STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315354	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Manor	2500 Ridgewood Road Wall, NJ 07719

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, it was determined that the facility failed to maintain the kitchen environment and equipment in a clean and sanitary manner prevent contamination from foreign substances and potential for the development of foodborne illness. This deficient practice was evidenced by the following: On 09/09/2025 at 8:33 AM, the surveyor conducted a tour of the kitchen with the Food Service Director (FSD) and observed the following: The large ice machine was observed with with visibly blackened areas on the exterior of the baffle (the component that directs the flow of ice into the storage bin). The FSD removed the baffle which exposed various blackened mold like in appearance areas inside of the ice machine. The FSD stated, that is not good, then turned off the ice machine.The large blue ice scoop was affixed to the wall in a holder, and not protected from potential contamination.The metal slats inside of the cooking hood where shiny in appearance with visible grease ton them, and one fire suppression nozzle had visible dust like debris stuck to it.The white plastic type cutting board, attached to the food service steam table was stained with visible grooved areas.Items stored underneath the cutting board, including partitioned plates were stored upright with visible debris observed inside the plates. At 8:56 AM, the surveyor accompanied the FSD to the kitchen service pantry while the breakfast meal was in progress. The surveyor observed that the specialized refrigerator with the lift up lid contained chicken salad, egg salad, ham and other items in containers that the FSD stated were used for the lunch meal. The heat from the breakfast meal service area was felt by the surveyor in the area of the refrigeration unit. The surveyor asked the FSD to take the temperature of food items, and the FSD utilized the a digital thermometer and placed it in the chicken salad wih the following temperature reading: 47.2, 46.9, then 45.7 degrees Fahrenheit. The surveyor asked the FSD if the items were potentially hazardous foods and he confirmed that they were.On 9/9/25 at 9:20 AM, the surveyor alerted the Licensed Nursing Home Administrator (LNHA)of the food temperature concerns and debris in ice machine. On 09/09/25 at 9:45 AM, the FSD stated the repair company addressed the ice machine, and the ice machine required a goop filter. The surveyor reviewed the copy of the repair invoice dated 9/9/25 which revealed a a slime eliminator was needed, and the coil was cleaned in the refrigeration unit because the temperature was dropping. A review of the Kitchen Cleanliness Policy and Procedures, undated revealed: Policy: To maintain a safe and sanitary kitchen environment that complies with health regulations and promotes the well-being of residents. Procedures : 1. General Cleanliness: All food preparation and serving areas must be cleaned and sanitized daily. Surfaces, equipment, and utensils should be free from food debris and spills at all times. NJAC8:39-17.2 (g)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that the facility failed to ensure: a) a timely nutritional assessment was completed after admission, b) identified nutrition interventions were implemented, and c) nutritional interventions were revised for a resident who experienced a significant weight loss. This deficient practice was identified for 1 of 2 residents reviewed for nutrition (Resident #4) and who was identified as being at nutritional risk, and at risk for pressure ulcers and was evidenced by the following:On 09/09/2025 at 12:44 PM, the surveyor observed Resident #4 in the living room on the main floor and was sitting in a wheeled recliner. Resident #4 was watching television with other residents. Upon staff interview, staff stated the resident had fed self and consumed 100% of stuffed shells and broccoli, and did not eat dessert since they did not like sweets. On 09/11/2025 at 9:34 AM, the surveyor reviewed the electronic medical record for Resident #4 which revealed diagnoses which included, but were not limited to: history of falling, displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing, and hypothyroidism. The Nursing admission Screening dated 6/14/25, revealed the resident had a history of Dementia, was confused and had right hip edema, and it was checked off as 0 for pitting (pits occur when applying pressure). Skin: A surgical incision and bruising were identified at the right hip and MASD (moisture associated skin damage) on the coccyx. The height and weight under vital signs were left blank. A review of the Weight Summary report for Resident #4 revealed the following weights:6/15/25- 151 pounds (#) admission Weight6/18/25- 147# (Recorded by the Registered Dietitian-RD)6/25/25- 146#7/9/25- 146#7/16/25- 145#7/23/25-140# (Recorded by the RD)8/6/25-138# (Recorded by the RD) [8 # weight loss -5% X 1 month]8/25/25-139# (Recorded by the RD) 9/6/25- 135# - 9/10/25 at 14:55 (2:55 PM) the weight was struck out and documented as incorrect documentation by the RD. The surveyor calculated from the admission weight -151# to 9/6/25 weight, 135 #, Resident #4 sustained a 15 # (10%) weight loss in less than 3 months.The Nutritional assessment dated [DATE] (completed 33 days after admission) and locked 7/25/25, by the RD revealed under Relevant Medical Conditions, No Edema; Weight status trends revealed 4.1% weight loss X 1 month and 1.4% X 1 week. The Food and Fluid Intake/Diet History Data revealed: 7/21/25, intake 50% noon meal. states feels full easily. Skin Issues: MASD-coccyx (moisture associated skin damage is the general term for inflammation or skin exposure caused by prolonged exposure to a moisture source such as urine). Nutritional Concern and Nutritional Diagnosis: Inadequate oral intake due to poor appetite as evidenced by weight decline 3.5 % X less than 2 weeks .Increased nutrition risk for pressure ulcer. The Nutritional assessment dated [DATE] and locked 8/11/25 by the RD revealed: Most recent weight 138 #, 8/6/25. Nutritional Assessment: . 8/8/25 RD reassessment [due to] weight change . Goals/Intervention: Increased nutrient needs [due to skin issue, weight loss, [as evidenced by] [stage] III [pressure ulcer] sacrum (full thickness skin loss that extends into the subcutaneous tissue), [weight loss] 5% times 1 month and increased nutrition risk for [pressure ulcer]. Nutritional interventions: HNS [House Nutritional Supplement 1 X daily, increase Prostat to 30 ML twice daily .A Weight Change Note, documented by the RD on 8/8/25 at 15:42 [3:42 PM], revealed: Note Text: Weight Warning: Value 138: Date 8/6/25, (5.5%, 8.0)-7.5% Change (8.6%, 13.0) RD reassessment initiated; 3 Day intake monitor requested.A review of the Care Plan for Resident #4 revealed: Resident has nutritional problem result to increased nutrient needs [due to] skin issue, weight loss [as evidenced by] [Stage III Pressure Ulcer Sacrum], weight loss 5% X 1 month, Anemia, Increased nutrition risk for [pressure ulcer], Date Initiated 8/11/25. The Goal Date Initiated: 8/11/25 The resident will maintain adequate nutritional status as evidenced by maintaining weight >135#, no [signs/symptoms] of malnutrition, and consuming at least 60% of meals and 100% supplements daily through review date. The Interventions, Initiated 8/11/25: included: Provide and serve regular diet as ordered, Provide and serve supplements as ordered ., RD to evaluate and make diet change (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommendations [as needed] and the resident needs a calm, quiet setting at meal times with adequate eating time. The resident prefers to sit in the 1st seating in the [main dining room]. Encourage the resident's socialization and interaction with table mates during meals. Although, Resident #4 was identified on 7/16/25 as having inadequate oral intake due to poor appetite as evidenced by weight decline 3.5 % X less than 2 weeks .Increased nutrition risk for pressure ulcer, there was no nutrition Care Plan initiated until 26 days later, and after Resident #4 sustained additional weight loss. The 3 Day intake monitor requested that was documented in the 8/8/25 RD note was also not included in the Care Plan.On 09/11/2025 10:08 AM, the surveyor interviewed the RD in the presence of the survey team. The surveyor asked the RD about the weight that documented on 9/6/25 at 135 #, and there was a Strike Out Date/Strike Out By/Strike Out Reason dated 9/10/25 at 14:55 (2:55 PM), Incorrect Documentation. The RD stated that Resident #4 was on weights and I crossed it out because it did not corroborate with the 130# weight which the RD stated was documented in the weight book, and was not documented in the electronic medical record. [This would have indicated an additional 5-pound weight loss] The RD also confirmed that there was no reweight completed to determine if the weight documented in the weight book was accurate. The surveyor asked what the Nutrition Goal was for Resident #4 and the RD stated for weight stabilization, and Resident #4 would be weighed that day. When asked what the facility reweight policy was, the RD stated, if there was a 5# change, the resident would be reweighed within two days. The surveyor asked it was policy to cross off a weight from the medical record if it was not confirmed it was an error, the RD stated, no, it was an error. The RD stated Resident # 4 would be weighed today and when asked if the weight loss was significant the RD stated, now the weight loss is significant.On 09/11/2025 10:47 AM, the RD informed the surveyor that Resident #4 was weighed and weighed 128#, which indicated the resident lost an additional 11# (7%) since 8/25/25. The surveyor asked the RD what nutrition interventions were implemented upon admission, and upon identifying the weight loss for Resident #4, the RD stated the first Nutritional Assessment, the Resident's weight was 151#. The RD stated that Resident #4 was at increased risk for a pressure ulcer upon admission due to Anemia. The RD stated, since it was post- operative anemia, she stated she chose to monitor the weekly weight and encourage the resident to eat for the nutrition interventions. The RD stated the second weight obtained was 147 # and weight was taken 3 days after admission. The surveyor asked what nutrition interventions were implemented at that time and the RD stated, at that time, I didn't implement any interventions and just completed the admission Assessment. The surveyor asked if the resident had edema upon admission and the RD stated per the admission notes there was no edema. The RD stated the next weight was 146 #, and additional 1 # weight loss from the previous week and the RD stated she reevaluated the resident's nutritional status on 7/17/25. On 09/11/2025 at 10:59 AM, the surveyor asked the RD about the 3-day intake monitor requested (documentation of all the foods that are eaten to determine nutritional intake) that was documented in the 8/8/25 RD note. The RD stated that she did not notify the nurses of her recommendation for the 3-day intake monitoring and confirmed it was not completed. When asked when specific interventions were implemented to prevent weight loss, the RD stated she implemented interventions, including a house supplement on 8/11/25.On 09/11/2025 at 12:32 PM, the surveyor interviewed the Minimum Data Set Coordinator (MDS-an assessment tool) about Resident #4. The surveyor asked who was included in the Interdisciplinary Team (IDT), and the MDS stated the Nurse, RD, Social Worker, Therapy and Activities. The surveyor asked if the IDT was aware of the weight loss, and if the IDT was going to proceed with a significant change MDS, and the MDS stated that the first time she was made aware of the weight loss for Resident #4 was on 9/10/25 and the resident did not decline in two areas. The surveyor asked if the resident was admitted with a pressure ulcer and the MDS stated, not a pressure ulcer, dermatitis, and it developed into a Stage III pressure ulcer, The surveyor asked if the facility had met with the family and the MDS stated there was a care conference held on 6/18/25 with the family and the IDT. The surveyor reviewed the Care Conference (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation, dated 6/18/25 which revealed: Resident is followed by the RD. Family requested to incorporate nutritional supplements. Weekly weights ongoing .On 9/12/25 at 11:22 AM, the survey team met with the Director of Nursing (DON) and Licensed Nursing Home Administrator during the exit conference. In response to the surveyor requesting, on 9/11/25, a timeline of the weight loss with interventions the DON provided the following: Resident admitted [DATE]; On 7/16/25: RD reassessment: Began process for interdisciplinary plan of care due to weight changes which included Prostat (Protein Supplement) and a multivitamin . 8/8/25 Care Plan Updated add, Mighty Shake added (liquid nutritional supplement). A review of the undated Resident Nutritional Assessments policy revealed: Nutritional Assessment: the consultant dietitian on each resident completes a nutritional assessment within 14 days of admission.NJAC 8:39-27.1(a)

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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. Based on observation, interview, and record review, it was determined that the facility failed to adhere to accepted standards of infection control practices for the proper storage of respiratory tubing and mask after use for 1 of 2 residents reviewed (Resident # 35). The deficient practice was evidenced by the following: On 9/09/25 at 10:21 AM, the surveyor observed Resident #35 seated in a recliner chair in the room. Resident #35 had a Nebulizer machine and a Nebulizer mask (used for breathing treatments) with white stains and was directly placed on top of the nightstand. The Nebulizer mask also touched the Nebulizer machine and was in close proximity of the resident's phone and toiletries items.On 09/9/25 at 12:35 PM, the surveyor returned to the room after the resident had been assisted with care, received morning medication, and observed the Nebulizer mask on the nightstand face down and in direct contact with the surface, was not protected. The mask was not dated. The surveyor attempted to interview the resident, but the resident could not proceed with the interview.On 09/10/2025 at 8:20 AM, the surveyor observed the resident in bed. The Nebulizer mask was noted on the nightstand as observed the day before and not protected.On 9/10/25 at 9:50 AM, the surveyor accompanied the Registered Nurse (RN) to the room where we both observed the Nebulizer mask, with white stained areas, that was on the nightstand in the same position as observed on 9/9/25 and was in closed proximity of other items and was not protected. The RN stated that the mask should not have been on the table. When asked to elaborate on how the mask should be stored, the RN stated if the treatment was a standing order the mask would be kept at the bedside. If the Nebulizer treatment was ordered as needed, the mask would be discarded.On 9/11/25 at 10:30 AM, the surveyor reviewed the medical record for Resident #35. The admission record reflected that Resident #35 was admitted to the facility with diagnoses which included, but were not limited to; muscle weakness, hypertension, and unspecified congestive heart failure. A review of the nurse's progress notes dated, 8/27/25 timed 12:18 PM, revealed the following: Noted increased in chest congestion, seen and evaluated by hospice, diminished lung sounds noted with upper chest congestion, [02] Oxygen saturation] 92 %, (Normal 95% to 100%). No difficulty breathing noted. New recommendation noted for DuoNeb (breathing treatment) 1 vial [QID] four times a day x 1 week. (MD) physician aware and new order noted reflecting recommendation. A review of the Order Summary Report for September 2025, revealed the following orders for Resident #35: Ipratropium-Albuterol inhalation Solution 0.5-2.5(3) MG (milligrams)/ML (milliliter) Ipratropium-Albuterol 1 vial inhale orally four times a day for chest congestion for 7 days. Start Date: 08/27/2025A review of the Medication Administration Record (MAR) reflected that Resident #35 received the Nebulizer treatment on 8/27/25, 8/28/25, 8/29/25, 8/30/25, 8/31/25, 9/1/25 and 9/2/25 as scheduled: 0900, 1300 (1:00 PM), 17:00 (5:00 PM and 21:00 PM (9:00 PM). The order was a standing order for 7 days.The surveyor requested the facility's policy for storage of respiratory care equipment.On 9/10/25 at 11:07 AM, the Director of Nursing (DON) provided the undated facility policy's titled, Administration Medication through a Metered Dose Inhaler (Nebulizer) . Purpose: The purpose of this procedure is to provide guidelines for safe administration of oropharyngeal inhaled medications:The following were noted under Administer medication: Rinse the mouthpiece with warm water to remove medication residue.Discard all disposable items into designated containers. The DON confirmed that the mask should have been discarded. NJAC 8:39-19.4 (K)