistance. Further review of the CP with a focus [Name Redacted] is high risk for falls related to generalized weakness, side effects of medications and seizures. The interventions reflected be sure call light is within reach and encourage to use it for assistance as needed Call bell within reach. On 1/21/25 at 10:17 AM, during an interview with the surveyor, the Certified Nurse Aide (CNA) stated she was familiar with Resident #43. The CNA stated Resident #43 was not able to take care of themselves and would use the call bell when they needed any help. The CNA further stated the resident could move their right side (right arm) only, so the CNA stated she would place the call bell to resident's right side which was the resident's good side. The surveyor accompanied the CNA to resident's room and observed the resident's left hand out of the blanket. Resident #43 was moving their left arm, and the right arm was covered under the blanket. In the presence of the surveyor and the CNA, Resident #43 stated I can't reach the call bell with my right arm. The CNA moved the call bell closer to the resident's left side where the resident could reach. The CNA stated the call bell should not be on the resident's right side because the resident would not be able to use the call light. On 1/21/25 at 10:53 AM, during an interview with the surveyor, the Registered Nurse (RN) stated Resident #43 was quadriplegic (paralyzed in their both arms and legs). The RN further stated that Resident #43 was able to use their call bell when it was placed on their special side. The surveyor notified the RN of the above-mentioned observations. The RN confirmed if the call bell was on Resident #43's right side, then the resident would not be able to use the call bell. The RN further stated that the call bell should be placed where the resident can reach it comfortably. On 1/21/25 at 1:34 PM, during an interview with the surveyor, the Assistant Director of Nursing (ADON) stated if the resident was paralyzed on their right side, the call bell would be placed on their dominant (Left) side where they could reach it in case the resident had an emergency and needed to call for help. The surveyor notified the ADON of the above-mentioned observations. A review of the facility's policy, Call Bells revised 1/2025, included under Policy section: Resident will utilize a call bell at bedside as a means for communication to respond to resident's request and needs. On 1/23/25 at 11:33 AM, the survey team met with the facility administration. The surveyor notified the facility management of the above-mentioned concerns for Resident #43. The DON acknowledged that the resident should have the call bell placed on their unaffected side. On 1/23/25 at 2:10 PM, the survey team met with the facility administration for an Exit Conference. The facility had no additional information to provide. NJAC 8:39-27.1 (a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 31654 Based on interview and document review it was determined that the facility failed to ensure that all residents that maintained a Personal Needs Account (PNA) that approached the limit that could jeopardize a resident's eligibility for Medicaid or Supplimental Security Income (SSI). This deficient practice was identified for all residents who maintained Personal Needs Accounts at the facility and was evidenced by: A review of the Funds Balance Report for 01/15/2025 revealed a list of eighty five active resident names with a balance of $84, 036.27 Due to patients. There were twenty -one residents listed with PNA funds that range from $1,852.93 to $3,997.38. On 01/21/25 at 10:32 AM, the surveyor, in the presence of the survey team interviewed the Certified Social Worker (CSW) regarding the PNA accounts and if the CSW was involved with the PNA. The CSW stated that the business office handled the PNA. The CSW stated the business office will send a list of residents with PNA money, and the Certified Nurse Aide or family would let us know if the resident needed anything and the facility had catalogues to order items from. The CSW stated that if the family ordered items that we could reimburse them if they provide the receipt. The surveyor asked if the resident had money in their PNA that was more than $2,000.00 would that be a concern? The CSW stated, They cannot go over $2,000.00, or they are not eligible for Medicaid. The CSW stated we are working getting the residents to spend the money and if the resident's cannot tell us what they need we try to ask staff. The surveyor asked the CSW about an Unsampled Resident (UR) who had a balance of $2,195.16 and what was the plan for the UR's PNA. The CSW stated that is not what she handled, it was the Per Diem Social Worker's responsibility to handle the PNA over $2,000.00. On 01/21/25 at 10:52 AM, the surveyor interviewed the Business Office Manager (BOM) who confirmed that there was a list of active residents who had PNA and she received the list monthly. She stated that the list would be reviewed and whoever had money the facility would spend it down on the resident's behalf. On 01/22/25 at 10:43 AM, the surveyor interviewed the Per Diem (PDSW) Social Worker regarding her role related to the PNA accounts. The PDSW stated she stated, I got the list today, and when asked if that was her usual job she responded, no, ma ' am. The PDSW stated she is the Social Work Director at another facility and at the current facility one day per week. The PDSW stated, the process would be that the business office manager is supposed to send out the statements and there should also be a system in place to confirm that the statements for the resident PNA were sent. The PDSW stated she received the list of the current PNA money that morning and reviewed the list of the resident accounts with PNA funds over/ approaching $2,000.00. The PDSW looked at the list and stated, it hasn't been touched and when the PNA funds approached $1,800.00, the money should be spent down. She stated there is no way around it and confirmed since surveyor inquiry, it is happening now. On 01/23/24 at 2:30 PM, the facility administration had no further information to provide regarding the PNA balances. NJAC 8:39-9.5(c)

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 31654 Based on interview and document review it was determined that the facility failed to ensure that a Surety Bond was in place to protect all resident funds held by the facility. This deficient practice affected all residents who maintained a Personal Needs Account with the facility and was evidenced by the following: On 01/15/25 at 2:08 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a copy of the facility's surety bond and a list of all the resident funds held by the facility. On 01/15/25 at 2:37 PM, the LNHA provided a copy of a Certificate of Liability Insurance Date: 01/15/2025 (the survey entrance date) with Crime- Including Burglery listed as the type of insurance coverage provided. The surveyor questioned the LNHA regarding the policy that he provided and he stated, this is what they (corporate oversight) gave me. A review of the Funds Balance Report for 01/15/2025 revealed a list of eighty five active resident names with a balance of $84, 036.27 Due to patients. On 01/17/25 at 8:38 AM, the surveyor asked the LNHA about the residents funds and if they were kept in interest bearing accounts. The LNHA stated that information was not kept at the facility, and I'm still working on it, I will have it later this morning. The surveyor again, asked about the surety bond and showed the document to the LNHA that was titled Certificate of Liability, and asked if there was another document. The LNHA stated, no, that is what the facility used, and he confirmed he was told by the corporate management staff. NJAC 8:39-9.5c(3)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 177957, # NJ 180392 Based on interviews, record review, and pertinent facility documents provided by the facility from 01/15/25 through 1/22/25, it was determined that the facility failed to notify the family/responsible party when a resident (Resident #264) had a change in condition and required transport to the emergency room . This deficient practice occurred for 1 of 1 closed medical records reviewed for resident (Resident #264) who had a change in condition. The deficient practice was evidenced by the following: According to Resident #264's Admission Record, the Resident was admitted to the facility on [DATE], with diagnoses which included but were not limited to: Acute and chronic respiratory failure hypoxia, Epilepsy, tracheostomy status and dependence on respiratory ventilators. The Discharge assessment dated [DATE], reflected that Resident #264 was severely cognitively impaired and totally dependent on staff for all activities of daily living (ADLs). Review of Resident #264's Care Plan (CP) initiated 2/27/2024, revealed the following: Under Focus: The resident is at risk for falls related to poor safety awareness, impaired balance, poor trunk control side effects of medication and non verbal. Mechanical lift transfer. Under Goal: The resident will be free of falls. Under Interventions: Mechanical lift transfer x 2 assist, initiated 2/27/2024. Further review of Resident #264's CP initiated 08/13/2024, revealed the following: under Focus, at risk for bleeding related to anticoagulation therapy related to Atrial Fibrillation, Under Goal, resident will be free from adverse reactions of signs and symptoms of bleeding related to anticoagulation therapy. Review of an 11/06/24 Progress Notes (PN) timed 11:13 AM, written by the Respiratory Therapist, revealed the following: Resident received in recliner chair, on [NAME] vent setting: AC18/350/40%/P+5. Alarm on and audible functional. Trach [name redacted] in placed, secured midline and airway patent. Suction with scanty secretion. No respiratory distress noted. Will continue to monitor. Review of Resident #264's PN written by the Respiratory Therapist on 11/6/2024 at 4:53 PM, revealed that the resident was in bed, and had no bruises. Review of a PN dated 1/06/2024, at 9:30 PM, written by the Registered Nurse (RN), revealed that the resident representative came to visit and reported at 9:15 PM that Resident #264 had a hematoma (collection of blood) to the the right eye and ecchymosis (bruise) to the facial area measuring 16 centimeters (cm) x 10 cm. In addition, the RN revealed that staff provided care to Resident #264 at 5:00 PM, and did not report any discoloration or concerns. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #264's medical records showed no documentation that the resident had a bruise to the right facial area, and a hematoma to the right eye prior to the 11/06/24 at 9:30 PM. The medical records did not reveal how Resident #264 acquired the bruise to the right facial area and the hematoma to the right eye, or that the resident's family and responsible party was notified. Review of Resident #264's Incident Report (IR) dated 1/06/24 at 9:30 PM, revealed the following: Resident representative reported hematoma and bruise to the right facial area. The Nurse Practitioner was called and ordered to transfer Resident #264 to the hospital for evaluation. Further review of Resident #264's IR dated 11/6/24 at 9:59 PM, showed that the Physician was notified of the incident at 9:20 PM when the resident representative reported the incident. Based on the nurse's statement and a phone interview conducted on 1/21/25 at 1:20 PM, with the nurse, the Certified Nursing Assistant (CNA) did not report the incident. The RN stated during the interview that, a resident family is notified whenever a resident has a fall or any incident, it does not have to be a fall with injury. The RN stated that she was very concerned and could not explain why the CNA did not report the incident immediately. The nurse was made aware of the incident at 9:15 PM, 5 hours later. The Director of nursing (DON) classified the incident as a significant event and reported the incident on 11/06/24 at 11:18 PM, to the Department of Health. Review of the Jersey Universal Transfer Form (NJUTF) dated 11/06/24, revealed the resident was transferred to the hospital. The reasons for transfer was right eye swelling with discoloration. On 1/22/25 at 10:15 AM, the surveyor conducted a face to face interview with the CNA who was assigned to Resident #264 on 11/6/24. When asked if she had reported the bruise to the nurse immediately, she presented some conflicted stories, she stated that the night was very chaotic, she could not remember the time she reported the incident. The surveyor then asked if she remained in the room until the resident was assessed by the nurse. She replied, No . The CNA Confirmed that she transferred Resident #264 in bed between 3:00 PM-5:00 PM. She observed the bruise after executing the transfer and stated the bruise was identified and reported to the nurse by the resident representative five hours later at 9:15 PM. Resident #264 was transferred to the hospital and diagnosed with traumatic hematoma of the right orbit. During an interview with the Director of Nursing (DON) on 1/16/25 at 11:30 AM, the surveyor reviewed the statements written by all the staff involved in the residents care over the last 24 hours from the incident. The DON stated that she noticed the discrepancies but did not want to ask staff to change their statements. The resident representative (RR) contacted the surveyor on 1/23/24 at 3:10 PM, and the expressed concerns over not being informed of the incident prior to finding the bruise. The RR stated Resident #264 was transferred to another facility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Notification of Changes with a revised date of 1/2025, included but was not limited to the following: Under Policy Statement: It is the policy of this facility to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: An accident involving the residents which results in injury and has the potential for requiring physician interventions Significant change in the residents's physical, mental, or psychological status. A decision to transfer or discharge the resident from the facility. N.J.A.C: 8:39-13.1(c)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to maintain safe handrails on 1 of 5 Resident Units. This deficient practice was evidenced by the following: On 1/15/25 at 9:53 AM, the surveyor toured the 3rd floor and observed the following: Outside of room [ROOM NUMBER], the corner handrail was not securely connected to the next piece of handrail. Outside of room [ROOM NUMBER], the handrail was cracked. By the soiled linen room, the handrail was not secure. Across from room [ROOM NUMBER], the handrail was not secure to the wall. Outside of room [ROOM NUMBER], the handrail was not connected to the next piece. In the out cove by the telephone for resident use, the handrail was not secure to the wall. Outside of room [ROOM NUMBER], the handrail was cracked and not secure. Outside of room [ROOM NUMBER], the corner piece of handrail was loose from the connecting piece. On 1/15/25 at 10:00 AM, a maintenance worker was on the 3rd Floor Unit. The maintenance worker stated that maintenance staff was responsible for checking the handrails. He further stated that the handrails should all be connected, and he confirmed that the handrails observed on the 3rd floor were not safe or secure. On 1/16/25 at 11:06 AM, the surveyor observed that the 3rd Floor Unit handrails were in the same condition as observed on 01/15/25 and were not fixed . On 1/16/25 at 11:41 AM, the surveyor reviewed the 3rd floor Maintenance Log. There was one page with two entries dated 1/13/25, but there was no entry on 01/15/25 when the handrails were identified as needing to be repaired and secured. On 1/16/25 at 11:45 AM, the Registered Nurse Unit Manager (RN/UM) on the 3rd floor stated she had entered the handrails into the maintenance log. The RN/UM stated maintenance knew about the handrailsdays ago, but that the other pages in the logbook related to the handrails appeared to have been removed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 12:06 PM, two maintenance staff entered the conference room in the presence of two surveyors. One maintenance staff stated that the 3rd floor was a Dementia Unit, and the residents tear the handrails out all the time. The surveyor asked if there was a process in place to address his concerns that the residents tear the handrails out, and the maintenance staff stated, no, but that would be good. On 1/21/25 at 11:16 AM, the surveyor requested a policy and procedure regarding the maintenance of the handrails from the facility. The facility provided a policy, Maintenance Repairs and the surveyor was informed that there was no policy or procedure for the handrails. A review of the facility provided policy, Maintenance Repairs revised 1/2025, included but was not limited to; Policy: maintain a safe, clean, and functional environment for residents . through timely repairs, routine maintenance, and room inspections. Procedure: 1. The maintenance department is responsible for conducting routine checks, repairs and inspections throughout the facility. 7. Maintenance performs routine checks of . hallways . On 1/23/25 at 11:32 AM, the above concerns were presented to the facility administration. NJAC 8:39-31.2(e)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 180392 Based on interview, record review and review of other pertinent documents, it was determined that the facility failed to ensure a thorough and complete investigation was completed to determine the causal factor of an injury of unknown origin to ensure that resident abuse or neglect had not occurred for a resident (Resident #264) who was in a persistent vegetative state (disorder of consciousness caused by brain damage), dependent on staff for all care, and required a mechanical ventilator for breathing. Resident #264 was found on 11/06/24, with a hematoma (blood filled injury) to the right eye, and ecchymosis (a bruise) to the right facial area measuring 16-centimeter (cm) x 10 cm. Resident #264 was transferred to the emergency roiagnom on [DATE], and was diagnosed with traumatic hematoma of the right eye. The deficient practice was identified for 1 of 2 residents reviewed for accidents and evidenced by the following: On 01/21/25 at 10:00 AM, the surveyor reviewed the closed electronic medical record for Resident #264. According to the Admission Record, Resident #264 was admitted to the facility with diagnoses which included, but were not limited to; acute and chronic respiratory failure, hypoxia, Epilepsy, tracheostomy status and dependence on respiratory ventilators. A review of Resident #264's Quarterly Minimum Data Set (an assessment tool used to facilitate the management of care) dated 09/04/24, reflected that the resident was coded as being Comatose and yes to being in a persistent vegetative state/ no discernible consciousness. Resident #264 was totally dependent on staff for all care. A review of Resident #264's Care Plan (CP) included a Focus Initiated: 02/27/24 for being at risk for falls related to poor safety awareness, impaired balance and poor trunk control, side effects of medications, non-verbal, and required mechanical lift transfers. Interventions included to use mechanical lift for transfers with two persons assisting with the transfer. The Progress Notes revealed an Interdisciplinary Team (IDT) Note dated 11/06/24 at 10:20 PM, which revealed: Made aware by CNA (Certified Nurse Aide) that Resident #264 was noted with discoloration and swelling of the right eye. NP (Nurse Practitioner) notified. Per NP send Resident #264 out to hospital for further evaluation and treatment. Report given to the nurse, Resident Representative (RR)was at bedside. A review of the IDT Progress Note dated 11/06/22 at 10:22 PM, revealed: Transportation arranged with the Hospital (name redacted) Emergency Services. Further review of the IDT Progress Note dated 11/07/24 at 8:05 PM revealed: Follow up to emergency room . Resident was admitted with diagnoses traumatic hematoma to right orbit (eye socket). (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	On 1/16/25 at 10:30 AM, the surveyor reviewed the facility's investigation and the Reportable Event Record received by the Department of Health on 11/08/24. There was no causal factor identified for the injury and the statements attached to the incident report contained the following discrepancies: CNA #1 who provided care to Resident #264 on 11/06/24, provided two statements which revealed the following: The first statement dated 11/06/24, CNA #1 documented that on 11/06/24, that she put [Resident #264] in bed and found the resident with a black eye to the right side of the face and reported to the nurse. Signed CNA #1, 3:00 PM-11:00 PM shift [Prior to the mechanical lift transfer]. The second statement dated 11/06/24, CNA #1 documented that on 11/06/24, in the evening I put resident back in bed with mechanical lift. Resident was sitting in recliner chair and we assisted back to bed lying on left side. Once back in bed. I noticed resident had redness to face by eye. I reported discoloration to the nurse [After the mechanical lift transfer]. The surveyor reviewed the statement provided by CNA #2 who documented that on 11/06/24, in the evening I assisted my co-worker to place resident [#264] back into bed with the mechanical lift. Resident was sitting in the recliner chair and we assisted back to bed lying on left side. Once back in bed I noticed resident had redness to face by eye. The assigned CNA reported the discoloration to the nurse. Review of the Registered Nurse's (RN) statement dated 11/6/24 at 9:15 PM, documented that they worked the 3:00 PM to 11:00 PM shift on the 2nd floor ventilator unit (a unit with residents that are dependent on a mechanical breathing machine) and was assigned to the Resident in room [ROOM NUMBER]. At 3:00 PM, I made rounds and the resident was sitting in recliner chair along the bedside and did not notice any changes to [Resident #264]. At 5:00 PM, resident was provided care and placed back to bed by CNA. At approximately 8:30 PM, Resident's family came to the unit to provide care for her parent. At 9:15 PM, Resident #264's family member informed me that the resident was noted with a hematoma and swelling of the right eye. On 1/17/25 at 8:52 AM, the surveyor interviewed the Respiratory Therapist (RT) who confirmed that two staff members had to be in the room to transfer a ventilator dependent resident from the bed to the recliner chair. The RT confirmed that on 11/06/24, he had assisted CNA #3 with the transfer from the bed to the recliner chair during the day shift (7:00 AM to 3:00 PM), and confirmed that there was no injury observed. The RT informed the surveyor that on 11/06/24 at 4:53 PM, he observed Resident #264 in bed and did not assist with the transfer back to the bed, and he was not made aware of the injury to the resident's eye. On 01/17/25 at 11:59 AM, the surveyor reviewed the facility provided incident report, including the statements attached, with the Director of Nursing (DON). The DON stated that she was aware of the discrepancies in CNA #1's statements, and could not provide any rationale for not clarifying the discrepancies prior to submitting the investigation to the Department of Health (DOH). The DON stated, there was a misunderstanding and miscommunication about the investigation. The DON stated she had understood Resident #264 sustained the injury during the transfer, and then stated that Resident #264 possibly hit the right eye on the mechanical lift. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	On 01/17/25 at 12:05 PM, the surveyor conducted a second interview with the RT. The RT was on duty that day and stated that one nurse and one CNA were supposed to transfer any resident out of the bed and then back to bed if the resident was using a mechanical ventilator (machine that moves air in and out of the lungs to assist with breathing). The RT stated that some CNAs worked as floaters (worked on various units) to the unit and they had not been trained to transfer residents with the ventilator attached. The RT stated, for safety reasons, a nurse had to be in the room to assist with the transfer, or if the nurse could not assist, she would then delegate the task to the respiratory therapist who would supervise the transfer of the ventilator dependent resident. When asked if there was a policy for transferring a resident who used a ventilator, he stated, this is the norm, not too sure if there is a policy. Based on the documents provided by the facility, which included the Incident Report, Reportable Event Record, Investigative Summary, Skin Assessment and Impairment Form and Statements, there was no documented evidence that the RN or the RT assisted CNA #1 with the transfer of Resident #264 as explained by the RT as being the standard protocol for transferring a ventilator dependant resident when the injury was observed on 11/06/24. On 1/21/2025 at 1:09 PM, the surveyor interviewed the RN who worked and cared for Resident #264 on 11/06/24. The RN stated that CNA #1 did not report the injury to her and stated the resident representative visited at 9:15 PM and reported the injury. The RN stated once she was made aware, she attended to the injury by measuring the area, initiated neurological checks, applied ice compresses, monitored for bleeding, and notified the nursing supervisor and the NP. She then received an order to transfer Resident #264 to the hospital for further evaluation and treatment. On 01/21/25 at 11:47 AM, the surveyor interviewed the Medical Director (MD) regarding the injury sustained by Resident #264 during the transfer. The MD stated that he was told by the DON the injury was caused by the hook from the mechanical lift and was not provided with any additional information. In the summary provided to Department of Health along with the Reportable Event Record, the DON indicated that Resident #264 had periods of involuntary movements related to hypoxia and seizure disorder as well as cough spasms. The Interdisciplinary Team concluded that the resident during transfer may have coughed or had involuntary movement and may have leaned into [Resident #264] mechanical lift cross- bar. Interviews with staff familiar with the resident routine revealed that the resident was immobile. On 1/22/24 at 10:15 AM, two surveyors conducted an in person interview with CNA#1 who stated that she recalled the incident, and she confirmed that she observed the injury after transferring Resident #264 in bed. When asked if she remained in the room with the resident and waited for the nurse to come and assess the injury, CNA #1 stated she had too much to do that day, and she moved on and attended to other residents. The surveyor then inquired regarding the 2nd statement, CNA #1 read the statement and stated, another co-worker coached her to write the second statement, but she did not observe any injury to the resident face and right eye while the resident was sitting in the chair. On 1/22/24 at 12:00 PM, the surveyor conducted a telephone interview with CNA #2 (whom CNA #1 claimed assisted with the transfer for Resident #264). CNA #2 stated that when she entered the room, [Resident #264] was in the room and on the mechanical lift alone with CNA#1. She then observed the facial bruise and advised CNA #1 to report the injury to the nurse. When asked if she had assisted CNA #1 with care she stated, No, I left the room and continued with my assignment. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	On 1/22/25 at 1:15 PM, the surveyor interviewed CNA #3 assigned to the 7:00 AM- 3:00 PM shift regarding Resident #264's care. CNA #3 stated that she cared for Resident #264 daily, Resident #264 was immobile, had poor trunk control, and required two persons assist with transfer. CNA #3 further stated that on 11/06/2024, she transferred Resident #264 to the recliner chair with the Respiratory Therapist. During the day she periodically checked Resident #264 and no injury was noted to the right eye. On 1/23/25 at 10:56 AM, the surveyor reviewed the investigation with the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The LNHA stated that in reviewing the RN's statement and the investigation, he could see there was some discrepancies. The LNHA added the investigation was not concise and thorough, and that his expectation was that the facility would thoroughly investigate injuries of unknown origin. On 1/23/25 at 1:30 PM, during the exit conference no additional information was provided. On 1/23/25 at 2:30 PM, the RR for Resident #264 contacted the surveyor and stated the that the facility informed them that they could not determine how the injury occurred. On 02/05/25 at 12:30 PM, the surveyor reviewed the Hospital records for Resident #264's transfer to the Emergency Department on 11/06/24. The records revealed a physician note dated 11/07/24 at 7:58 AM which documented: Patient presented to the Emergency Department for recently noticed orbital trauma. Clinical Impression: Final Diagnosis: Suspected Elder Abuse, Initial Encounter; Traumatic Hematoma of Right Orbit, Initial Encounter. A review of the facility titled, Abuse Prevention Program last revised 1/2025, under identification indicated the following: All residents sustaining bruises, skin tears, any marks of the skin, and any fractures or injuries, which are of unknown origin, shall be identified as potential abuse incidents and investigated as such. NJAC 8:39 4.1 (a)(5), 27.1(a)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423 Based on interview and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 2 of 36 residents (Resident #143 and Resident #26) reviewed for accuracy of MDS coding. The deficient practice was evidenced as follows: On 1/15/25 at 9:39 AM, during initial tour, Surveyor #1 observed a sign posted on the wall outside of Resident #143's room, No Smoking (in red), Piped in Oxygen in Use. Upon entrance to Resident #143's room, the surveyor observed the resident watching television (TV) in bed. The surveyor observed a pack of cigars on the table next to the resident and asked the resident what that was. The resident took a cigar out of the case and stated it's a cigar while showing it to Surveyor #1. On 1/16/25 at 8:50 AM, the surveyor reviewed the medical record for Resident #143. According to the Admission Record (AR), Resident #143 was admitted to the facility with diagnoses which included but were not limited to; Hypertension (high blood pressure), Heart Failure (is a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), hyperlipidemia (abnormally high levels of fats in the blood), and Diabetes mellitus (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of Resident #143's most recent Comprehensive MDS, dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident had moderately impaired cognition. The further review of the MDS revealed the resident was coded no as being a current tobacco user. A review of Resident #143's Individualized Care Plan (CP) reflected the resident was a smoker. Interventions included Smoking contract reviewed with the resident. Resident signed updated smoking agreement on 07/09/24 and understands smoking safety procedures and hours of operation 10 AM-12:30 PM, 4:00 PM and 7:00 PM. On 1/17/25 at 11:37 AM, during an interview with Surveyor #1 the MDS Coordinator (MDSC) stated the nurses would complete the smoking assessment on all newly admitted residents. The MDSC further stated if a newly admitted resident was a smoker, that would be coded in the Comprehensive MDS by her. The MDSC reviewed the MDS in the presence of the surveyor and confirmed the MDS was not coded that the resident was a smoker. The MDSC further stated that she should have coded Resident #143 as a smoker in section J and stated it was missed. On 1/23/25 at 11:33 AM, the survey team met with the facility administration. The surveyor notified the facility management of the above-mentioned concerns for Resident #143. On 1/23/25 at 2:10 PM, the survey team met with the facility administration for an Exit Conference. The facility had no additional information to provide. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	38079 b.) On 1/22/25 at 11:27 AM, during an interview with Surveyor #2, the MDS coordinator stated the process to perform MDS review would be that she would review the Progress Notes (PN), medications and would interview residents to collect the information needed for MDS'. She further stated she was responsible for the information in the MDS and that it was, important to truly reflect resident status. On 1/22/25 at 12:24 PM, Surveyor #2 reviewed the closed record for Resident #26 which documented the following: The AR revealed that Resident #26 was admitted with diagnoses which included but were not limited to; chronic pain syndrome, anxiety, and dependence on renal dialysis (the process of filtering waste from the blood when the kidneys are not functioning). The PN dated 10/17/24, documented a discharge summary and noted the resident was discharged home today. The most recent MDS in the electronic medical record was dated 09/02/24 and was an Admission assessment. On 1/23/25 at 11:32 AM, the concern was presented to the facility administration. On 1/23/25 at 12:31 PM, the facility provided an MDS documenting Resident #26's discharge on 10/17/24 that was dated as completed after surveyor inquiry on 01/22/25. A review of the facility provided policy, MDS 3.0 Assessment Process effective 01/09/25, included but was not limited to; . completed on admission, quarterly, annually, when a change in condition occurs and as per [name redacted] schedule. The purpose . is to accurately assess residents . 2. Mandatory transmission of export ready assessments will be done weekly . NJAC 8:39-11.1, 11.2(d)(e)(g)1

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on observation, interview and record reviews, it was determined that the facility failed to administer medication in accordance with the physician order and professional standards of nursing practice. This deficient practice was observed for one of 1 of 1 residents (Resident #60) reviewed for medications during the initial tour conducted on 01/15/25 and 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 casefinding, 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 casefinding; 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 1/15/25 at 8:46 AM, the surveyor observed Resident #60 sitting in a wheelchair at the bedside. The resident was awake and alert and on the bedside table, the surveyor observed a medication cup with 5 tablets inside. On the right side of the bedside table, the surveyor observed 5 vials of albuterol sulfate (medication used to treat breathing difficulties caused by asthma and other lung conditions). The surveyor then observed the nurse at the other end of the hallway. The medications in the cup were identified by the nurse as colace 100 mg (milligrams) (a stool softener), Steglator 5 mg (medication used to help lower blood sugar), lasix 40 mg (a diuretic agent), potassium chloride 40 Meq (milliequivalent - a mineral supplement used to treat or prevent low amounts of potassium in the blood), metoprolol 25 mg (medication used to treat high blood pressure). On 1/15/2025 at 9:00 AM, the surveyor interviewed the resident regarding the medications observed on the bedside table. The resident informed the surveyor that the nurses would leave the medication at the bedside and they would then take the medication with their meals. The breakfast meal had been delivered to the 4th floor around 7:30 AM. On 1/15/25 at 9:15 AM, the surveyor accompanied the Unit Manager Registered Nurse (UM/RN) to Resident #60's room and we both observed the medications left on the bedside table. The UM/RN stated that the resident will take the medication after breakfast. When inquired if the resident was assessed as being capable to self-administered medication, the UM/RN replied, No. The UM/RN stated, the nurse had to ensure that the resident took the medication prior to exit the room. It is a concern, another resident can go to the room and take the medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 9:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who left the medications at the bedside. The LPN confirmed that she left them at the bedside and she stated she forgot to return to ensure that the resident took the medications. When inquired regarding the facility protocol for administering medications, the nurse stated that she should not leave the medication at the bedside as another resident can go to the room and interfere with the medications. On 1/21/25 at 12:40 PM, the surveyor reviewed the Electronic medical record and noted there was no assessment that the resident could self administered medications. A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses, which included but were not limited to; acute respiratory failure, shortness of breath and pulmonary fibrosis. The Quarterly Minimum Data Set (MDS) dated [DATE], revealed that Resident #60 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicative of intact cognition. A review of the Physician Order Sheet (POS) for January 2025 reflected a physician order (PO) dated 10/05/23 for Ipratropium-Albuterol Solution 0.5-2.5 (3 ml) (milliliter) inhale orally every 6 hours for shortness of breath. The POS also included the following orders for January 2025: Colace 100 mg twice daily, (dated 01/07/2023), Lasix 40 mg twice daily (01/09/2023) metoprolol tartrate 25 mg (milligram) twice daily (02/04/2023) Steglatro 5 mg (03/15/2023), Potassium chloride 20 Meq (milliequivalent) (04/08/2023). The surveyor reviewed the electronic medication administration record (EMARs) for January 2025 that revealed the nurses had been documenting that the Albuterol was administered to Resident # 60 as ordered by the physician. On 01/15/25, the LPN initialed the EMAR that the following medications: colace 100 mg, lasix 40 mg, potassium chloride, 20 Milliequivalent, Steglatro 5 mg, and metoprolol 25 mg, had been administered although the medications were still on the bedside table. The Comprehensive Care Plan initiated on 6/20/2019, did not reflect a focus for Self administering medication. There was no documented evidence that Resident #60 was assessed by the Interdisciplinary Team, nor there was a physician order for self administration of medication. On 1/21/25 at 12:40 PM, the surveyor again reviewed the Electronic medical record and noted there was no assessment that the resident was able to self administered medications. The facility was made aware of the above concerns on 1/22/2025. The Director of Nursing (DON) stated that was not the facility protocol to leave medications at the bedside. A review of the facility policy and procedure titled, Medication Administration Policy last revised 1/2025, revealed the following: Policy: Medications shall be administered in a safe and timely manner, and as prescribed. Procedure: 1. Only persons licensed or permitted by the State to prepare, administer and document the administration of medication may do so. (continued on next page)

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Alaris Health at St Mary's	135 South Center Street Orange, NJ 07050

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure #19. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Team, has determined that they have the decision-making capacity to do so safely. NJAC 8:39-11.2(b), 29.2(c)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 167555 Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to provide appropriate incontinence care, and personal hygiene care for 2 of 2 residents (Resident #33 and Resident #8) reviewed for Activities of Daily Living. The deficient practice was evidenced by the following: 1. On 1/15/25 at 9:45 AM, the surveyor observed Resident #33 in bed and a strong urine odor was observed in the room. The resident was able to answer questions and informed the surveyor that they had not been changed since last night. On 1/15/25 at 10:15 AM, the surveyor returned to the room and observed the resident in the same position. The resident indicated that they had not had incontinence care. On 1/15/25 at 10:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who had Resident #33 on her assignment. The CNA revealed that she reported to work at 7:00 AM this morning, she delivered the breakfast tray and she had not yet provided care to Resident #33. The CNA added that incontinence care was provided by the 11:00 PM-7:00 AM shift. On 1/15/25 at 10:40 AM, the surveyor entered Resident #33's room accompanied with the Unit Manager (UM) and the CNA. The surveyor requested the resident's incontinent brief to be checked by the staff. The surveyor observed that Resident #33 was wearing two incontinent briefs which were both saturated with urine. The UM asked the resident why do you have two briefs on and the resident replied, ask the staff. On 1/17/25 at 10:30 AM, the surveyor reviewed Resident #33's electronic medical record. Resident #33's Admission Record (AR) revealed Resident #33 was admitted to the facility with diagnoses which included but were not limited to; Morbid obesity, chronic kidney disease, hypertension and unspecified glaucoma. The quarterly Minimum Data Set (MDS) an assessment tool dated 1/14/25, revealed that Resident #33 had some cognitive impairment, Resident #33 received a score of 07 out of 15 on the Brief Interview for Mental Status (BIMS). Section G of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #33 was dependent on staff for care. Review of the Care Plan for Resident #33 initiated on 4/15/2020, included a Focus area for Bowel and Bladder incontinence related to Dementia and impaired mobility. The goal was Resident #33 will remain free from skin breakdown due to incontinence and brief use. The interventions were to establish voiding patterns, and check as required for incontinence. The care plan did not indicate when staff were to provide care to the resident and the frequency for staff to turn and reposition the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/21/25 at 8:43 AM, the surveyor went to Resident #33's room, Resident #33 was in bed sleeping. The breakfast tray was left opened on the bedside table. The surveyor checked with the CNA for incontinence care. at that time and the resident's incontinent brief was saturated with urine. 2. On 1/15/25 at 10:03 AM, the surveyor observed Resident #8 after morning care had been provided with the nails long and jagged, and a yellow substances was underneath all of the finger nails. Resident #8 was unable to engage with the surveyor. On 1/16/25 at 10:04 AM, the surveyor returned to the room and observed that Resident #8 had just completed breakfast. The resident's nails were still long, jagged with a yellow substance underneath. On 1/16/25 at 10:19 AM, the surveyor interviewed the CNA who cared for Resident #8. The CNA stated that Resident #8 was on hospice and cared for by the hospice aide. On 1/17/25 at 11:15 AM, the surveyor reviewed Resident #8's medical record which revealed the following: Resident #8 was admitted to the facility with diagnoses which included but were to limited to; Dysphagia, sepsis and diabetes mellitus. According to the MDS dated [DATE], Resident #8 had a BIMS score of 01 out of 15 indicating that Resident #8 was cognitively impaired. The MDS also indicated that Resident #8 required extensive assistance for ADLs. A review of Resident #8's Comprehensive Care plan provided by the facility on 01/22/25, initiated on 06/29/22 and last revised 01/14/25, revealed that Resident #8 did not have a care plan in place for ADLs self care performance deficit. The comprehensive Care Plan last revised 1/14/25, addressed falls, skin integrity, abnormal bleeding, nutrition . The care plan did not address ADL care. Based on the MDS assessment, Resident #8 was totally dependent on staff for care. On 01/21/25 at 8:52 AM, the surveyor observed staff at the bedside. The staff identified herself as the Hospice Aide. The surveyor then inquired regarding nail care and the staff stated clearly, I am a Home Health Aide. I am not allowed to trim the residents nails. The CNAs were responsible to trim the resident's nails. The above concerns with incontinence care and nails care were discussed with the facility management during the survey and again on 01/22/25. The Director of Nursing (DON) indicated that the staff were responsible to provide resident nail care. NJAC 8:39-27.1 (a)(e)(of)

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. 31654 Based on observation, interview, record review and review of pertinent documents it was determined that the facility failed to ensure there was no delay in treatment for a resident who required podiatry care that was ordered on 12/04/2024 and the podiatrist consult was completed 01/20/25, and the resident wore pressure relieving boots as per physician order. This deficient practice was identified for 1 of 1 resident (Resident #38) reviewed for foot care and was evidenced by the following: On 1/15/25 at 10:07 AM, the surveyor observed Resident #38 was in awake and alert in bed, with feet outside of covers and were not off loaded or in boots. Both feet were observed to be encrusted with a thick yellow, cracked and dry skin. The right foot had approximately a dime sized round black area above the right heel on the sole of the foot. The left foot had what appeared to be a black pencil eraser sized area on the ball of the foot. There were various colored flakes of what appeared to be skin scattered on the bed sheet by the resident's feet. On 01/22/25 at 8:00 AM, the surveyor reviewed the medical record for Resident #38 which revealed: A twenty-five-page Care Plan (CP) with current and canceled Focus areas that included a list of diagnoses, which included, but was not limited to; Type Diabetes Mellitus, hypertension, pneumonia and dependence on supplemental oxygen. A CP Focus: Resident has diagnosis of Diabetes Mellitus and is at risk for endocrine complications, Date Initiated: 12/04/24 with a Goal: Resident will have no complications related to Diabetes through the review date. Target Date: 03/20/2025 with Interventions, Dated Initiated: 12/04/24 Check all of body for breaks in skin and treat promptly as ordered by Medical Doctor; Check skin when assisting with ADLs (activity of daily living) Date Initiated 12/04/24 and Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Report any of the above to the Medical Doctor, Date Initiated 12/04/24. The Order Summary Report dated, 01/17/25 revealed: - Heel boots to b/l (bilateral heels every shift, Order Date: 12/11/24. -Consults: Podiatry consult and treat as needed, Order Date:12/04/24. -Skin Assessment every day shift every Monday and Friday, document using the following codes: O-No skin impairments, 1-Previous skin impairment present, 2-Newly identified skin impairment if you respond with a *2*, further documentation in progress notes is required. On 01/21/25 at 1:19 PM, the surveyor reviewed the paper medical record and could not locate a Podiatry consult. On 01/22/25 at 8:46 AM, two surveyors (#2 and #3) observed Resident #38 in bed without off loaded heels or wearing boots. Both heels remained dry, cracked with flakes present and the blackened areas remained. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/22/25 at 9:22 AM, the Surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) regarding the Podiatry consult ordered 12/04/24. The LPN/UM stated that the Podiatrist was at the facility weekly, confirmed the order was on 12/04/24 and stated the Podiatrist consult for Resident #38 was completed on 1/20/25 and the LPN/UM printed a copy for the surveyor. The LPN/UM stated normally, he normally comes right away [the podiatrist] and not sure why he came so late. The surveyor asked if the resident was supposed to wear the heel protectors and she stated, the resident was supposed to wear them. The LPN/UM also reviewed the entire paper record to ensure there was no other Podiatry consultation. The surveyor reviewed the Podiatry consultation Dated 01/20/2025, Late Entry, which documented Moderate Xerosis Bilateral [dry skin], Assessment: Plan. Debridement nails x 10 topical applied, lotion for dry skin. Encourage Physical Therapy Range of Motion for Lower Extremity. Discussed need for support hose for Lower Extremity Bilateral, Diabetes Mellitus care discussed with staff will follow, suggest foot and heel protectors due to immobility daily for pressure relief. On 01/22/25 at 9:29 AM, the surveyor explained the observations to the LPN/UM regarding the blackened areas observed on Resident #38's feet. The LPN/UM reviewed the Podiatry Consultation and the areas were not indicated and the LPN/UM went with the surveyor to observe Resident #38's feet. The LPN/UM looked at Resident #38's feet and confirmed the black areas and stated she would call the Podiatrist to make sure the areas were not overlooked. The Podiatry Services Policy, Effective 2/2017, Revised 1/2025 revealed Policy: Routine and emergency podiatry services are available to meet the resident's health services in accordance with the resident's assessment and plan of care. Policy Interpretation and Implementation: 1. Routine and emergency podiatry services are available to meet the resident's needs. On 01/23/25 at 2:10 PM, during the facility exit conference, the Director of Nursing provided a copy of a Late Entry Note Effective Date: 01/22/25 documented by the LPN/UM which revealed spoke with the Podiatrist who stated the resident had aging spot on bottom of both feet that are not open wounds, and are not DTIs (deep tissue injuries). The facility did not respond to why the resident was not wearing the ordered boots, or why the Podiatry Consultation was completed six weeks after it was ordered. NJAC 8:39-27.1(a)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48423 Complaint NJ # 180392 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to a.) ensure effective interventions were implemented and monitored for a resident (Resident #143) who resided in a piped-in oxygen room and was identified as a smoker and was observed smoking inside their room on 10/19/24. This deficient practice occurred for 1 of 1 residents reviewed for safe smoking. Observations on 1/15/25, 1/16/25, and 1/17/25, confirmed Resident #143 who resided in a piped-in oxygen room, kept their smoking materials in their room. The facility's failure to ensure all residents were protected from serious injury, harm or death from explosion or fire, from smoking inside of a room that had oxygen piped in through the walls resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 10/19/24, when Resident #143 was found by a Registered Nurse (RN #1) to be smoking in their room. From 1/15/25 through 1/17/25, the surveyor observed smoking materials inside of the resident's room and within arm's reach of Resident #143 and inside of an oxygen rich environment due to the facility utilizing oxygen that was piped in through the walls. The facility was notified of the IJ on 1/17/25 at 2:26 PM. The facility provided an acceptable Removal Plan (RP) which was verified on-site by the survey team on 1/21/25. The facility further failed to b.) ensure that two staff members were present to safely transfer a resident who was dependent on a ventilator for breathing and utilized a mechanical lift, who sustained a 16-centimeter (cm) x 10 cm traumatic hematoma to the right orbit (eye socket) and required hospitalization on [DATE]. This deficient practice was identified for 1 of 1 residents (Resident #264) reviewed for accidents; the facility also failed to c.) ensure effective interventions and adequate supervision was provided to a resident (Resident #34) with a history of substance abuse who was found on 07/14/24, with erratic behavior and drug paraphernalia observed on the bed and on 08/08/24, with slurred speech making incoherent statements that tested positive for cocaine, opiates, and morphine; and d.) protect all residents from potential fire or gaining access to illicit drugs by ensuring effective interventions for the same resident (Resident #34) who on 12/19/24 was found lethargic, not responding to commands, and had a lighter and a vape (electronic cigarette) pen in their room. This deficient practice was identified for 1 of 2 closed records reviewed for accidents (Resident #34). The evidence was as follows: Part A (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	A review of the facility's Smoking Safety policy revised/reviewed 1/2025, revealed Policy: It is the purpose of this facility to ensure smoking safety at all times while resident in the facility. Procedure: 1. All smoking residents will receive and sign the Smoking Agreement Contract. If the resident refuses to sign the contract, the resident will lose the privilege of smoking. 2. Upon admission, smokers will be assessed for smoking safety. 3. The Social Worker will review the Smoking Assessment Contract with the resident and answer any questions if needed. The Social Worker will have the resident sign the contract at this time. 4. Cigarettes and lighting materials are held in the security office. The resident will not keep lighters, matches and/or lighting materials with them while not actively smoking or in a smoking area. On 1/15/25 at 9:39 AM, during the initial tour, Surveyor #1 observed a sign posted on the wall outside of Resident #143's room which indicated, No Smoking (in red), Piped-In Oxygen In Use. Upon entering Resident #143's room, Surveyor #1 observed the resident in bed watching television. At that same time, Surveyor #1 observed a pack of cigars on the table next to the resident and the surveyor asked the resident what they were. The resident took a cigar out of the case and stated it's a cigar while holding it and showing it to the surveyor. On 1/16/25 at 8:50 AM, Surveyor #1 reviewed the electronic medical record for Resident #143. According to the Admission Record face sheet (an admission summary) Resident #143 was admitted to the facility with diagnoses which included but were not limited to; hypertension (high blood pressure), heart failure (condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), hyperlipidemia (abnormally high levels of fats in the blood), and diabetes mellitus (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of Resident #143's most recent quarterly Minimum Data Set (MDS), an assessment tool dated 10/28/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 09 out of 15, which indicated the resident had a moderately impaired cognition. A review of a nursing Progress Notes (PN), created on 10/19/24 at 7:18 PM, indicated [resident] was seen in room smoking cigarette; educated [resident] not to smoke in room. The [resident] shown area designated for smoking, states okay . A review of Resident #143's individualized comprehensive care plan (ICCP) initiated on 7/09/24, reflected that Resident #143 was a smoker. Interventions included: Smoking contract reviewed with [Resident #143]. Resident signed updated smoking agreement on 07/09/24, and understands smoking safety procedures and hours of operation 10:00 AM, 12:30 PM, 4:00 PM, and 7:00 PM. A further review of the resident's ICCP revealed a smoking focus area created on 10/19/24 at 7:18 PM, which revealed Resident #143 was seen smoking a cigarette in their room. The goal was for the resident to not smoke in their room. Interventions initiated on 10/22/24, included: cigarettes and lighter given to security; cigarettes and lighter were taken from resident's room; educated on risk of smoking in room; encouraged to ask for assistance if needs help; Medical Doctor and family made aware; Resident #143 will be monitored for smoking every shift for smoking; the resident was shown designated smoking area; smoke detector was immediately placed in room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 1/16/25 at 11:44 AM, Surveyor #1 observed Resident #143 sitting in a wheelchair in their room with two loose cigars adjacent to the resident's meal tray and within the resident's reach. On 1/17/25 at 8:19 AM, Surveyor #2 interviewed the Security Guard (SG) who stated he was responsible to distribute the smoking materials and lighters for resident use. The SG Stated there was a Smoking Times list and a list of residents who smoked affixed to the wall and Resident #143's name was not listed. The SG stated for each smoking time, there would be a staff member assigned at 10:00 AM, 1:00 PM, 4:00 PM and 7:00 PM. Surveyor #2 asked if Resident #143 smoked since their name was not on the list of residents who smoked, and the SG removed a plastic bag labeled with Resident #143's name out of the desk drawer and the bag contained two packages of cigars and a lighter. Surveyor #2 asked if the residents could smoke in their rooms and the SG stated, no, we have oxygen on the floor. Surveyor #2 asked why Resident #143 was not on the list of smokers, and the SG stated Social Services needed to update the list. Surveyor #2 asked if a resident smoked in their room would it be a problem, and the SG stated, yes, because I would need to know, the resident's room would have to be checked, and the resident would have to be closely monitored. The SG stated, anything tobacco would have to come through me. Surveyor #2 asked if residents were allowed to keep the cigarettes in their room, and the SG stated, no, they cannot keep cigarettes in their room. Surveyor #2 then asked what should happen if staff found a resident with cigarettes in their room, and the SG stated he should be notified because the residents were not allowed to have them on the floors at all, there is oxygen on the floors. Surveyor #2 then asked if Resident #143 had been found smoking in their room, and the SG stated, he heard nothing about that, and that he should be immediately notified if any cigarettes were found in the room. The SG stated Resident #143 usually smoked once a day or less; usually at 1:00 PM. On 01/17/25 at 8:20 AM, Surveyor #1 observed Resident #143 sitting in a wheelchair in their room with two loose cigars on the tray table within reach of the resident and a cigar box was on top of the nightstand. The resident stated, I buy my own cigars; I walk to the store. Surveyor #1 asked Resident #143 if they had a lighter and the resident then gestured with both hands waving towards the nightstand, and stated, I put it up. Surveyor #1 asked the resident if they could show their lighter to the surveyor, and Resident #143 then began rummaging through their nightstand and stated, I can't find it. On 1/17/25 at 8:45 AM, Surveyor #1 interviewed RN #1, who stated that the residents smoked in the designated area as per the smoking schedule. RN #1 stated all residents were assessed for smoking upon admission, and staff let Security know if the resident was a smoker. RN #1 stated the residents were not allowed to smoke in their rooms and if they were caught smoking in their rooms, their smoking supplies were removed from their room and stored either with Security or inside the medication cart. RN #1 stated Resident #143 had smoked in their room before, and all the smoking supplies were taken away from the resident. RN #1 further stated smoking was not allowed in the rooms due to residents using oxygen and the risk of fire. On 01/17/25 at 9:16 AM, Surveyor #1 accompanied RN #1 to Resident #143's room, and the RN observed two packs of sealed cigars inside the resident's nightstand drawer. RN #1 stated Resident #143 was not allowed to have smoking supplies in their room and immediately removed the cigar packs from the resident's room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 1/17/25 at 9:21 AM, Surveyor #1 interviewed the Assistant Director of Nursing (ADON), who stated residents were not allowed to smoke in their rooms. The ADON stated, we check all of the resident's rooms everyday for residents who are smokers. The ADON then stated that she checked Resident #143's room yesterday and today, and the resident did not have cigarettes in their room. Surveyor #1 then informed the ADON about the observations from 1/15, 1/16, and 1/17. Surveyor #1 asked if there was any documentation for completed room checks, and the ADON stated it was not documented. On 1/17/25 at 10:04 AM, during an interview with Surveyor #1 & #3, RN #1 stated she observed Resident #143 smoking in the bathroom inside their room on 10/19/24. RN #1 stated she was doing rounds and smelled smoke, and found Resident #143 in the bathroom smoking. RN #1 stated she then immediately took the cigarette from the resident and observed that there were also cigarettes inside the resident's drawer, and provided those cigarettes to the Supervisor, who then provided them to Security. The RN then stated she had informed the Director of Nursing (DON) of what occurred, and the RN was directed to complete the incident report. On 1/17/25 at 11:00 AM, Surveyor #1 interviewed the Social Worker (SW), who stated when a new resident who was a smoker was admitted to the facility, the resident signed a Smoking Agreement Contract (SAC), and the resident was added to the smoking list. The SW further stated the updated smoking list was sent to the team which included the Licensed Nursing Home Administrator (LNHA), DON, SG, unit nurse managers (UNM), Activity Director (AD), and maintenance department. The SW stated, I would go over the smoking schedule and rules with the newly admitted residents. The SW further stated that the nurses were required to complete a Smoking Assessment upon admission and quarterly. Surveyor #1 requested to see the SAC for Resident #143, and the SW provided an undated and unsigned copy of Resident #143's SAC that had a handwritten name on it. The SW acknowledged the contract was not signed, and the SW was not able to explain why. The SW then provided an updated smoking list and explained she had updated it earlier because she had not been aware that Resident #143 was a smoker. The SW reviewed Resident #143's ICCP with Surveyor #1, which indicated that Resident #143 signed the SAC after it was reviewed with the resident. On 01/17/25 at 11:37 AM, Surveyor #1 interviewed the Minimum Data Set Coordinator (MDSC), who stated the nurses completed the Smoking Assessment (SA) on all newly admitted residents. The MDSC reviewed the SA in the presence of Surveyor #1 and then stated the SA was incomplete for Resident #143. On 1/17/25 at 11:59 AM, Surveyor #1 interviewed the ADON, who stated that the process for the SA was that it was completed by the UNM, ADON, and MDSC upon admission, then quarterly and again if the resident had stopped smoking. After the completion of SA, the resident's name was added to the smoking list. The ADON reviewed SA in the presence of Surveyor #1, and confirmed the SA was incomplete for Resident #143. On 1/17/24 at 1:10 PM, Surveyor #1 interviewed the SG who stated that he did not know who Resident #143 was because he was not a regular smoker. Upon Inquiry, the SG stated he was unaware of the smoking incident that occurred on 10/19/24. (continued on next page)

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Alaris Health at St Mary's	135 South Center Street Orange, NJ 07050

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	An acceptable Removal Plan (RP) was received on 1/17/25 at 8:31 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the resident's room was immediately searched and smoking material was removed from the room; resident's representative party was re-educated about the smoking policy and that any smoking material needed to be handled directly to the security guard or staff; a new smoking contract was completed with Resident #143 and responsible party; IDT team met to discuss resident's smoking plan of care; physician's orders were added to Medication Administration Record for room search every shift for any smoking material; all department heads and Unit Managers were in-serviced on smoking procedures by the Director of Nursing; Smoking policy was revised; smoking list was updated to reflect all current smokers in the building; smoking contract was revised; and all current smokers had a new smoking assessment completed. The survey team verified the RP as implemented on-site on 1/21/25 at 11:24 AM. 27193 Part B Refer to F610 On 01/21/25 at 10:00 AM, the surveyor reviewed the closed electronic medical record for Resident #264. According to the Admission Record face sheet, Resident #264 was admitted to the facility with diagnoses which included but were not limited to; acute and chronic respiratory failure, hypoxia, epilepsy, tracheostomy status and dependence on respiratory ventilators. A review of Resident #264's quarterly MDS dated [DATE], reflected that the resident was coded as being comatose and yes to being in a persistent vegetative state/no discernible consciousness. Resident #264 was totally dependent on staff for all care. A review of Resident #264's ICCP included a focus area initiated on 02/27/24, for being at risk for falls related to poor safety awareness, impaired balance and poor trunk control, side effects of medications, non-verbal, and required mechanical lift transfers. Interventions included to use mechanical lift for transfers with two persons assisting with the transfer. A review of the Progress Notes revealed an Interdisciplinary Team (IDT) Note dated 11/06/24 at 10:20 PM, which included the IDT was made aware by CNA that Resident #264 was noted with discoloration and swelling of the right eye. The Nurse Practitioner (NP) was notified and ordered the resident to be sent to the hospital for further evaluation and treatment. A report was given to the nurse, and Resident's Representative (RP) was at bedside. A review of the IDT Note dated 11/06/22 at 10:22 PM, revealed that transportation was arranged with the [hospital name redacted] Emergency Services. A review of the IDT Note dated 11/07/24 at 8:05 PM, revealed a follow-up to the emergency room . The resident was admitted with diagnoses traumatic hematoma to right orbit (eye socket). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 1/16/25 at 10:30 AM, the surveyor reviewed the investigation and the Reportable Event Record completed by the facility dated 11/06/24. There was no causal factor identified for the injury. A review of a statement for CNA #1's, who cared for the resident revealed the following: On 11/06/24, CNA #1 documented that on 11/06/24, that she went in the afternoon to put Resident #264 in bed, and I found right face with a black eye and I reported to the nurse. The statement was signed CNA 3:00 PM-11:00 PM shift. (This note was documented before the mechanical lift transfer) On 11/06/24, CNA #1 documented that on 11/06/24, in the evening I put resident back in bed with a mechanical lift. The resident was sitting in the recliner chair and we assisted the resident back to bed lying on their left side. Once back in bed, I noticed resident had redness to face by eye. I reported discoloration to the nurse. (This note was documented after the mechanical lift transfer) The surveyor reviewed the statement provided by CNA #2, who also worked on the unit with CNA #1. CNA #2 documented that on 11/06/24, in the evening I assisted my co-worker to place resident back in bed with mechanical lift. The resident was sitting in the recliner chair and we assisted the resident back to bed lying on their left side. Once back in bed, I noticed the resident had redness to face by eye. The assigned CNA reported the discoloration to the nurse. A review of RN #2's statement dated 11/6/24 at 9:15 PM, indicated that they worked the 3:00 PM to 11:00 PM shift on the 2nd floor ventilator unit and was assigned to Resident #264. At 3:00 PM, I made rounds and the resident was sitting in a recliner chair along the bedside and I did not notice any changes to Resident #264. At 5:00 PM, the resident was provided care and placed back to bed by the CNA. At approximately 8:30 PM, the Resident Representative (RR) came to the unit to provide care for the resident. At 9:15 PM, the RR informed her that the resident was noted with a hematoma and swelling of the right eye. On 1/17/25 at 8:15 AM, the surveyor interviewed a staff CNA regarding the protocol to transfer residents with the mechanical lift. The CNA stated that two staff members had to be in the room for the transfer. On 1/17/25 at 8:52 AM, the surveyor interviewed the Respiratory Therapist (RT), and he confirmed that two staff had to be in the room to transfer a ventilator dependent resident from the bed to the recliner chair. When inquired regarding Resident #264, he confirmed that on 11/06/24, he had assisted CNA #3 with the transfer from the bed to the recliner chair in the morning, and there was no injury observed. The RT informed the surveyor that on 11/06/24 at 4:53 PM, he observed Resident #264 in bed and he did not assist with the transfer back to bed, nor was he made aware of the injury. On 01/17/25 at 11:59 AM, the surveyor reviewed the facility provided incident report and the statements attached with the DON. The DON stated that she was aware of the discrepancies in CNA #1's statements and could not provide any rationale for not clarifying the discrepancies prior to the submission of the investigation to the Department of Health (DOH). The DON stated there was a misunderstanding and miscommunication about the investigation. The DON stated she had understood Resident #264 sustained the injury during the transfer and stated that Resident #264 possibly hit the right eye on the mechanical lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 01/17/25 at 12:05 PM, the surveyor conducted a second interview with the RT. The RTF on duty that day revealed that one nurse and one CNA were to transfer any resident out of the bed and back to bed if the resident was on a mechanical ventilator (machine that acts as bellows to move air in and out of the lungs). The RT stated that some CNAs worked as floaters to the unit and they were not trained to transfer residents with the ventilator attached. The RT stated for safety reasons, a nurse had to be in the room to assist or if the nurse could not assist, the nurse delegated the task to the RT who supervised the transfer. When asked if there was a policy for transferring a resident with a ventilator, he stated, this is the [normal], not too sure if there is a policy. A review of the documents provided revealed that the RN nor the Respiratory Therapist assisted CNA #1 with the transfer. On 01/21/25 at 11:47 AM, the surveyor interviewed the Medical Director (MD) regarding the injury sustained by Resident #264 during the transfer. The MD stated that he was told by the DON the injury was caused by the hook from the mechanical lift and was not provided with any additional information. On 1/21/25 at 1:45 PM, the surveyor interviewed the NP, who ordered Resident #264 to be transferred to the hospital for a computed tomography scan (CT Scan; a noninvasive medical procedure that uses X-Rays to create detailed cross-sectional images of the body). The NP stated that since the bruise was significant and since no one knew the source of the injury, she ordered the CT scan to ensure there were no fractures. A review of the summary provided to DOH on 11/08/2024, the DON indicated the following: Resident #264 has periods of involuntary movements related to hypoxia and seizure disorder as well as cough spasms. The Interdisciplinary Team concludes that resident during transfer may have coughed or had involuntary movement and may have leaned into [Resident #264] mechanical lift cross- bar. Interviews with staff familiar with the resident routine revealed that the resident was immobile. Actions included to: .4. Transfer to Hospital for Evaluation; 5. Mechanical lift Competencies with CNAs; 6. Maintain 2 person assist with mechanical lift transfer and care; CNA #1 had Resident #264 on the mechanical lift alone in the room. CNA #2 was not in the room when CNA #1 initiated the transfer and placed Resident #264 on the mechanical lift. Utilize soft padding on the mechanical lift crossbar during resident transfers. On 1/22/24 at 10:15 AM, two surveyors conducted an in person interview with CNA #1, who stated that she recalled the incident. CNA #1 stated that the evening shift was very chaotic, and that she observed the injury after transferring Resident #264 in bed. CNA #1 stated that Resident #264 always scratched their face, and the injury could be self-inflicted. When asked if she remained in the room with the resident and waited for the nurse to come and assess the injury, CNA #1 stated she had too much to do that day; she moved on and attended to other residents. The surveyor then inquired about the 2nd statement, and CNA #1 read the statement and stated, another co-worker coached her to write the second statement, but she did not observe any injury to the resident face and right eye while the resident was sitting in the chair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 1/22/24 at 12:00 PM, the surveyor conducted a telephone interview with CNA #2, whom CNA #1 claimed assisted her with the transfer. CNA #2 stated that when she entered the room, [Resident #264] was in the room and on the mechanical lift alone with CNA#1. CNA #2 observed the bruise and advised CNA #1 to report the injury to the nurse. When asked if she assisted CNA #1 with care, CNA #2 stated, No, I left the room and continued with my assignment. On 1/22/25 at 1:15 PM, the surveyor interviewed CNA #3, who was assigned to the 7:00 AM-3:00 PM shift regarding Resident #264's care. CNA #3 stated that she cared for Resident #264 daily; that Resident #264 was immobile, had poor trunk control, and required a two-persons assist with transfers. CNA #3 further stated that on 11/06/24, she transferred Resident #264 to the recliner chair with the Respiratory Therapist. During the day she periodically checked Resident #264, and no injury was noted to the right eye. On 1/23/25 at 10:56 AM, the surveyor reviewed the investigation with the LNHA in the presence of the survey team. The LNHA stated that in reviewing RN #2's statement and the investigation, he could see there were some discrepancies. The LNHA added the investigation was not concise and thorough, and that his expectation was that the facility would thoroughly investigate injuries of unknown origin. On 1/23/25 at 1:30 PM, during the exit conference no additional information was provided. A review of the facility's Incident/Accidents policy dated 05/01/14, and last revised 1/2024, included Policies and Procedures are guidelines. They are intended to communicate information that generally applies to facility operations. Current rules, regulations and laws take precedence over guidelines. Policy: Each resident receives adequate supervision and assistive devices to prevent accidents; Purpose: A system to prevent and/or minimize further incidents and accidents; All interventions should be placed in treatment record and signed by nurses. A review of the facility's Abuse Prevention Program dated last revised 1/2025, under identification indicated the following: All residents sustaining bruises, skin tears, any marks of the skin, and any fractures or injuries, which are of unknown origin, shall be identified as potential abuse incidents and investigated as such . The policy for Hoyer lift transfer was not provided. 31654 Part C On 01/17/25 at 8:46 AM, Surveyor #2 reviewed the closed electronic medical record (EMR) for Resident #34. A review of the Admission Record face sheet revealed Resident #34 had diagnoses including, but not limited to; sepsis, chronic viral hepatitis C, and opioid dependence. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	A review of an IDT Progress Notes (PN) dated effective 07/14/24 10:50 AM, and created on 07/15/24, by the nursing department included that on 7/14/24, the primary nurse called the supervisor for the Resident #34, and upon the supervisor's arrival, the supervisor found the resident on the bed with erratic behavior and uncontrolled movement. The room was fully searched, and drug related equipment was found on the resident's bed. The supervisor immediately confiscated the equipment. Education was given to the resident about the risks of substance abuse, and that these actions violate the policies of the hospital (the facility). The MD was made aware, and ordered the resident to be transferred to the hospital for evaluation, and ordered a toxicology screen. A review of the Laboratory (Lab) Results Report with a collection date of 07/16/24, revealed Resident #34 tested positive for cocaine metabolite. A review of the IDT PN dated late entry effective 08/08/24 at 1:26 PM, created on 11/24/24 at 1:27 PM, by the DON, included the resident was noted with restless behavior; talking very animated and excited; slurring speech; at time making incoherent statements. The resident declined to be transferred to the emergency room (ER) for evaluation. The resident was educated on risk versus benefit of using illicit substances, and urine toxicology obtained per physician order. A review of the Lab Results Report with a collection date of 08/08/24, revealed Resident #34 tested positive for cocaine metabolite, opiates, morphine, and methadone. A review of a IDT Note dated 08/15/25 at 10:12 AM, included urine drug screen results received. The resident was positive for opiates, positive for cocaine, and positive for morphine. The resident was positive for methadone which was prescribed. The DON and physician were notified. A review of the IDT PN dated late entry effective 12/19/24 at 11:56 AM, included at 10:39 AM, the resident was noted in the wheelchair in room lethargic with pupils dilated and not responding to commands. The NP ordered the resident be sent to the ER, and 911 was called. A STAT (immediate) drug screen ordered per physician and resident refused. The resident was noted with a vape pen and lighter in possession which were confiscated. The NP was made aware of the resident's refusal to go to ER. A review of the Order Summary Report for the admitted [DATE], for Resident #39, revealed an physicians order (PO) to maintain one-to-one (1:1) supervision every shift ordered on 11/27/24. A PO that may have visitors under supervision as needed ordered 12/02/24, and an order for methadone HCL oral concentrate 10 (milligram/milliliter) (mg/ml); give 50 mg by mouth once a day for opioid dependence. A review of Resident #34's ICCP included the following focus areas: A focus area initiated on 07/15/24, for the resident having a past history of drug abuse and was a risk for relapse. The goal was to keep Resident #34 safe with the interventions including daily room searches initiated on 07/15/24. A focus area initiated 10/25/24, that the resident was a smoker with a goal to be a safe smoker. An Intervention included the Smoking Contract was reviewed and signed on 10/25/24. A focus area for the resident being on methadone for substance abuse, and on 07/14/24, the resident was noted with erratic behavior and uncontrolled movements, room check was done and suspected drug related items found on resident bed . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	A focus area for Resident #34 noted on 12/20/24, with erratic behaviors and uncontrolled movements and a room check was done and suspected drug related items found on the bed. A lighter and vape was confiscated. A focus area that Resident #34 will be free of illicit substances was initiated on 12/20/24. On 01/22/25 at 9:02 AM, Surveyor #2 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who was familiar with Resident #34. The LPN/UM stated she used to be on Resident #34's floor, and she stated that Resident #34 was alert and oriented and had an issue with addiction. Surveyor #2 asked about the methadone clinic process and when Resident #34 was found with drug paraphernalia. The LPN/UM stated Resident #34 smoked and went outside and was observed going to the fence and someone came and handed the resident something and quickly ran off. Resident #34 was asked what was given and stated to the LPN/UM it was nothing, and the LPN/UM then found Resident #34 not responding properly and they lifted the bed and found a home-made type twisted-up metal object under the resident's bed that was some sort of item used with drugs. Surveyor #2 asked about what was done to prevent Resident #34 from obtaining illegal drugs again, and the LPN/UM stated Resident #34 had 1:1 monitoring for a few weeks and then, got off of 1:1. On 01/22/25 at 9:45 AM, Surveyor #2 asked the DON for all incidents, grievances, investigations related to Resident #34 and they were provided them at 11:30 AM the same day. An Investigative Summary for the Concern on 07/14/24 at 8:55 PM, when Resident #34 was acting erratic and drug related paraphernalia was found on the bed. The undated Investigative Findings included that Resident #34's roommate observed the resident going to the fence in the smoking courtyard, but could not see what was happening. The resident (Resident #34) was found with a glass pipe on the resident's bed shortly after, and the drug panel was positive for cocaine metabolites. The conclusion revealed that the DON told the resident that illicit substances will not be tolerated due to risk of harm to self. Actions included: 1. Resident placed on every thirty-minute checks for 3 days . A statement signed by an unidentified person on 07/14/24, revealed Resident #34 was observed going to the gate continuously during the smoking time. Three Thirty-Minute Monitoring Sheets dated 07/15/24, 07/16/24, and 07/17/24, had a time and space next to the time for the 11:00 PM-7:00 AM (11-7) shift, 7:00 AM-3:00 PM (7-3) and 3:00 PM-11:00 PM (3-11) shift. The handwritten documents did not identify who filled them out each shift, and did not represent all meals, or s [TRUNCATED]

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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. 48423 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer oxygen therapy according to the physician order, and ensure oxygen equipment was stored properly. This deficient practice was identified for 1 of 3 residents (Resident #47) reviewed for respiratory care and 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. During initial tour on 1/15/25 at 11:04 AM, the surveyor observed Resident #47 sitting in a wheelchair in their room. The resident was on Oxygen (O2) via nasal cannula (NC) (a medical device to provide supplemental oxygen therapy to people who have lower O2 levels) at 5 Liter per Minutes (LPM). The surveyor observed an O2 tank behind the resident's wheelchair, connected to a NC which was wrapped around the left handle of the wheelchair. The NC was not in any protective covering and was exposed to the environment. On 1/21/25 at 9:14 AM, the surveyor observed Resident #47 resting in the bed. The resident was on O2 at 4 LPM. The surveyor observed the resident's wheelchair closer to the window with the NC wrapped around the left handle of the wheelchair and in direct contact with resident's socks which were hanging back of the wheelchair. The NC was not in any protective covering and was exposed to the environment. The surveyor reviewed the medical records of Resident #47 and revealed: According to the Admission Record, Resident #47 was admitted to the facility with Pneumonia (an infection that affects one or both lungs), Anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), chronic obstructive pulmonary disease [COPD] (an ongoing lung condition caused by damage to the lungs) with exacerbation (flare up), and type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) without complications. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Quarterly Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, dated 11/15/24, revealed the resident had a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated that the resident had intact cognition. Further review of the MDS did not document that Resident #47 received O2 therapy. A review of the Order Summary Report for Resident #47 revealed Physician Orders (PO) as follows: - O2 at 4 LPM via NC every shift with the start date from 4/12/24 to 1/16/25. - O2 at 3 LPM via NC every shift with the start date 1/20/25. A review of the resident's Care Plan (CP) included a focus area that indicated, . O2 therapy related to SOB (shortness of breath)/ CHF (Congestive Heart Failure) (heart failure). The Interventions included give medications as ordered by physicians; O2 at 2 L/NC as ordered, initiated on 6/11/22. On 1/21/25 at 9:48 AM, during an interview with the surveyor, the Registered Nurse (RN) stated when she made rounds, she would check if the residents were on the correct amount of oxygen as per physician orders. The RN stated that she would store the oxygen tubing or other equipment in a special bag when the oxygen was not in use because of safety precautions and to avoid contamination. The RN stated Resident #47 was on 3LPM of oxygen as per physician order. The surveyor informed the RN of above-mentioned findings regarding resident's O2 at 5 LPM during initial tour and 4 LPM prior to the interview. The surveyor accompanied the RN to Resident #47's room. The RN spoke with the resident and the resident stated, I use 4 LPM at night.The resident confirmed that the oxygen was at 4 LPM. The RN stated, they (the residents) need to be educated on the importance of maintaining doctor's orders. In the presence of the surveyor, the RN observed the NC wrapped around the left handle of the wheelchair. RN stated the NC should have been placed in the bag. The RN then discarded the NC from the wheelchair. On 1/21/25 at 1:20 PM, during an interview with the surveyor, the Assistance Director of Nursing (ADON) stated when residents are on oxygen, the nurses should follow physician orders and make the sure the residents were on the right setting as per the physician orders. The ADON stated that all oxygen equipment would be stored in a special plastic bag when not in use. The surveyor informed the ADON of the above findings. The ADON stated NC wrapped around the wheelchair handle was not acceptable. On 1/23/25 at 11:33 AM, the survey team met with the facility administration. The surveyor notified the facility management of the above-mentioned concerns for Resident #47. A review of the facility provided Oxygen Therapy revised 1/2025 included: Under Preparation and Observations: The licensed nurse shall: 1. Review the physician's order for oxygen administration. Oxygen therapy is administered only as ordered by a physician or as The physician's order will specify the rate of flow, route, and rationale. 2. Review the resident's care plan. 3. Assemble the equipment and supplies as needed - 3rd bullet point- Plastic bag for oxygen equipment storage. Under Procedure: 1. Review Physician's order for oxygen therapy. 5. Connect oxygen tubing And turn on oxygen to the prescribed flow rate. 7. Store unused devices in plastic bag. On 1/23/25 at 2:10 PM, the survey team met with the facility administration for an Exit Conference. The facility had no additional information to provide. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-11.2(b); 25.2(c)4; 27.1(a)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 38079 Based on interview and document review, it was determined that the facility failed to ensure residents had cognitive ability before signing arbitration agreements. This deficient practice was identified for 1 of 3 residents (Resident #61) reviewed for arbitration agreements. This had the potential to result in resident representatives not being able to resolve disputes with the facility in a court of law. The deficient practice was evidenced by the following: On 1/15/25 at 10:18 AM, Surveyor #4 observed Resident #61 in bed. The resident did not respond to the surveyor when spoken to. A staff member was entering the room and stated the resident could not see. On 1/15/25 at 11:12 AM, the Licensed Nursing Home Administrator (LNHA) informed Surveyor #1 that the facility utilized arbitration agreements which were part of the admission agreement. The facility provided a list of residents who had signed arbitration agreements. On 01/16/25 at 11:06 AM, during a phone conversation with Surveyor #1, Resident #61's representative explained the resident was legally blind. The representative further stated that the staff does not involve them with anything and that they were unaware of an arbitration agreement. The representative included the resident was not able to sign any papers and stated what are you talking about? A review of the Admission Record (an admission summary) revealed Resident #61 had diagnoses which included but were not limited to; legal blindness, brief psychotic disorder, and cerebral infarction (a pathological process resulting in an area of dead tissue in the brain). A review of the Voluntary Binding Arbitration Agreement (VBAA) revealed it was signed by Resident #61 on 7/10/19. Page 3 of the Agreement revealed a section for the resident's legally authorized representative or resident but was signed only by the resident and the facility representative. A review of the Minimum Data Set (MDS) an assessment tool dated 8/10/19, included a Brief Interview for Mental Status (BIMS) of 02 out of 15 indicative of severe cognitive impairment. On 1/23/25 at 9:11 AM, in the presence of two surveyors the Admissions Director (AD) stated it was her responsibility to provide the VBAA along with other papers. She stated it would be provided to the resident and/or the family to read over and they can sign or decline. The Ad explained she would go through and read the papers with the resident and/or family and go into detail if they wanted. She further explained that the VBAA was, in essence, the arbitration was . if there was anything we [facility] did we would go in front of a small group and a judge? When inquired about a resident's cognitive status, the AD responded that the BIMS would always be checked prior to any papers being signed and that the resident would require a BIMS of 13 or higher. She stated that a BIMS of 12 would be when a resident would be getting impaired. When inquired about Resident #61, the AD revealed she was not working at the facility at that time and that a BIMS of 02 was not sufficient for the resident to understand or sign an agreement. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided policy, Arbitration Agreement revised 1/2024, included but was not limited to; Procedure: . will be explained to the resident or their representative in a form, manner and language they understand; . ensure the resident or their representative acknowledges they understand the agreement and have the right to rescind the agreement within 30 calendar days. On 1/23/25 at 11:32 AM, the above concern was addressed with the facility administration. The facility had no additional information to provide. NJAC 8:39-4.1(a)8(b)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on interview and review of pertinent documents it was determined that the facility failed to maintain an effective comprehensive data driven Quality Assurance and Performance Improvement program by failing to review all services provided including to ensure significant events were reviewed to determine root cause to prevent further occurrences. This deficient practice occurred for residents with a history of smoking in their room, holding drug paraphernalia and a lighter in their room (Resident #143 and Resident #34), and for a resident (Resident # 264) who was dependent on staff for all care, and sustained an injury of unknown origin that required hospitalization on [DATE]. This deficient practice had the potential to affect all residents who resided in the facility and was evidenced by the following: Refer to 689L, 610G a. During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR Part 483.25(d)(2) F 689 as the facility failed to follow their smoking policy to ensure effective interventions were implemented and monitored for a resident with a history of smoking in their room. The facility documented Resident #143 was found smoking in their room on 10/19/24. Observations on 1/15/25, 1/16/25 and 1/17/25, confirmed that the Resident #143 held their cigars in their room. The IJ began on 10/19/24 when Resident #143 was found by a Registered Nurse to be smoking in their room. From 1/15/25 through 1/17/25 the surveyor observed smoking materials inside of the resident's room and within arm's reach of Resident #143. Resident #143 had piped in oxygen into their room. The facility was notified of the IJ on 1/17/25 at 2:26 PM. The facility provided an acceptable Removal Plan (RP) which was verified on-site by the survey team on 1/21/25. On 1/15/25 at 9:39 AM, during the initial tour, Surveyor #1 observed a sign posted on the wall outside of Resident #143's room, No Smoking (in red), Piped-In Oxygen In Use. Upon entrance to Resident #143's room, Surveyor #1 observed the resident was in bed watching television. At that time, Surveyor #1 observed a pack of cigars on the table next to the resident and asked the resident what they were. The resident took a cigar out of the case and stated it's a cigar while holding it and showing it to the surveyor. On 1/16/25 at 11:44 AM, Surveyor #1 observed resident #143 sitting in a wheelchair in their room, with two loose cigars adjacent to the resident's meal tray and within the resident's reach. On 01/17/25 at 8:20 AM, Surveyor #1 observed Resident #143 again sitting in a wheelchair in their room, and two loose cigars were on the tray table within reach of the resident, and a cigar box was on top of the nightstand. The resident stated, I buy my own cigars. I walk to the store. Surveyor #1 asked Resident #143 if they had a lighter and the resident then gestured with both hands waving towards the nightstand, and stated, I put it up. Surveyor #1 asked the resident if they could show their lighter to the surveyor, and Resident #143 then began rummaging through their nightstand and stated, I can't find it. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/17/25 at 8:45 AM, during an interview with Surveyor #1, the Registered Nurse (RN) stated the residents smoked in the designated area as per the smoking schedule. The RN stated all residents were assessed for smoking upon admission and staff would then let Security know if the resident was a smoker. The RN stated the residents were not allowed to smoke in their rooms and if they were caught smoking in their rooms, their smoking supplies would be removed from their room and stored either with Security, or inside the medication cart. The RN stated Resident #143 had smoked in their room before, and all the smoking supplies were taken away from the resident. The RN further stated smoking was not allowed in the rooms due to residents using oxygen and due to the risk of fire. On 01/17/25 at 9:16 AM, Surveyor #1 accompanied the RN to Resident #143's room and the RN observed two packs of sealed cigars inside the resident's nightstand drawer. The RN stated Resident #143 was not allowed to have smoking supplies in their room and immediately removed the cigar packs from the resident's room. b. On 01/17/25 at 8:46 AM, Surveyor #2 reviewed the closed electronic medical record (EMR) for Resident #34. Review of the Admission Record revealed Resident #34 had diagnoses including, but not limited to; sepsis, chronic viral hepatitis C, and opioid dependence. Review of a Progress Notes (PN) - Type: IDT Note, Effective Date: 07/14/24 10:50 AM, Created Date: 07/15/24, Department: Nursing: Created by Unit Manager: On July 14, 2024, the primary nurse called the supervisor for the patient in room [ROOM NUMBER]B, and upon the supervisor's arrival, the supervisor found the patient on the bed with erratic behavior and uncontrolled movement. The room was fully searched, and drug related equipment was found on the patients' bed. The supervisor immediately confiscated the equipment. Education was given to the resident about the risks of substance abuse, and that these actions violate the policies of the hospital MD (physician) was made aware, and ordered the resident to be transferred to the hospital for evaluation, and ordered a toxicology screen . Review of the Lab Results Report, Collection Date 07/16/24, revealed Resident #34 tested positive for Cocaine Metabolite. Review of a PN - Type: IDT [Interdisciplinary] Note, Late Entry, Effective Date: 08/08/2024, 1:26 PM, Created by Date: 11/24/24 at 1:27 PM, by the Director of Nursing (DON), 08/08/824 at 1:20 PM, resident noted with restless behavior, talking very animated and excited, slurring speech, at time making incoherent statements . Declined transfer to ER for evaluation Resident educated on risk verse benefit of using illicit substances, urine toxicology obtained per physician order . Review of the Lab Results Report, Collection Date 08/08/2024, revealed Resident #34 tested positive for Cocaine Metabolite, Opiates, Morphine and Methadone. Review of an IDT Note: Dated 08/15/25 at 10:12 AM, Note Text: Urine drug screen results received. Resident positive for opiates, positive for cocaine, positive for morphine. Resident positive for Methadone which is prescribed. DON and physician notified. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a PN - Type: IDT Note, Late Entry, Effective Date: 12/19/24 at 11:56 AM, At 10:39, resident noted in wheelchair in room lethargic with pupils dilated and not responding to commands. NP (Nurse Practitioner) ordered for resident to be sent to ER (emergency room). 911 Called. STAT (immediate) drug screen ordered per physician and resident refused. Resident Noted with vape pen and lighter in possession which were confiscated. NP made aware of resident's refusal to go to ER . On 01/23/25 at 8:53 AM, Surveyor #2 interviewed the Medical (MD) Director and asked if he was made aware of Resident #34 who was found in the facility in his/her room, not responding, and found with vape and a lighter and drugs were found in the resident's system. The MD he was not aware, stated no, not at all was I aware of this. Surveyor #2 asked what should have been done after that should have been done. The MD stated, that is concerning the resident should get a warning discharge as could cause a huge fire, of course. c. On 1/16/25 at 10:30 AM, the surveyor reviewed the investigation and the Reportable Event Record completed by the facility. There was no causal factor identified for the injury. CNA #1 who cared for the resident provided two statements. -11/06/24 CNA #1 documented that on 11/06/24 that she came this afternoon to put resident 114 in bed, I found right face with a black eye and I reported to the nurse. Signed CNA 3:00 PM-11:00 PM shift. [Before the mechanical lift transfer] -11/06/24 CNA #1 documented that on 11/06/24 in the evening I put resident back in bed with mechanical lift. Resident was sitting in recliner chair and we assisted back to bed lying on left side. Once back in bed. I noticed resident had redness to face by eye. I reported discoloration to the nurse. [After the mechanical lift transfer] The surveyor reviewed the statement provided by CNA #2 who also worked on the unit with CNA #1. CNA #2 documented that on 11/06/24 in the evening I assisted my co-worker to place resident back in bed with mechanical lift. Resident was sitting in recliner chair and we assisted back to bed lying on left side. Once back in bed I noticed resident had redness to face by eye. Assigned CNA reported the discoloration to the nurse. The Registered Nurse's (RN) statement dated 11/6/24 at 9:15 PM, documented that at 3:00 PM, worked the 3:00 PM to 11:00 PM shift on the 2nd floor ventilator unit and assigned to the Resident in room [ROOM NUMBER]. At 3:00 PM I made rounds and the resident was sitting in recliner chair along the bedside and did not notice any changes to Resident #264. At 5:00 PM resident was provided care and placed back to bed by CNA. At approximately 8:30 PM Resident's family came to the unit to provide care for her parent. At 9:15 PM, Resident #264 and informed her that the resident was noted with a hematoma and swelling of the right eye. On 1/17/25 at 8:15 AM, the surveyor interviewed a random CNA regarding the protocol to transfer residents with the mechanical lift. The CNA stated that two staff members had to be in the room for the transfer. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/17/25 at 8:52 AM, the surveyor interviewed the Respiratory Therapist (RTF) and he confirmed two staff had to be in the room to transfer a ventilator dependent resident from the bed to the recliner chair. When inquired regarding Resident #264, he confirmed that on 11/06/24 he had assisted CNA #3 with the transfer from the bed to the recliner chair in the morning, and there was no injury observed. The RTF informed the surveyor that on 11/06/24 at 4:53 PM, he observed Resident #264 in bed and did not assist with the transfer back to bed, nor was he made aware of the injury. On 01/17/25 at 11:59 AM, the surveyor reviewed the facility provided incident report and the statements attached with the Director of Nursing (DON). The DON stated that she was aware of the discrepancies in CNA #1's statements and could not provide any rationale for not clarifying the discrepancies prior to submit the investigation to the Department of Health (DOH). The DON stated there was a misunderstanding and miscommunication about the investigation. The DON stated she had understood Resident #264 sustained the injury during the transfer and stated that Resident #264 possibly hit the right eye on the mechanical lift. On 01/17/25 at 12:05 PM, the surveyor conducted a second interview with the RTF. The RTF on duty that day revealed that one nurse and one CNA were to transfer any resident out of the bed and back to bed if the resident was on a mechanical ventilator (machine that act as bellows to move air in and out of the lungs). The RTF stated that some CNAs worked as floaters to the unit and they were not trained to transfer residents with the ventilator attached. For safety reasons, a nurse had to be in the room to assist or if the nurse could not assist, she would delegate the task to the respiratory therapist who would supervise the transfer. When asked if there was a policy for transferring a resident with a ventilator, he stated, this is the norm, not too sure if there is a policy. Based on the documents provided, the RN nor the respiratory therapist assisted CNA #1 with the transfer. On 01/21/25 at 11:47 AM, the surveyor interviewed the Medical Director (MD) regarding the injury sustained by Resident #264 during the transfer. The MD stated that he was told by the DON the injury was caused by the hook from the mechanical lift and was not provided with any additional information. On 1/21/25 at 1:45 PM, the surveyor interviewed the NP who ordered that Resident #264 be transferred to the hospital for a CT scan (computed Tomography Scan a noninvasive medical procedure that uses X-Rays to create detailed cross-sectional images of the body). The NP stated that since the bruise was significant and since no one knew the source of the injury she ordered the CT scan to ensure there were no fractures. On 1/22/25 at 12:00 PM, the surveyor conducted a telephone interview with CNA #2. CNA #2 stated that CNA #1 was waiting in the resident's room. When she entered the room, Resident #264 was already in the mechanical lift and being transferred. Once the resident was in bed, she observed the bruise and advised CNA #1 to report the bruise to the nurse. CNA #2 stated that she did not assist CNA#1 with care, and she left the room to attend to her assignment. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/17/25 at 2:51 PM, the facility provided the surveyor with 2 QAPIs: 1. Dated 10/19/24, Date Completed: . to be continued on a monthly basis until 4 quarters of 100 % is achieved; Contact: Administrator and Director of Nursing (DON); Problem Statement: All current smokers are assessed and care planned accordingly; Goal: to ensure that all residents and staff are aware of the facility smoking policy and all residents who smoke may do so safely; Root Causes: 1. Resident non-compliance, 2. Residents were identified needing frequent, 3. Resident responsible party education on the facility smoking policy; Under Tasks: Eight tasks listed with a Start Date 10/19/24 for 1-4 and for 5-8 the Start Date was left blank. The Comments (status, outcomes, evaluations, etc.) was left blank for all eight tasks. 2. An undated QAPI with a Problem Statement: Substance abuse creates safety risks, disrupts care, and violates facility policy: Contact: Administrator and DON; Goal: Implement a program to identify and manage substance abuse, and to reduce incidents. Four Tasks, with a Start Date: 07/15/24 and 07/17/24, with an Estimated Completion Date: Ongoing; Comments (status, outcomes, evaluation, etc.) was left blank. On 01/23/25 at 8:53 AM, the Surveyor #2 interviewed the Medical (MD) Director and asked if he was made aware of Resident #34 who was found in the facility in his/her room, not responding, and found with vape and a lighter and drugs were found in the resident's system. The MD he was not aware, stated no, not at all was I aware of this. Surveyor #2 asked what should have been done after the that occurred. The MD stated, that is concerning the resident should get a warning discharge as could cause a huge fire, of course. The surveyor asked about the MD's role in QAPI. The MD stated he attended the quarterly QAPI meeting. The surveyor asked if there was any specific QAPI he was involved with and he stated, no. The surveyor asked the MD if he had been made aware of the IJ related to the smoking paraphernalia found during multiple observations, and the surveyor asked if that was a concern. The MD stated, yes, of course this is a concern, this is the first I am hearing of the IJ. The surveyor asked if the MD had been aware that the resident was found smoking in the bathroom and the MD replied, no. The MD stated he was surprised that he had not been made aware, especially with the piped in oxygen he should have been made aware. On 01/23/25 at 10:16 AM, in the presence survey team, the surveyor interviewed the LNHA about the QAPI program. The surveyor asked who oversaw the QAPI program and he confirmed he was the QAPI coordinator. The surveyor asked the LNHA to list of the current active QAPIs. The LNHA stated the facility had the following active QAPIs: falls, substance abuse, and smoking. The surveyor reviewed the previously provided QAPIs with the LNHA and asked if the QAPI for smoking was related to the incident on 10/19/24 when the resident was found smoking in the bathroom. The LNHA stated, no, this is what I have. The surveyor asked about the QAPI titled Substance Abuse. The surveyor asked the LNHA what the specifics were related to the goal To implement a program to identify and manage substance abuse, and to reduce incidents and was there any supporting documentation. The LNHA stated the goal was to identify the origin of the issue, to collectively establish and intervention to prevent it. The LNHA stated, he did not have more than the document that was already provided. The surveyor asked the LNHA if significant events and incidents/ reportable events were reviewed at QAPI. The LNHA stated we review finding but we don't necessarily review all incidents. The surveyor asked if the incident with Resident #264 sustaining the injury was reviewed at QAPI and the LNHA stated that was not brought to QAPI, we reviewed the general concept. The surveyor asked if that incident was considered a significant event, and the LNHA stated, yes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at St Mary's	135 South Center Street Orange, NJ 07050

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

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Quality Assurance and Performance Improvement Plan policy (undated) revealed: Design and Scope: The purpose of QAPI in the organization is to take a proactive approach to continually improve the way we care for and engage our residents . Feedback, Data Systems and Monitoring: Performance Indictors for all QAPI Designated goals are evaluated. These indicators can be process and/ or outcome measures. All data will utilize internal and external benchmarking . On a quarterly basis, data will be collected and reported to the QAPI Committee from the following areas: Input from caregivers, residents, families and others, Adverse Events, Performance Indicators The Administrator's Job Description, signed by the Licensed Nursing Home Administrator (LNHA) on 07/22/24 revealed: The Administrator is responsible for planning and is accountable for all activities and departments of Facility subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Administrator administers, directs, and coordinates all activities of the facility to assure that the highest degree of quality of care is consistently provided to the residents. 9. Concerns his/herself with the safety of all nursing facility residents in order to minimize the potential for fire and accidents. Also, ensures that the facility adheres to the legal, safety, health, fire and sanitation codes by being familiar with his/her role in carrying out the facility's fire, safety and disaster plans and by being familiar with current MSDS (material safety data sheets). NJAC 8:39- 33.1 (c)(e); 33.2(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observations, interviews, record reviews, and review of pertinent documentation, it was determined that the facility failed to prevent the spread of potential infection by failing to don (put on) Personal Protective Equipment (PPE) prior to entering the room of residents on contact precautions. This deficient practice was identified for 2 of 2 residents (Resident #144 and Resident #147) reviewed for Transmission-based Precautions (TBP). The deficient practice was evidenced by the following: 1. On 01/15/25 at 8:57 AM, the surveyor observed Resident #144's room with signage outside the door alerting all to stop, Contact Precautions everyone must: . put on gown before room entry, put on gloves before room entry . There was a three-drawer plastic bin outside of the door with PPE gowns and gloves. At that time, the Registered Nurse Unit Manager (RN/UM) walked past the Licensed Practical Nurse (LPN) who was outside the door and into Resident #144's room. The RN/UM did not don a PPE gown or gloves. The RN/UM placed an item in the resident's drawer. On 01/15/25 at 8:58 AM, the RN/UM exited the room and stated to the surveyor, I was not doing care. The surveyor asked what the expectation would be when entering a contact precaution room. The RN/UM replied, I have nothing to say, you got me. I should have worn a gown. On 01/15/25 at 12:11 PM, the surveyor reviewed the Admission Record R) which revealed Resident #144 had diagnoses which included but were not limited to; dependence of respirator ventilator status, and sepsis (an extreme reaction to an infection in the body). A review of the Order Summary Report (ORS) as of 01/14/25, included an order dated 10/25/24, Contact Precaution every shift for C. Auris Colonized (Candida Auris a fungus that can cause multidrug resistant infections). A review of the most recent admission Minimum Data Set (MDS) an assessment tool dated 10/31/24, included a Brief Interview for Mental Status (BIMS) of 00 out of 15 which indicated a severely impaired cognition. A review of the individual comprehensive care plan (ICCP) documented a focus area date initiated 10/24/24, on Contact Precautions related to C-Auris Colonized and interventions included to wear PPE gown and gloves when entering the room. 2. On 1/16/25 at 8:06 AM, the surveyor observed Resident #147'2 room with signage outside the door alerting all to stop, Contact Precautions everyone must: . put on gown before room entry, put on gloves before room entry . There was a three-drawer plastic bin outside the door with PPE gowns and gloves. The surveyor observed the Registered Dietitian (RD) inside the room and was handling the tube feeding bottle which was hanging up and connected to Resident #147. The RD was not wearing a PPE gown or gloves. Upon exiting the room, the RD was asked about the signage and the resident being on contact precautions. The RD stated she should have followed the contact precaution sign and wore PPE to prevent spreading infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 9:42 AM, the surveyor reviewed the AR which revealed Resident #147 had diagnoses which included but were not limited to; sepsis, dependence on respirator ventilator status, and gastrostomy (artificial opening in the stomach for nutritional support). A review of the ORS dated 1/21/25, included the following physician's orders (PO) dated 1/2/25 for Contact Precautions every shift for positive C. Auris and positive CPO (a bacteria resistant to a class of antibiotics). A review of the most recent quarterly MDS dated [DATE], included documentation that a BIMS was not conducted as the resident was not understood. A review of the ICCP documented a focus area date initiated 11/13/24, on enhanced barrier precaution due to colonized C. Auris and positive CPO gene and an intervention for Contact precaution to wear PPE gowns and gloves when entering the resident room. A review of the facility provided education revealed the following: The RD was trained in Infection Control PPE and competency. The training was signed by the RD and the instructor and dated 9/25/24. The RN/UM was trained on the proper use of PPE which was signed and dated 6/4/24; wearing the appropriate PPE in resident rooms which was signed and dated 6/18/24; Proper use of PPE which was signed and dated 7/22/24; and preventing spread of infection with TBP and the use of PPE which was signed and dated 9/26/24. A review of the facility provided policy, Infection Control-Standard Precautions, Enhanced Barrier Precautions and Transmission Based Precautions revised 3/22/24, included but was not limited to; the policy to ensure appropriate infection prevention and control measures area taken to prevent the spread of . infections. Contact Precautions shall apply to all residents infected or colonized with an infectious agent . Contact Precautions require the use of gown and gloves every entry into a resident's room . On 01/21/25 at 9:16 AM, the Director of Nursing (DON) and the Infection Preventionist (IP) were interviewed by the surveyor. The DON and IP both acknowledged that they were made aware of the two above breaches in infection control. The IP confirmed that the facility currently had an influenza outbreak, and had residents with C. Auris, and with CRE/CPO. On 1/23/25 at 11:32 AM, the facility administration was made aware of the above concerns regarding infection control. NJAC 8:39-19.4(a)