STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315356	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Nursing at Fellowship Village	8000 Fellowship Drive Basking Ridge, NJ 07920

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 record review, it was determined that the facility failed to: a) maintain kitchen equipment in a clean, safe and sanitary manner, b) maintain proper food storage in a clean, safe and sanitary manner and c) maintain kitchen garbage in a clean, safe and sanitary manner, and free from pests as evidenced by the following:On 3/30/26 at 9:37 AM, in the presence of the Food Service Director (FSD), the surveyors observed the following in the kitchen:The can-opener blade had areas missing and a congealed orange residue in the top left corner. The FSD acknowledged the blade had not been changed and it could cause potential harm to the residents. She further stated that the can opener blade and shaft are washed daily through the high temperature wash machine.Cutting boards (4 green and 8 white plastic) were observed to have deep etching and black /brown discoloration on them. The FSD acknowledged the surveyor concerns and stated, they do go through the high temperature wash machine, she could not identify what the discoloration was on the cutting boards.In the dry storage area, 2 storage containers (sugar and white rice) were noted to have the scoops in the product instead of on the hook within the container. The FSD acknowledged the scoops were stored incorrectly and stated that correct storage helps to prevent infection and cross contamination.In the freezer the surveyor observed multiple frozen food items that were not sealed or stored in containers with tight fitting lids. The unsealed food (vegetable burgers, okra, pumpkin, macadamia cookies, and link sausage) was open to air, frost and pollutants. The FSD acknowledged they should be sealed after opening to prevent frost, poor food quality and cross contamination of food products.During the tour of the kitchen the surveyor observed 6 trash cans without appropriate covers on them (1 at the employee wash sink, 2 in the food prep area,1 in the cook area, and 2 at the dirty tray line). The FSD acknowledged the surveyor's concerns.On 4/1/26 at 3:12 PM, the survey team met with Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Infection Preventionist (IP), Regional Director of Nursing (RDON) and [NAME] President of Clinical Operations (VPCO). The LNHA acknowledged the surveyor's concerns and stated that the equipment should be cleaned, maintained and lidded to prevent injury or cross contamination. He further stated the freezer food should be sealed to prevent food quality issues, food borne illnesses and cross contamination of products.On 4/2/26 at 9:37 AM, the surveyor interviewed the Resident District Manager (RDM), who stated that the can-opener blade should be changed regularly to ensure safety for the residents and ensure that no metal fragments entered the food. He further stated that the cleaning of equipment should be hand scrubbed and then put through the high temp wash machine to prevent food borne illness and maintain safe and sanitary environment for the staff and residents. The RDM acknowledged the surveyor's concerns and agreed they were not done according to facility policy.A review of the manufacturer guidelines for the can opener, provided by the FSD, revealed; recommended supplies .cleaning brush.procedures.2) The can opener can be taken to the three compartments sink to be disassembled, washed, rinsed and sanitized.Note; Blade and gear should be checked monthly for wear. If gear appears to be worn or sharp grooves appear in blade, they should be replaced. This will reduce the risk of can slivers entering the food product.A review of the Food and Supply Storage dated 5/95 and revised 1/24, revealed; dry storage. hang the scoop.scoops may (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	be stored in bins on a scoop holder. The food level must be no closer than one inch below the handle of the scoop.NJAC 8:39-17.2(g)

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on observations, interviews, record review, and review of facility provided documents, it was determined that the facility failed to provide medically related social services for a resident who transitioned in care from rehabilitation to long term care (Resident #16). This deficient practice was identified for 1 of 1 long term care (LTC) residents reviewed for social work services and was evidenced by the following:On 3/30/26 at 10:38 AM, during the initial facility tour, the surveyor observed Resident #16 in their room with the door open. Resident #16 stated they fell and got injured, needed rehabilitation, and then added, I've been here forever. Resident #16 stated they used to live in an apartment and wished they could return. On 3/31/26 at 10:26 AM the surveyor observed Resident #16 sitting in their room, waving for the surveyor to come in. Resident #16 stated they preferred to stay in their room and chose not to socialize with other residents. Resident #16 stated they did not know if the facility had a social worker (SW) or not and could not recall discussing their plan of care, including their transition to long term care, with anyone. On 4/1/26 at 9:46 AM, during an interview with the surveyor, the Director of Nursing (DON) stated the decision to transition a resident to long term care was made by the resident and their doctor after their rehabilitation was finished. The DON stated the doctor made notes in the resident's chart, and the Social Worker (SW) made notes in care plan meetings. The DON stated the SW saw LTC residents quarterly and for any concerns, and care plans were reviewed quarterly and for any changes in the residents' needs. The DON, in the presence of the surveyor, reviewed the Electronic Medical Record (EMR) for Resident #16 including a SW note dated 1/9/26 that included the sentence, Discontinue treatment plan. The DON stated, I don't know why she wrote that. I don't know what that means. The DON, in the presence of the surveyor, searched the EMR for additional SW notes from 2025 or 2026 and was unable to locate any. On 4/1/26 at 11:45 AM, during an interview with the surveyor, the SW stated, I don't counsel, I just do social work. The SW stated that she met with families for decision making and discharge planning and was familiar with Resident #16 who she saw once a week to talk, because the resident was a homebody. The SW, in the presence of the surveyor, reviewed the EMR for Resident #16. The SW acknowledged she could not locate documentation of conversations with Resident #16 or their family in the EMR at this time and would get back to the surveyor. The surveyor reviewed the EMR and hybrid paper chart for Resident #16, which revealed the following: A review of the census tab in the EMR reflected Resident #16 had been in their current room for approximately a year and a half. A review of the admission Record (an admission summary) revealed Diagnoses which included but were not limited to; repeated falls and depression. A review of the Minimum Data Set, a resident assessment and care screening tool, dated 3/27/26, reflected a Brief Interview for Mental Status score of 15 out of 15 which indicated the resident was cognitively intact. A review of the individual comprehensive care plan (ICCP) reflected a focus area initiated on 6/26/24, cancelled on 1/9/26, which revealed that support was needed to facilitate a safe discharge plan to return home. The associated interventions included to assist and encourage the client/representative to identify any barriers or concerns regarding needs and a safe discharge, and to provide support to the client/representative for reaching goals and developing a safe discharge plan. The responsible staff assigned to that intervention was SW. The surveyor was unable to locate other current or active focus areas or interventions assigned to the SW. A review of Evaluations titled Care Plan Conference Interdisciplinary Team Summary (care plan meeting summary) reflected a quarterly care plan meeting summary with date and time of meeting entered as 2/26/25 at 11:31AM, signed by the SW on 4/1/26 after surveyor inquiry; A Other care plan meeting summary with date and time of meeting entered as 12/1/25 at 6:00 AM, signed by the SW on 4/1/26 after surveyor inquiry; A quarterly care plan meeting summary with date and time of meeting entered as 4/1/26 at 3:10AM, signed by the SW on 4/1/26 with an effective date and time of 4/1/26 3:09PM, after surveyor inquiry. A review of the Progress notes reflected a plan of care note (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with effective date and time of 1/9/26 8:56 AM which contained the note text, Resident is now a LTC (long term care) resident in [facility redacted] LTC neighborhood. Discontinue treatment plan; A Social Service note with an effective date and time of 4/1/26 8:03 PM, after surveyor inquiry, reflected the note text, Reflective summary on ongoing Discussions: Social work has had ongoing involvement with resident. On 4/1/2026 at 3:11 PM, the Licensed Nursing Home Administrator, the DON, the Infection Preventionist, the [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were made aware of the above concerns. No additional information was provided. The surveyor reviewed the facility provided job description for Social Worker dated 2023 reflected the SW would contribute to and/or direct/delegate contribution of social services goals and approaches to the comprehensive care plan. The Social Worker would encourage residents/responsible parties to participate in the development of their care plan, and invite them to care plan meetings accordingly. The Social Worker will accurately and completely document social service actions and interactions in each resident's medical record. NJAC 8:39-27.1(a); 39.4

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observations, interviews, record review, and review of pertinent documentation, it was determined that the facility failed to obtain consent to ensure that the residents did not receive an unnecessary medication for 2 of 5 residents reviewed for unnecessary medications, (Resident #10 and #61).This deficient practice was evidenced by the following:1.) On 3/30/2026 at 10:10 AM, the surveyor observed Resident #10 in bed with the TV on. The resident greeted the surveyor but was unable to hold a conversation. On 3/31/2026 at 11:50 AM, the surveyor observed Resident #10 lying in bed. An empty juice cup with a straw was observed on the overbed table. The resident greeted the surveyor and asked when lunch was coming. The surveyor had observed staff in the hallway delivering lunch trays and made Resident #10 aware. The surveyor asked Resident #10 if they were in any pain or discomfort, the resident responded that they were fine and that they were not interested in talking. The surveyor reviewed the medical records for Resident #10. A review of the admission Record, an admission summary, revealed that Resident #10 had diagnoses which included, but were not limited to; anxiety disorder (a mental health condition involving persistent, excessive fear or worry that interferes with daily life, exceeding normal stress), unspecified dementia (symptoms of cognitive decline—such as memory loss, confusion, or personality changes—are present, but the underlying cause cannot be definitively identified), depression (a common, serious mood disorder characterized by persistent sadness, loss of interest, and low energy, severely affecting daily life for at least two weeks), and unspecified psychosis (symptoms like hallucinations, delusions, or disorganized behavior that disrupt functioning but do not meet the full, specific criteria for disorders such as schizophrenia or bipolar disorde) not due to a substance or known physiological condition. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/7/2025, included that the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated that the resident had severe cognitive impairment. Further review of the MDS, revealed that the resident was dependent on staff for activities of daily living (ADLs) and received psychoactive medications (medications that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). A review of the Individual Comprehensive Care Plan (ICCP) included a focus area, dated 11/9/2025, that the resident was taking Risperdal, an antipsychotic medication (a type of psychoactive medication specifically used to manage psychosis (hallucinations, delusions), schizophrenia, bipolar disorder, and severe agitation by balancing brain chemicals like dopamine and serotonin), and had a potential for adverse reactions due to the medication. Interventions included monitoring for adverse effects of antipsychotic medications and to report mood or behavioral changes and treat them as ordered if they occurred. Other interventions included psychiatry and psychology consultations as needed. Another focus area, dated 11/9/2025, included that the resident was at risk for falls related to confusion, incontinence, and psychoactive drug use. Interventions included anticipating and meeting the resident's needs, and to promptly assist if needed. A focus area, dated 1/8/2025, included that the resident used antidepressant medication. Interventions included monitoring for side effects and reporting them. A review of the Order Summary Report (OSR), included the following physician orders (PO): (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PO, dated 10/28/25, for: Risperdal Oral Tablet (Risperidone), give 0.25 mg by mouth two times a day for psychosis. A PO, dated 8/12/2025, for: Effexor XR Oral Capsule Extended Release 24 Hour 150 MG (Venlafaxine HCl), give 1 capsule by mouth one time a day for depression. A PO, dated 11/1/2025, for: Complete Weekly Psychotropic documentation on Saturday on 7-3 shift. List medications in note. Choose antipsychotic/antianxiety or Mood meds/sedative/hypnotic (Venlafaxine, Risperidone), every day shift every Saturday. On 3/31/2026 at 1:50 PM, the surveyor requested Resident #10's pharmacy medication regimen review and the initial consent for psychotropic medications from the Director of Nursing (DON). On 4/1/2026 at 11:12 AM, the surveyor completed review of the requested material. During review the surveyor observed that in the resident's admission packet was a form titled Consent for use of Psychoactive Medication Therapy which included the resident's original admission date in 2024, and was filled out with the resident's information, the psychoactive medications to be used, and that the proposed course was for prolonged treatment; but the form was not signed until 3/31/2026, the date of surveyor inquiry. On 4/1/26 at 12:22 PM, the surveyor interviewed Registered Nurse (RN) #1, who stated that residents receiving psychoactive medications were monitored for behaviors and had them documented weekly in their respective charts. RN #1 stated that monitoring was done to observe for any adverse medication reactions and to observe if the medications were effective for the resident. She then stated that when starting a new psychoactive medication, a psychological evaluation was done beforehand by the provider. Asked whether a consent form should be used for psychoactive medications, the RN responded that the facility confirms consent during the admission with a form in the admission packet and that the importance of informed consent was to inform a resident or caretaker of the risks versus benefits of a medication. When presented with Resident #10's Consent for use of Psychoactive Medication Therapy form the RN acknowledged that it was signed the previous day 3/31/2026 by her and another nurse when they received consent over the phone and that it was previously unsigned. On 4/1/26 at 12:39 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) #1. RN/UM#1 stated that providers would order psychoactive medications, and nursing would monitor any adverse effects. She stated that every psychotropic medication had a weekly monitoring attached to it where behaviors or adverse effects would be charted every week and then reviewed by the providers. The RN/UM#1 stated that consent was to be obtained upon admission for residents with psychoactive medications, even if the resident was already on the medication, as a consent to continue giving the medication at the facility. When presented with Resident #10's Informed Consent for Psychoactive Medications form, RN/UM#1 acknowledged that the form was part of the resident's admission packet; that the informed consent was signed on 3/31/26 after surveyor inquiry and that every resident should have had the form completed during their admission. On 4/1/26 at 1:38 PM, the surveyor interviewed the Director of Nursing (DON) regarding informed consent of psychoactive medications. The DON stated that even if a resident was admitted with a psychoactive medication, the facility would review it with them or their representative to make sure they understood the risks versus benefits. She then stated that written or verbal consent would be obtained during admission for a continuation, or before starting a new psychoactive medication (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered by a provider for existing residents. The DON acknowledged that Resident #10's Informed Consent for Psychoactive Medications was signed on 3/31/26, after survey inquiry, and was left blank during the resident's original admission. On 04/01/2026 at 3:18 PM, the surveyor presented the above concerns with psychoactive medication consent to the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, Assistant DON, and Regional Director of Clinical Operations. The LNHA acknowledged the surveyor's concerns and then stated that the initial consent should be completed during admission. 2.On 3/30/2026 at 9:36 AM, during the initial tour, the surveyor observed an oxygen in use sign on the door frame of Resident #61's door. The resident was in a reclining chair wearing oxygen (O2) via a nasal canula (NC) at 2l (liters) per minute (min). The resident stated, so far the care is good. The surveyor reviewed the electronic medical record (EMR) for Resident #61 A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, unspecified (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions), anxiety disorder, unspecified, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life), Chronic Obstructive Pulmonary Disease (COPD- a progressive, treatable lung disease—often including emphysema or chronic bronchitis—that restricts airflow and makes breathing difficult), unspecified congestive heart failure (CHF-a condition that occurs when the heart cannot pump blood efficiently to meet the body's needs) and Type 2 Diabetes Mellitus (DM2-a condition in which the body has trouble controlling blood sugar). A review of the admission Minimum Data Set, an assessment tool dated 3/20/26, revealed the resident had a Brief Interview for Mental Status of 15 out of 15, indicating the resident was cognitively intact. Further review revealed the resident was receiving oxygen, insulin and an antidepressant. A review of the individual comprehensive care plan revealed a focus of client is admitted for SA (subacute) care .due to respiratory distress, DM2 and CHF, date initiated 3/13/2026. Further review revealed a focus of use antidepressant medication (Remeron) r/t (related to) Depression, date initiated 3/21/2026 and an intervention of educate [name redacted]/family/caregivers abouts risks, benefits, and the side effects and/or toxic symptoms of anti-depressant medication, date initiated 3/21/2026. Further review of the ICCP did not reveal a focus or intervention of wearing oxygen or of receiving insulin. A review of the Order Summary Report revealed the following POs: - Mirtazapine Oral Tablet 15 MG (Remeron) Give 1 tablet by mouth one time a day for depression start 3/13/2026, 9:00 PM, discontinued 3/15/26. -Mirtazapine Oral Tablet 15 MG (Remeron) Give 1 tablet by mouth at bedtime for depression start 3/15/2026, 9:00 PM. A review of the March 2026 Medication Administration Record (MAR) revealed the above-mentioned POs had been documented as completed as ordered from the date of orders. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the progress notes revealed a Nurse's Note on 3/13/2026 at 4:33 PM.admission packet was reviewed with resident.call made to [identifiers redacted] will be here tomorrow to sign all necessary documents. Further review did not reveal any additional documentation regarding the admission packet. On 3/31/2026 at 12:13 PM, the surveyor reviewed the paper chart for Resident # 61 which revealed a two page Consent for use of Psychoactive Medication Therapy there was no information filled out. In the area of: Statement of Consent: there was no I Do or I Do Not consent to the use of: line was left blank. The signature lines from the resident, the resident representative (RR) or the nurse completing the form were blank. The area Telephone Consent was left blank. On the first page of the admission packet there was a post it note that read.spoke with [identifier redacted] will be here tomorrow to sign all necessary documents.On 3/31/2026 at 12:25 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1, who was Resident #61's assigned nurse. She stated when a new admission comes, she started the new admission paperwork, but the Registered Nurse (RN) completed the assessment, the medication review and the care plan. LPN #1 stated she had written the post it note on the front of the packet. LPN #1 stated that it was endorsed to the next shift that the RR was coming in the next day to complete the paperwork. She had acknowledged the paperwork should have been completed but it was not. On 4/1/2026 at 12:39 PM, the surveyors interviewed RN/UM #1, who stated any medication that the resident was started on at the facility, she would review it with the RR. She stated in the admission packet there was a consent form for psychotropic medications started upon admission. She stated, yes, we still get consent for a medication that they (the resident) were taking prior to admission. RN/UM #1 stated it was important to make sure family is aware, this patient is getting this psychotropic. She stated every resident that comes to the facility, especially taking psychotropics, they have to make sure the family was in agreement, even if it was over the telephone. RN/UM #1 accessed the EMR for Resident #61 and acknowledged the resident was started on Mirtazapine on admission. She stated we missed it; the whole packet (admission packet) was not signed. She stated, for some reason that was missed. On 4/1/2026 at 1:39 PM, the surveyors interviewed the Director of Nursing (DON), who acknowledged Resident #61's Consent for use of Psychoactive Medication Therapy that was included in the admission packet should have been completed but it was not. She stated they should review medication with them (the resident) making sure they understood why they were taking the medication. She added it could be written or verbal consent, but it should be documented. On 4/1/2026 at 3:11 PM, the Licensed Nursing Home Administrator, the DON, the Infection Preventionist, the [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were made aware of the above concerns. No additional information was provided. A review of the facility's policy Psychotropic Medication Use revised 10/30/25, revealed Policy: Our community is committed to protecting residents' rights to be free from abuse, neglect, exploitation, and unnecessary chemical restraints.Definitions: Psychotropic Drug: a medication that affects brain activity, including antipsychotics, antidepressants, anti-anxiety drugs, and hypnotics.5. Informed Consent: Residents or their legal representatives must be informed of: Purpose of medication, Benefits and risks.Consent must be document in the medical record prior to initiation of or changes in psychotropic medication therapy.8. Psychotropic Medication Initiation and Changes: Prior to initiating (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or increasing a psychotropic medication, the resident, family and/or resident representative must be informed of the benefits.9. Documentation: Medical records must include: Diagnosis justifying medication use and changes. N.J.A.C. 8:39-27.1 (a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to a.) complete a background check for 1 out of 65 employees (Employee #4) and b.) complete refence checks for 1 out of 65 employees (Employee #5). This deficient practice was identified for newly hired employees reviewed since last survey of 11/4/2024.This deficient practice was evidenced by the following:On 3/30/26 at approximately 9:40 AM, during the entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), all newly hired employee files for active and inactive employees from 11/4/24 to the current date.A review of the employee personnel files revealed the following:For Employee #4, a Homemaker with a date of hire (DOH) 5/5/25, there was no evidence of a background check prior to the start of employment.For Employee #5, a Certified Nursing Assistant (CNA) with a DOH 8/26/25, there was no evidence of reference checks prior to the start of employment. On 4/1/26 at 3:11 PM, the LNHA and Director of Nursing (DON) were made aware of the above concerns regarding background checks and reference checks for newly hired employees.On 4/2/26 at 11:29 AM, the surveyor interviewed the Senior Human Resources Journalist, LNHA and Human Resources Recruiter (HR Recruiter). The HR Recruiter stated that they normally receive two references checks prior to hire. She stated that if they could not get in contact with a reference resource, they would document the attempt in their employee file. She further stated that background checks were completed prior to the employees' first day of hire. She then stated the importance of completing background checks and reference checks was to ensure there was no criminal history and to ensure they were a viable candidate to work with the senior population at the facility. On 4/2/26 at 10:16 AM, the survey team met with the LNHA and the DON. The LNHA stated that the facility had no additional information to present for the above concerns. A review of the facility's Selection and Hiring Policy policy, revised 11/1/24 revealed.all applicants must meet minimum qualifications and complete recruitment process, including: provision of employment and personal references.successful completion of criminal background check.new hires generally may not begin work until references are received and verified.all offers of employment are conditional upon successful completion of pre-employment requirements, which may include: criminal background checks and reference verification.background checks will be conducted after a conditional offer is made. Screenings includes, at minimum, criminal history, employment references, and credential verification.A review of the facility's Employment History Checks: policy, revised 11/1/24 revealed.the goal of this policy is to provide a consistent approach to conducting reference checks on prospective employees, current employees, certain volunteers and contractors.it is necessary to contact previous employers or volunteer organizations of an applicant to obtain information about the individual's training, experience, knowledge, skills, and abilities and verify his or her job history.employment references will be conducted on all candidates after a conditional offer or employment has been extended. Human resources is responsible for coordinating and completing all reference checks.prior to making an offer of employment, at least two references will be obtained, two of which will be supervisory references, including the top candidate's current supervisor whenever possible.A review of the facility's P & P: Abuse Prevention policy, undated revealed .all potential employees will be screened for a history of abuse, neglect or mistreating residents according to the following guidelines .reference checks will be performed by H/R using info screen and telephone verification. Copies are kept in the personnel file. This is done on all employee applications before a decision is made to hire the employee. Criminal background checks are performed by an outside vendor on all potential applicants. Results are kept in the file . NJAC 8:39-9.3(b)

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	315356	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skilled Nursing at Fellowship Village	8000 Fellowship Drive Basking Ridge, NJ 07920

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review, interview, and facility policy review, the facility failed to ensure a written copy of the baseline care plan was completed and provided to the resident and/or resident representative (RR) within 48 hours of admission for 1 of 20 sampled residents (Resident #61) reviewed for baseline care plan. This deficient practice was evidenced by the following:On 3/30/2026 at 9:36 AM, during the initial tour, the surveyor observed an oxygen in use sign on the door frame of Resident #61's door. The resident was in a reclining chair wearing oxygen (O2) via a nasal canula (NC) at 2l (liters) per minute (min). The resident stated, so far the care is good.The surveyor reviewed the electronic medical record (EMR) for Resident #61A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, unspecified (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions), anxiety disorder, unspecified, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life), Chronic Obstructive Pulmonary Disease (COPD- a progressive, treatable lung disease-often including emphysema or chronic bronchitis-that restricts airflow and makes breathing difficult), unspecified congestive heart failure (CHF-a condition that occurs when the heart cannot pump blood efficiently to meet the body's needs) and Type 2 Diabetes Mellitus (DM2-a condition in which the body has trouble controlling blood sugar). A review of the admission Minimum Data Set (MDS), an assessment tool dated 3/20/26, revealed the resident had a Brief Interview for Mental Status of 15 out of 15, indicating the resident was cognitively intact. Further review revealed the resident was receiving oxygen, insulin and an antidepressant. A review of the individual comprehensive care plan (ICCP) revealed a focus of; client is admitted for SA (subacute) care .due to respiratory distress, DM2 and CHF, date initiated 3/13/2026. Further review revealed a focus for the use of antidepressant medication (Remeron) r/t (related to) Depression, date initiated 3/21/2026, with an intervention to educate [name redacted]/family/caregivers abouts risks, benefits, and the side effects and/or toxic symptoms of anti-depressant medication, date initiated 3/21/2026. Further review of the ICCP did not reveal a focus or intervention for using oxygen or for receiving insulin.A review of the progress notes revealed a Nurse's Note on 3/13/2026 at 4:33 PM,.admission packet was reviewed with resident.call made to [identifiers redacted], will be here tomorrow to sign all necessary documents. Further review did not reveal any addition documentation regarding the admission packet. On 3/31/2026 at 12:13 PM, the surveyor reviewed the paper chart for Resident # 61 which revealed a two page Client's Baseline Care Plan Summary Client's Name [identifier redacted] Date: 3/13/2026, no other information was filled out. There was no signature from the resident, the RR or the nurse completing the form. On the first page of the admission packet there was a sticky note that read.spoke with [identifier redacted] will be here tomorrow to sign all necessary documents. On 3/31/2026 at 12:25 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1, who was Resident #61's assigned nurse. She stated that when a new admission comes, she started the new admission paperwork but the Registered Nurse (RN) completed the assessment, the medication review, and the care plan. LPN #1 stated the care plan should include diagnoses, medications such as insulin or breathing treatments. LPN #1 reviewed the paper chart for Resident #61 stated she had started the admission packet for the resident. At that time, she reviewed the baseline care plan and acknowledged that it was not completed. She stated she had written the sticky note on the front of the packet. LPN #1 stated that it was endorsed to the next shift that the RR was coming in the next day to complete the paperwork. She had acknowledged the paperwork should have been completed but it was not. On 3/31/2026 at 12:49 PM, the surveyor interviewed the RN/Unit Manager (RN/UM) #1, who stated she usually reviewed the new admission medications and completed the baseline care plan. She stated the resident or RR usually did not sign the base line care plan on admission, but they (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would usually sign it during the care plan meeting which was usually around day 5 of the admission. RN/UM #1 stated that a baseline care plan should be completed within 24 hours of admission and should include diagnoses, falls, skin, pain and COVID status. She stated the purpose of a care plan was the plan of care, what we are going to do if the patient needs things. At that time, RN/UM #1 reviewed Resident #61's paper chart, in the presence of the surveyor. She acknowledged the baseline care plan was not completed and it was not signed but should have been. On 3/31/2026 at 1:09 PM, the surveyor interviewed the Director of Nursing (DON), who stated baseline care plans were completed by the admitting nurse under supervising UM. She stated the UM reviewed the baseline care plan with the resident and if the resident was unable to sign, it would be reviewed with the RR. At that time, she reviewed the admission packet with the surveyor and acknowledged the baseline care plan was not completed and was not signed by the resident, RR or verified by the nurse. On 4/1/2026 at 12:39 PM, during a follow up interview, RN/UM #1 stated the whole admission packet was not completed or signed. She stated, for some reason that (the admission packet) was missed. On 4/1/2026 at 3:11 PM, the Licensed Nursing Home Administrator, the DON, the Infection Preventionist, the [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were made aware of the above concerns. A review of the facility policy P&P Baseline Care Plans revised 10/30/25, revealed Policy.will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.1. The baseline care plan will: a be developed within 48 hours of a resident's admission.3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 4. A written summary of the baseline care plan shall be provided to the resident and representative.5. A supervising nurse/nurse designee is responsible for providing the written summary of the baseline care plan to the resident and representative.6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided.7. If the summary was provided via telephone, the nurse shall indicate the discussion, sign the summary document, and make a copy of the written summary before mailing the summary to the resident/representative. NJAC 8:39-11.2(d)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, interviews, record review and review of facility provided documents, it was determined that the facility failed to update the Individualized Comprehensive Care Plan (care plan) for 2 of 20 sampled residents (Resident #7 and #16) reviewed for care planning. This deficient practice was evidenced by the following: 1. On 3/30/26 at 9:59 AM, during an initial tour, the surveyor observed Resident #7 sitting in their room with the door open. Resident #7 stated they can't swallow right so they had surgery. The surveyor observed a capped feeding tube (a medical tubing inserted directly into the stomach delivering nutrition, fluids and medications) on the resident's abdomen which extended from under their shirt. Resident #7 stated they received meals (liquid nutrition), water, and medication through the feeding tube. Resident #7 stated they were also able to enjoy their favorite drink, coffee, in the morning, after being taught how to swallow it safely by speech therapy. Resident #7 stated the coffee had to be thick, and he had to swallow a few times after each sip but enjoyed it. The surveyor reviewed the Electronic Medical Record (EMR) and hybrid paper chart for Resident #7. A review of the admission Record (an admission summary) reflected diagnoses which included but were not limited to; dysphagia (difficulty or inability to swallow) and gastrointestinal hemorrhage (stomach/intestinal bleeding). A review of the Speech Therapy (ST) communication/diet recommendation form reflected .initiate pleasure feeds. signed by the ST and the receiving nurse, followed by the dates 3/12/26 and 3/13/26. A review of the physician's orders reflected an order dated 3/13/26 for Regular diet. Mechanical soft texture, Nectar/mildly thick consistency for diet. Pleasure feedings on request only. A review of the March 2026 Medication Administration Record (MAR) included the order for pleasure feedings initiated on 3/13/26, with entries signed for day, evening, and night shifts each shift from 3/13/26 up to and including 3/31/26. A review of the individual comprehensive care plan (ICCP) included a focus area of admission for aspiration (something other than air getting into the airway, such as food or water) .with an associated intervention to follow safety precautions as ordered, NPO (nothing by mouth) status, date initiated 2/16/26. Another focus area for nutrition revealed the resident was a nutrition/hydration risk related to NPO status, tube feeding dependency, and persistent dysphagia. Interventions included: NPO, provide bolus feeding.five times daily. date initiated 2/19/26. 2. On 3/30/26 at 10:38 AM, during an initial tour, the surveyor observed Resident #16 sitting in their room with the door open. Resident #16 stated they had a fall and received rehabilitation at the facility. The surveyor observed the resident moving their arms and legs, sitting and standing without assistance. Resident #16 stated that the nurse brought medications and the kitchen provided meals, but otherwise they took care of themselves including dressing, bathing, and other activities of daily living. The surveyor reviewed the EMR and hybrid paper chart for Resident #16. A review of the admission Record reflected diagnoses which included, but were not limited to; repeated falls, and muscle weakness. A review of the ICCP included a focus area initiated on 6/26/24 which revealed that the resident was admitted for SA (subacute) care for ambulation (movement) due to s/p (status post) fall. The associated interventions included the following which were initiated 10/4/24; [brand name redacted] cervical collar on at all times for every shift, for protection, and Sling to RUE (Right Upper Extremity) on at all times- may remove for skin checks and ADLs (Activities of Daily Living) every shift. A review of the physician's orders including active, discontinued, and completed orders reflected a discontinued order for cervical collar with start date 5/17/24, discontinued on 10/23/24, and a discontinued order for sling to RUE with start date of 6/26/24, and discontinued on 10/23/24. On 3/30/26 at 10:25 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that Resident #7 had a feeding tube for nutrition and medicine. LPN #1 added that Resident #7 also received pleasure feeds (small amounts of preferred foods or liquids consumed while following precautions, to improve quality of life) based on the recommendation from speech therapy and doctor's orders. On 4/1/26 at 9:46 AM, the surveyor (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed the Director of Nursing (DON) who stated a resident's care plan was initiated by the nurse upon admission and updated as the resident's condition changed. She stated the care plans were reviewed by the clinical team at least quarterly (every 3 months). On 4/1/26 at 11:31 AM, the surveyor re-interviewed LPN #1 who stated she had been the nurse for Resident #7 and Resident #16 for a few months. LPN #1 in the presence of the surveyor, reviewed the care plan for Resident #7. LPN #1 acknowledged the care plan reflected the resident's NPO status but did not reflect the pleasure feeds initiated on 3/13/26. LPN #1, in the presence of the surveyor, then reviewed the care plan for Resident #16. She acknowledged that Resident #16 did not have a cervical collar or arm sling, and maybe those were old items on the care plan. LPN #1 stated that she attended care plan meetings and updated care plans when she knew something had changed with a resident. LPN #1 stated that Resident #16 hadn't changed so she had no reason to review or update their care plan. She stated that if she was not the one who changed the resident's orders, she was not the one who updated the care plans and would have to ask around to see who updated them. On 4/1/2026 at 3:11 PM, the Licensed Nursing Home Administrator, the DON, the Infection Preventionist, the [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were made aware of the above concerns for Resident #7 and #16. A review of the facility policy and procedure titled Care Plans - Updating for Status Changes revised 10/24/25, revealed the following Policy Explanation and Compliance Guidelines:1. The comprehensive care plan will be reviewed, and revised or updated as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan . c. The care plan will be updated with the new or modified interventions accordingly. d. Care plans will be modified as needed by the Nurse and, or other, designated team member. h. The Director of Nursing provides oversight of the care plan process by prioritizing with the team the review of all residents experiencing a change in status to ensure care plans have been promptly updated to reflect current resident needs. NJAC 8:39-11.2

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observations, interviews, review of the medical record and other facility documents, it was determined that the facility failed to obtain a physician's order for a wrist splint and/or brace. This deficient practice was identified for 1 of 1 resident reviewed for Activities of Daily Living (Resident #70), and was evidenced by the following:On 3/30/26 at approximately 9:36 AM, the surveyor observed Resident #70 in bed with a resident representative (RR) in the room. The resident was wearing a left wrist brace. The RR stated to the surveyor that they took the brace off to wash the resident's left hand. The RR also stated that the left wrist had no function and needed support to keep it straight. The surveyor observed a blue brace on the windowsill of the room. The RR stated that the blue brace went on the left arm at night to keep it straight. The surveyor reviewed the electronic medical record (EMR) and the hard chart for Resident #70. A review of the admission Record (an admission summary) revealed diagnoses that included but were not limited to; muscle weakness, cognitive communication deficit (a condition where underlying cognitive impairments disrupt a person's ability to communicate effectively), and dermatitis (a common skin condition that causes irritation, itching, rash, or blisters). A review of the Order Summary Report (OSR) did not reveal a physician's order for a splint/brace to the left hand/wrist/arm or for a placement/removal schedule.A review of the Minimum Data Set (MDS), an assessment tool dated 3/19/26, revealed a Brief Interview for Mental Status of 14 out of 15 which indicated no cognitive impairment. Further review of the MDS indicated that the resident had impairment on one side, upper extremity.A review of the Individualized Comprehensive Care Plan (ICCP) dated 3/20/26, did not reveal any focus area or intervention for the use of a left arm/wrist/hand splint.A review of the Occupational Therapy (OT) Plan of Care signed 3/20/26, revealed Musculoskeletal System Assessment Left Upper Extremity (LUE) Range of Motion (ROM).Wrist=impaired; patient did not tolerate testing, wearing splint with wrist in neutral position with forearm supination.A review of the Progress Notes (PN) revealed a provider follow up note dated 3/27/26 which included .Moves extremities, left hemiparesis. LUE weakness.contracture: Continue brace, OT.Patient with risk for skin breakdown.On 4/1/26 at 9:00 AM, the surveyor interviewed the Registered Nurse/Charge Nurse (RN/CN) who stated the brace to Resident #70's left arm was there upon admission, the resident wore it at all times, and the staff removed it to check for skin integrity. The RN/CN stated the resident's left arm was flaccid (limp). The RN/CN stated if the resident felt itching or discomfort, staff removed the brace for a while. The RN/CN stated, It should be used at all times, that arm is contracted. She added, There is no order for that brace. I don't think it is care planned. The RN/CN continued, I have to ask physical therapy. On those kinds of splints or a brace the physical therapist would assess it and then let us know if they needed it or not. The doctor would also put in an order. We usually add it to the care plan. On 4/1/26 at 9:48 AM, the surveyor interviewed the Physical Therapist (PT), who stated that typically OT assessed braced. The PT further stated Resident #70 has only had the wrist immobilizer when I've worked with [them]. I haven't seen anything about a second brace. We would talk to nursing about it if, they have a piece of equipment .to get the appropriate order to use during therapy. On 4/1/26 at 11:18 AM, the surveyor interviewed the OT, who stated Resident #70's wrist brace came over with the resident from the hospital and OT had been looking at their arm positioning. The OT stated, We haven't established a wearing schedule. The OT further stated It (the wearing schedule) was not something that we assigned and had not been established yet. I thought the wrist brace was a doctor's order. The resting hand splint was the one we set a goal to look at. The OT described the process upon admission was if a resident was supposed to sleep with a brace, OT would have the resident wear it during the daytime while therapy was there. Then if the resident tolerated wearing the brace, therapy would write a recommendation for the brace to be worn at night. She stated they would give it (the recommendation) to the charge nurse to enter an order for the resident. The OT stated therapy would (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do training for the staff after the order was entered. The OT stated, We wouldn't give (a resident) something if we weren't confident, it wouldn't cause skin breakdown.On 4/1/26 at 1:16 PM, the surveyor interviewed the Director of Nursing (DON) who stated therapy should enter the order for a brace or splint after their evaluation and nursing would approve it. The doctor could also write the order, but nursing usually got it (the order) from therapy. If a resident had a brace or splint upon admission, the admitting physician would accept that order until therapy saw the resident.On 4/1/26 at 3:11 PM, the Licensed Nursing Home Administrator, the DON, the Infection Preventionist, the [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were made aware of the above concern. A review of the facility provided Splint/Brace Use policy, undated, revealed it was the policy of the community to ensure that all splints, braces, and orthotic devices were assessed, applied, monitored, and documented in a manner that promotes resident safety, maintains functional ability, and complies with all applicable federal and New Jersey regulations. The procedures indicated. All splints/braces must have a valid order from a licensed provider including: type and location of device, clinical indication, wearing schedule (on/off times), precautions or contraindications. Documentation must include: provider order, assessment findings, care plan interventions, application/removal times, monitoring results, resident tolerance and response, education provided. NJAC 8:39-27.1(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. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control standards and procedures to ensure that a resident's urinary catheter drainage bag was stored properly for 1 of 1 resident reviewed for urinary catheter (Resident #35) and was evidenced by the following: On 3/30/2026 at 9:56 AM, during the initial tour, the surveyor observed Resident #35's urinary catheter drainage bag attached to the handrail in the bathroom with the end of the uncapped tube tip on the floor. The surveyor also observed two signs in the bathroom, one on the wall above the toilet and the other on the side of the cabinet in the bathroom which stated, Please refrain from discarding Urinary collection bags!On 3/30/2026 at 11:59 AM, the surveyor observed Resident #35's same undated urinary catheter drainage bag attached to the handrail in bathroom with the end of the uncapped tube tip on the floor.On 3/30/2026 at 12:10 PM, the surveyor accompanied the Registered Nurse (RN) to Resident #35's bathroom and observed the undated urinary catheter drainage bag with the uncapped tip on the bathroom floor. When the surveyor asked the RN what the process was for urinary catheter care, the RN stated, the process is if the resident has an order for a [name redacted] bag, the drainage bag is used at night when the resident is in bed. The nurse gets the bag and dates it prior to putting it on the resident. In the morning, before the resident gets out of bed, the leg bag is put on, and the bedside drainage bag is emptied and bagged and kept in the bathroom. The RN confirmed the urinary catheter drainage bag tip was on the floor. The RN stated the urinary catheter drainage bag tip should not have been on the floor for infection control. The RN stated the Certified Nursing Aide (CNA) should have put the urinary catheter drainage bag in a plastic bag. When the surveyor asked the RN about the undated urinary catheter bag, the RN stated that the nurse that put the urinary catheter drainage bag on the resident during the 3:00 PM-11:00 PM shift should have dated the urinary catheter drainage bag, so the staff would know when it was due to be changed.On 3/31/2026 at 9:59 AM, during an interview with the surveyor, the CNA who was assigned to Resident #35 and provided care to the resident on 3/30/26 during the 7:00AM - 3:00 PM shift, stated she removed the night bag (urinary catheter drainage bag), washed it, and hung it on the handrail by the toilet so it could be reused. The CNA stated she had washed the night bag before and hung it on the rail but did not remember how many times she had done it, and that it depended on how soiled the drainage bag was. The CNA stated the urinary catheter drainage bag looked new, so that was why she washed it with soap and water. The CNA acknowledged that she should have stored the urinary catheter drainage bag in a plastic bag for infection control.On 4/01/2026 at 10:03 AM, during an interview with the surveyor, the Infection Preventionist (IP) stated the urinary catheter drainage bag should not have been hung there with the uncapped tip on the floor because it was an infection control issue. The IP further stated the CNA should have removed the urinary catheter drainage bag from the resident and discarded it as soon as she was finished taking care of the resident.On 4/01/2026 at 10:33 AM, during an interview with the surveyor, the Director of Nursing (DON) stated the urinary catheter drainage bag tubing tip should not have been on the floor because it was an infection control issue and once it touched the ground it was contaminated.On 4/01/2026 at 12:14 PM, during a follow up interview with the surveyor, in the presence of the DON, the IP stated that the signage that was posted in Resident #35's bathroom, was removed on 3/30/26. The IP further stated the signage, Please refrain from discarding Urinary collection bags! was not facility policy.The surveyor reviewed the medical records for Resident #35 which revealed the following:The Admissions Record (AR; an admission summary) reflected that Resident #35 was admitted to the facility, had diagnoses which included but were not limited to; retention of urine, Benign Prostatic Hyperplasia (BPH; causes the prostate to increase in size) with lower urinary tract symptoms, and obstructive and reflux uropathy (when urine can't flow either partially or completely through the ureter, bladder, or urethra due to some type of obstruction [blockage]).A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facilitate the management of care, dated 01/13/2026, included the resident had a Brief Interview for Mental Status score of 11 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS, reflected Resident #35 had an indwelling catheter (including suprapubic catheter .).A review of Resident #35's Order Summary Report revealed the following physician's order (PO):- Suprapubic Catheter 22 fr (French; size of catheter) care every shift for Suprapubic Catheter/BPH, date started 12/01/2025.-Bedside drainage bag to be applied when in bed every evening shift, date started 10/29/25.-Leg bag to be applied when OOB (out of bed) every day shift, dated started 10/29/25.A review of Resident #35's individual comprehensive care Plan (ICCP) revealed a focus of resident having infection that was difficult to treat related to (r/t) use of Suprapubic Catheter, date initiated 10/09/2025. Further review revealed a focus of the resident having an indwelling Suprapubic Catheter r/t to BPH, date initiated 10/16/2025. Further review of the ICCP did not reveal a focus or intervention for changing or disposing urinary drainage bag as per facility policy.On 4/1/2026 at 3:15 PM, the Licensed Nursing Home Administrator, the DON, the IP, the [NAME] President of Clinical Operations, and the Regional Director of Clinical Operations were made aware of the above concerns. A review of the facility policy P&P Appropriate Use of Indwelling Catheters - Skilled Nursing Catheter Indications/Intervention, revised on 1/30/2025, revealed it is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . Under Procedure: 6. Leg bags may be worn during the day but need to be removed and discarded, after which a new bedside drainage bag will be placed on the catheter at night.A review of the facility policy P&P Urinary Incontinence and Indwelling Catheter Indications/Intervention, revised on 09/22/2025, revealed Indwelling urinary catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice .A review of the facility policy Urinary Tract Infections (Catheter -Associated), Guidelines for Preventing, revised on 01/30/2025 revealed under Steps in the Procedure: 6. c. Do not place the drainage bag on the floor. NJAC 8:39 - 19.4(a)(5), 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315356	A. Building B. Wing	04/02/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of other pertinent facility documents, it was determined that the facility failed to implement their policy to a.) ensure all eligible residents were educated on the benefits and potential side effects of the influenza and pneumococcal immunizations and b.) document in the medical record the residents' education and refusal of the influenza and pneumococcal immunizations. The deficient practice was identified for 3 of 5 residents reviewed for immunizations (Resident #61, #70 and #73.)This deficient practice was evidenced by the following:1. On 3/30/2026 at 9:36 AM, during the initial tour, the surveyor observed an oxygen in use sign on the door frame of Resident #61's door. The resident was in a reclining chair wearing oxygen (O2) via a nasal canula (NC) at 2l (liters) per minute (min). The resident stated, so far the care is good. The surveyor reviewed the electronic medical record (EMR) for Resident #61 A review of the admission Record (AR-an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, unspecified (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions), anxiety disorder, unspecified, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life), Chronic Obstructive Pulmonary Disease (COPD- a progressive, treatable lung disease—often including emphysema or chronic bronchitis—that restricts airflow and makes breathing difficult), unspecified congestive heart failure (CHF-a condition that occurs when the heart cannot pump blood efficiently to meet the body's needs) and Type 2 Diabetes Mellitus (DM2-a condition in which the body has trouble controlling blood sugar). A review of the admission Minimum Data Set (MDS), an assessment tool dated 3/20/26, revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. A review of the progress notes revealed a Nurse's Note on 3/13/12026 at 4:33 PM.admission packet was reviewed with resident.call made to [identifiers redacted] will be here tomorrow to sign all necessary documents. Further review did not reveal any additional documentation regarding the admission packet. A review of the immunizations tab in the EMR for Resident #61 revealed 2025-2026 Seqirus Fluad Influenza Vaccine 0.5mL marked as Refused by resident, and PCV 21 Pneumococcal vaccine marked as refused. On 3/31/2026 at 12:13 PM, the surveyor reviewed the paper chart for Resident #61 which revealed a Consent for Flu Vaccine-Resident declinations marked as refused, not signed by the resident; but the nurse signed it on 3/13/26. The Flu Vaccine Consent-Resident Representative was completely blank. The [Name Redacted] Pneumonia Vaccination Consent form had the Resident's Name: [Identifier Redacted-Resident #61's name was printed]; a check mark next to [Identifier redacted Resident #61s name] and the word verbally was printed next to Do not give consent; the Signature line was blank. Further review of the packet, revealed on the first page of the admission packet there was a post it note that read.spoke with [identifier redacted] will be here tomorrow to sign all necessary documents. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/2026 at 12:25 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1, who was Resident #61's assigned nurse. She stated when a new admission comes, she started the new admission paperwork which included assessed for vaccinations. LPN #1 reviewed the paper chart for Resident #61 stated she had started the admission packet for the resident. She stated she had written the post it note on the front of the packet. LPN #1 stated that it was endorsed to the next shift that the RR was coming in the next day to complete the paperwork. She had acknowledged the paperwork should have been completed but it was not. On 3/31/2026 at 1:09 PM, the surveyor interviewed the Director of Nursing (DON), who stated vaccines were assessed by the nurse and the nurse managers on admission and the Infection Preventionist (IP) reviewed them the next day. The DON reviewed the admission packet and acknowledge the vaccinations paperwork was not signed by the resident or verified by the nurse. 2.On 3/30/26 at 9:36 AM, the surveyor observed Resident #70 in bed with their eyes closed and with family members in the room. A review of both the electronic medical record (EMR) and hard chart for Resident #70 was conducted. A review of the AR reflected diagnoses that included but were not limited to muscle weakness; cognitive communication deficit (a condition where underlying cognitive impairments disrupt a person's ability to communicate effectively); and asthma. A review of the immunizations tab in the EMR for Resident #70 revealed Pneumococcal immunization refused by family on 3/19/26. Education provided, risk vs benefits discussed with family. A review of the admission Minimum Data Set (MDS), an assessment tool dated 3/19/26 revealed a Brief Interview for Mental Status (BIMS) of 14 out of 15 which indicated minimal or no cognitive impairment. A review of the Medication Administration Record (MAR) for Resident #70, revealed the nurse marked the physician order for Pneumovax as other-see note at 00:11 AM on 3/20/26. A review of the progress notes in the EMR showed a note refused. On 3/31/26 at 2:15 PM, the surveyor reviewed Resident # 70's hard chart on the 101 unit, which revealed a document titled [name redacted] Pneumonia Vaccination Consent that was blank. 3.On 3/30/26 at approximately 9:50 AM, the surveyor observed Resident #73 with a family member in the room. The family member was wearing a gown and gloves, and the resident was ambulating using a walker. No concerns were reported by the resident or the family member. Two staff members entered the room wearing gowns and gloves. The staff stated the resident was on contact precautions. A review of both the EMR and hard chart for Resident #73 was conducted. A review of the AR reflected diagnoses that included but were not limited to pneumonia, unspecified organism; unspecified dementia; and need for assistance with personal care. A review of the immunizations tab in the EMR for Resident #73 revealed 2025-2026 Seqirus Fluad Influenza Vaccine 0.5mL Refused by resident on 3/20/26. Education provided, risks/benefits (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed. A review of the admission MDS dated [DATE] for Resident #73 revealed a BIMS score of 11 out of 15, which indicated moderate cognitive impairment. A review of the MAR for Resident #73 revealed the physician's order for Flu Vaccine marked drug refused on 3/20/26 at 19:33PM. On 3/31/26 at 2:15 PM, the surveyor reviewed Resident #73's hard chart on the 101 unit, which revealed a document titled Consent for Flu Vaccine-Resident, that was signed by the resident and by a witness on 3/20/26, with no consent or declination for the flu vaccine. The chart also contained a document titled Flu Vaccine Consent-Responsible Representative, that was signed by the representative and by a witness on 3/20/26, with no consent or declination for the flu vaccine. On 4/1/2026 at 3:11 PM, the Licensed Nursing Home Administrator, the DON, the Infection Preventionist, the [NAME] President of Clinical Operations and the Regional Director of Clinical Operations were made aware of the above concerns for Residents #61, # 70, and #73. No additional information was provided A review of the facility's policy Influenza (Flu)Vaccine Administration-Residents revised 6/12/23, revealed Policy: It is the policy of [name redacted] to strongly encourage and administer the annual influenza (flu)vaccine to its residents as essential protection against the Flu infection .The resident has the right to refuse the Flu vaccine. If the resident or representative refuses the Flu vaccination, the physician/NP/PA will be notified and attempt to reeducate the resident and encourage/strongly recommend receipt of the vaccination. A review of the facility's policy Pneumococcal Vaccine Administration revised 10/24, revealed Policy: It is the policy of [name redacted] to encourage and administer the Pneumococcal Vaccine to residents per Centers for Disease Control (CDC) recommendations as essential protection against Pneumococcal disease. Older adults are at greatest risk of serious illness and death related to Pneumococcal disease .The resident has the right to refuse the Pneumococcal Vaccine. An attempt will be made to encourage the vaccine through education about the benefits of the vaccine and the risks of not receiving it. As noted above, the Nurse will document education and any refusal of the Pneumococcal Vaccine in the MAR. The physician/APN/PA may also educate the resident. NJAC 8:39-19.4 (h) (i)