STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carnegie Post Acute Care at Princeton LLC	5000 Windrow Drive Princeton, NJ 08540

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the Admission Minimum Data Set (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 2 residents (Residents #339) reviewed for timing of assessments and was evidenced by the following: This deficient practice was evidenced by the following: On 2/21/25 a review of the electronic health record (EHR) reflected that Resident #339 was admitted to the facility on [DATE]. The Comprehensive Admission MDS was noted to be in progress. On 2/21/25 at 12:45 PM, the surveyor interviewed the MDS Coordinator, who stated the MDS assessment on a new admission was due within 14 days of admission. She further stated that she was working on this MDS now and that it should've been done the day before yesterday (2/19/25). A review of facility provided MDS Policy reviewed 10/2024 included: Policy: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS (Centers For Medicare and Medicaid) regulations and requirements. Purpose: 1. To outline the procedure of identifying and addressing residents' strengths and needs through the RAI (Resident Assessment Instrument) process 2. To provide information on the resident's condition 3. To facilitate development of a comprehensive care plan. 4. To ensure care delivery that enhances the resident's quality of life. 5. To help achieve the highest and practical level of self sufficiency. Procedure: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS Department 1. Schedules Minimum Data Set (MDS) and Care Plan Meeting in accordance to existing regulations governing RAI process. 3. Assures the completeness and accuracy of the information in the MDS. 5. Coordinates, signs and certifies the completion of the MDS. 6. Submits MDS data in required format to CMS. 8. Reviews and corrects errors with the MDS Coordinator. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2024, page 2-17, the Comprehensive Admission assessment must be completed no later than the admitted + 13 calendar days. NJAC 8:39-11.2 (e)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Based on interview, review of medical records and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete and electronically transmit the Minimum Data Set (MDS), an assessment tool, within 14 days of the resident's discharge. This deficient practice was identified for 1 of 1 resident, (Resident # 83) reviewed in the Resident Assessment Task for MDS record over 120 days old. On 2/18/25, the surveyor reviewed the MDS history in the electronic medical record (EMR), which revealed that Resident #83 was discharged on [DATE]. The surveyor was unable to locate a discharge MDS in Resident #83's EMR. On 2/18/25, the surveyor interviewed the MDS Coordinator, who stated the discharge MDS on Resident #83 should've been completed within 14 days of the discharge date . She also stated, I'm not sure what happened. On 2/25/25, after surveyor inquiry, the surveyor noted the discharge MDS was completed on 2/19/2025 and was transmitted on 02/20/2025 (completion was due by 12/16/2024 and transmission was due by 12/30/2024). A review of facility provided MDS Policy reviewed 10/2024 revealed: Policy: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS regulations and requirements. Purpose: 2. To provide information on the resident's condition Procedure: MDS Department 1. Schedules Minimum Data Set (MDS) and Care Plan Meeting in accordance to existing regulations governing RAI (Resident Assessment Instrument) process. 3. Assures the completeness and accuracy of the information in the MDS. 5. Coordinates, signs and certifies the completion of the MDS. 6. Submits MDS data in required format to CMS (Centers for Medicare and Medicaid Services). (continued on next page)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2024, page 2-19, the discharge return-not anticipated assessment must be completed no later than the discharge date + 14 calendar days with the transmission date no later than MDS completion date +14 days. NJAC 8:39-11.2 (e) 3

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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 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** 48964 Complaint #: NJ 00179151 Based on observation, interview, review of medical records, other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 3 of 31 residents reviewed (Resident #5, Resident #43, and Resident #53) for MDS accuracy. This deficient practice was evidenced by the following: 1. On 2/19/25 at 11:33 AM, the surveyor observed Resident #5, in a wheelchair, in the day room on the 2nd floor. The resident was noted with their head down and eyes closed. On 2/19/25 at 02:43 PM, the surveyor observed Resident #5, out of bed, in a wheelchair in the bedroom, yelling out for help. On 02/19/25 at 02:46 PM, the surveyor observed Resident #5, in a wheelchair in the 3rd floor dining room yelling help continually. A review of Resident #5's admission record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; cerebral infarction (stroke), major depressive disorder (depression), and type 2 diabetes (high blood sugar). A review of the Medication Administration Record (MAR) for January 2025 revealed documentation under behavior monitoring (screaming continuously) that indicated that screaming occured multiple times daily on all shifts during the look back period of 1/18/25 - 1/24/25 except for 1/19/25. A review of the comprehensive significant change MDS, dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating moderate cognitive impairment. Further review revealed, Section E of the MDS, question E022C, was coded 0, indicating no behavior symptoms exhibited during the look back period of 7 days. On 2/21/25 at 10:44 AM, the surveyor interviewed the MDS Coordinator, who when asked about the behavior coding, stated Resident #5 was not yelling during the lookback period. After reviewing the MAR, she stated she was going to modify the MDS to correct it. 2. On 2/14/25 at 10:49 AM, the surveyor observed Resident #43 in bed. The resident verbalized current smoking status and stated that the facility holds the cigarettes and lighter. On 2/18/25 at 2:00 PM, the surveyor observed Resident #43 in a wheelchair, getting onto the elevator on 2nd floor. The resident stated they were going out to smoke after getting cigarettes and lighter from the receptionist. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #43's admission record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; orthopedic aftercare following surgical amputation (removal of a limb), type 2 diabetes (high blood sugar), and major depressive disorder (depression) A review of the individual comprehensive care plan (ICCP) revealed a focus area of independent smoking, dated 8/14/22, with interventions including resident will follow the smoking policy, resident will be free of injury associated with smoking, complete smoking assessment upon admission, quarterly and as needed, and education to be provided to the resident regarding health complications related to smoking. A review of smoking evaluations completed 2/22/24, 5/21/24, 7/26/24, and 10/24/24 all indicate Resident #43 was safe to smoke unsupervised. A review of the annual comprehensive MDS dated [DATE], revealed the resident had a BIMS score of 15 out of 15, indicating intact cognition. Further review revealed Section J, question J1300, was coded 0, indicating no current tobacco use. On 2/21/25 at 10:44 AM, the surveyor interviewed the MDS Coordinator, who stated that Resident #43 was a smoker, the smoking assessment was overlooked when the MDS was completed. She further stated that she modified the MDS to correct it. 3. On 2/14/25 at 11:26 AM, the surveyor observed Resident #53 in bed. The resident stated, I'm in a pile of poop. The call bell was noted to be on and was answered by a certified nurse assistant (CNA) in about 3 minutes. On 2/18/25 at 01:06 PM, the surveyor observed Resident #53 in a wheelchair in the hallway. The resident stated they had therapy today and it was good. The resident was dressed and appeared neat and clean. On 2/19/25 at 9:47 AM, the surveyor observed Resident #53 lying in bed. The resident stated they were tired today and further stated that the staff helps them when needed within a reasonable time. On 2/20/25 at 9:44 AM, the surveyor observed Resident #53 lying in bed with their eyes closed, no odors noted. A review of Resident #53's admission record reflected the resident had diagnoses that included but were not limited to; surgical aftercare following surgery on the genitourinary system (kidneys, bladder, etc), major depressive disorder (depression), and epilepsy (seizures). A review of the IDCP (interdisciplinary care plan) summary dated 1/7/25, reflected the resident required partial/moderate assistance with toileting hygiene and personal hygiene and supervision or touching assistance with toilet transfer. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the ICCP revealed a focus area of ADL (activities of daily living) self care performance deficit related to osteoporosis (loss of bone density resulting in weaker bones) and history of fractures (broken bones) dated 8/12/23. Interventions included praise all efforts at self care, encourage participation to the fullest extent possible with each interaction, and encourage to use call bell for assistance. The ICCP also included a focus area of bladder incontinence related to the disease process dated 8/12/23 which included interventions of staff to check frequently for incontinence and for staff to wash, rinse, and dry perineum. A review of the quarterly MDS dated [DATE], revealed the resident had a BIMS of 15 out of 15, indicating intact cognition. Further review revealed Section GG, questions GG0130B, GG130I, GG0170F all coded as independent. On 2/21/25 at 10:44 AM, the surveyor interviewed the MDS Coordinator, who stated section GG is a little different, and that when she interviewed the CNA and the staff, they indicated the resident was independent. When surveyor showed her the IDCP Summary dated 1/7/25 and the task sheet for toileting hygiene which had many codes of 4, indicating supervision or touching assistance and a few codes of 3, indicating partial or moderate assistance needed during the 7 day look back period, she stated that she had seen that, but her interviews said the resident was independent. Review of MDS Policy Reviewed 10/2024 included: Policy: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS (Center for Medicare and Medicaid) regulations and requirements. Purpose: 1. To outline the procedure of identifying and addressing residents' strengths and needs through the RAI (Resident Assessment Instrument) process 2. To provide information on the resident's condition 3. To facilitate development of a comprehensive care plan. 4. To ensure care delivery that enhances the resident's quality of life. 5. To help achieve the highest and practical level of self sufficiency. Procedure: MDS Department 1. Schedules Minimum Data Set (MDS) and Care Plan Meeting in accordance to existing regulations governing RAI process. 3. Assures the completeness and accuracy of the information in the MDS. 5. Coordinates, signs and certifies the completion of the MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Submits MDS data in required format to CMS. 8. Reviews and corrects errors with the MDS Coordinator. N.J.A.C 8:39-11.1

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 48964 Complaint #: NJ 00179151 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face-to-face visits and wrote progress notes at least once every thirty days from April 2024 through January 2025 for 1 of 34 residents, (Resident #5) reviewed for physician visits. This deficient practice was evidenced by the following: On 2/19/25 at 11:33 AM, the surveyor observed Resident #5 in a wheelchair in the day room on the 2nd floor. The resident was noted with their head down and eyes closed. A review of Resident #5's admission record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; cerebral infarction (stroke), major depressive disorder (depression), and type 2 diabetes (high blood sugar). A review of the comprehensive significant change Minimum Data Set (MDS), an assessment tool dated 1/24/25, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating moderate cognitive impairment. A review of the electronic medical record (EMR) revealed a progress note from Resident #5's attending physician on 4/15/24. No further attending physician notes were found in the EMR by the surveyor. On 2/25/25 at 02:08 PM, the Director of Nursing (DON) provided physician visits for Resident #5 handwritten on paper dated 8/10/24, 9/29/24, 11/23/24. When the DON was asked if this was all the visits, he stated yes. When asked what the requirement was, he stated the regulation is every 30 days for long term care. On 2/25/25 at 02:22 PM, the Licensed Nursing Home Administrator (LNHA) provided additional physician visits for Resident #5 handwritten on paper dated 7/11/24, 12/15/24, and 2/16/25. Addition review of the EMR and handwritten physician notes did not reveal a progress note from the attending physician for May 2024, June 2024, October 2024, and January 2025. A review of facility provided policy Physician visits included: Policy: It is the policy and procedure of this facility that the Attending Physician must make visits in accordance with applicable state and federal regulations. Procedure: (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admissions, and then at least every sixty (60) days thereafter. NJAC 8:39-23.2 (d) reveals: A physician or advanced practice nurse shall visit each resident at least every 30 days unless the medical record contains an explicit justification for not doing so. Following the initial visit, alternate 30-day visits may be delegated by a physician to a New Jersey licensed physician assistant, in accordance with facility policies. N.J.A.C, 8:39-23.2 (d)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48964 Complaint #: NJ 00179151 Based on observations, interviews, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure adequate indication for a resident with behaviors prior to the administration of an antipsychotic medication (Seroquel). This deficient practice was identified for 1 of 6 residents (Resident #5) reviewed for unnecessary medications and was evidenced by the following: On 2/14/25 at 12:13 PM, the surveyor observed Resident #5 in a wheelchair with raised footrests in the 3rd floor dining room ready for lunch. On 2/19/25 at 9:55 AM, the surveyor observed Resident #5 in a wheelchair in the day room on the 2nd floor. The resident was sitting with their head down and eyes closed. On 2/19/25 at 10:28 AM, the surveyor observed Resident #5 in a wheelchair in the day room on the 2nd floor. The resident was sitting with their head down and eyes closed. On 2/19/25 at 11:33 AM, the surveyor observed Resident #5 in a wheelchair in the day room on the 2nd floor. The resident was sitting with their head down and eyes closed. On 2/19/25 at 12:28 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated regarding Resident #5 and the behavior of screaming, that they (the resident) are out of bed all day. They used to refuse to get out of bed. We have really encouraged them to be out of bed. We encourage activities. If the 2nd floor can't keep them occupied, then they go to the third floor. The team has spent much time on this and this is a big dilemma for the team. This resident is definitely a challenge. I don't have a very good answer. He further stated the team has put a lot of thought into this, it comes up in meetings all the time. On 2/19/25 at 02:43 PM, the surveyor observed Resident #5 in a wheelchair in the bedroom, yelling out for help. On 02/19/25 at 02:46 PM, the surveyor observed Resident #5 in a wheelchair in 3rd floor dining room yelling help continually. On 2/20/25 at 9:39 AM, the surveyor observed Resident #5 in the 2nd floor day room, sitting quietly in a wheelchair, an I love [NAME] trivia was going on in the activity room. On 2/20/25 at 12:19 PM, the surveyor observed Resident #5 in 2nd floor dayroom, sitting quietly in a wheelchair. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #5's admission record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; cerebral infarction (stroke), major depressive disorder (depression), and type 2 diabetes (high blood sugar). A review of the physician's orders revealed an order for Seroquel 50 mg at bedtime for mood disorder dated 12/19/24. An additional order, dated 1/6/25, was noted for Seroquel 50 mg at bedtime for schizophrenia. A review of the psychiatric progress note dated 12/19/24, revealed a recommendation for Seroquel for mood disorder. The following was also recommended on 12/19/24: Always consider supportive and individualized non-pharmacologic interventions, inc: redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement. Treat medical issues including pain, UTI, constipation, infection, physical issues, positioning, toileting. Encourage participation in activities, social engagement as tolerated and as possible for psychosocial wellbeing. A review of the Medication Administration Record (MAR) for January and February 2025 revealed documentation under behavior monitoring (screaming continuously) multiple times daily and throughout all shifts. A review of the comprehensive significant change Minimum Data Set (MDS), an assessment tool, dated 1/24/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating moderate cognitive impairment. A further review revealed Section N indicated the use of an antipsychotic and an appropriate indication for the use. A review of the individual comprehensive care plan (ICCP) revealed focus areas of use of psych medication for diagnosis of mood disorder and behavior problem of screaming and yelling with interventions including to inform resident and family members of indication for medication and side effects, administer medications as ordered, intervene as necessary to protect the rights and safety of others, and to offer gentle reminders. Further review of the medical records did not reveal a diagnosis of schizophrenia. On 2/25/25 at 10:30 AM, the surveyor spoke with the certified consultant pharmacist who stated that in January she had noted to clarify diagnosis for the use of Seroquel as mood disorder is not an approved diagnosis for Seroquel. Review of facility provided policy 1.0 Psychotropic Drug Use, revised 10/1/24 which included: Policy: When clinically appropriate, the facility staff will initiate non-medication approaches to care to assist in the treatment of alteration of the customer's behavior as behavioral redirection, environmental alterations, etc. Procedure: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Each customer receiving an antipsychotic medication for organic mental disorders (now referred to as dementia, Alzheimer's disease, or other cognitive disorders by DSM-IV) is observed for: 1. Episodes of the behavioral symptoms being treated and/or manifestations of the disordered thought process. 2. Adverse reactions and side effects 3. Appropriateness of drug selection and dosage C. Antipsychotics are not to be used if one (1) or more of the following is/are the only indication: 5. Anxiety 6. Depression w/o psychotic features 13. Agitated behaviors which do not represent a danger to the customer or others F. Each customer on an antipsychotic for organic mental syndrome with agitation or psychosis has a plan of action the includes dosage reduction and behavioral interventions unless clinically contraindicated as defined below. I. When psychotropic drugs are used outside the recommended dosage ranges of the federal interpretive guidelines, the physician or nursing staff (per physician explanation) documents the reason (i.e. maintenance or improvement of customer's functional status) for the higher dose and the absence of adverse drug reactions (ADRs). On 2/25/25 at 9:35 AM, the survey team met with the Director of Nursing and the Licensed Nursing Home Administrator (LNHA). The LNHA stated that the neurologist started the resident on the Seroquel, not us (the facility). Reference: A review of the manufacturer's specifications for Seroquel (quetiapine) under the black box warning reflected Warning: Increased Mortality In Elderly Patient with dementia related psychosis and suicidal thoughts and behaviors. Section 1 Indications and Usage included schizophrenia, bipolar disorder, and special considerations in treating pediatric schizophrenia and bipolar 1 disorder. Section 5.1 included, Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death . (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section 5.3 Cerebrovascular Adverse Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis . Cerebrovascular Adverse Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis. N.J.A.C. 8:39-27.1 (a)

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	315370	A. Building B. Wing	02/25/2025

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 Based on interview and review of pertinent facility documentation, the facility failed to a.) ensure the required committee members, the Infection Preventionist (IP), was present for one of seven Quality Assurance and Performance Improvement (QAPI) meetings and b.) review of Antibiotic Stewardship (AS). This deficient practice was evidenced by the following: A review of the facility provided QAPI Meeting 3rd Quarter dated 10/17/24, did not reveal the Infection Preventionist (IP) signed in. A review of the facility provided QAPI Meeting 4rd Quarter dated 1/16/24, revealed the Infection Preventionist (IP) signed in. On 02/25/25 at 1:21 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) to review the facility's QAPI. The LNHA reviewed the QAPI sign in sheets dated 10/17/24 and verified he did not see where the IP had signed in. The surveyor asked the LNHA to show the AS Information that was reviewed with the committee. The LNHA reviewed the QAPI binder and was unable to locate the AS data, he acknowledged that the other departments information was in the binder. During that meeting, the LNHA verified the IP attended the 1/16/25 meeting, but the LNHA was unable to show the AS information that was reviewed. He stated that usually the AS was printed and reviewed at the meeting. He then added that the information could be pulled from the electronic medical record system for tracking. The surveyor made the LNHA aware of the AS binders tracking from July 2024 to present were printedon 2/17/25 by the [NAME] President of Nursing. A review of the facility's policy, Antibiotic Stewardship reviewed 9/3/24 revealed. Policy: It is the policy of [NAME] Post Acute Care to implement an Antibiotic Stewardship program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infection, at the same time reducing the possible adverse events associated with antibiotic use. The Core Elements of stewardship . tracking measures, reporting data .about antibiotic resistance and opportunities for improvement .5. Tracking, a. IP will be responsible for infection surveillance and MDRO (multi-drug resistant organisms) b. IP will collect and review data. 6. Reporting: a. IP and/or other members of the ASP team will review and report findings to facility staff and to QA committee. A review of the facility's policy, Quality Assurance and Performance Improvement reviewed 5/2024, revealed Policy: Our company is committed to developing, implementing, and maintaining an effective, comprehensive, date-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. g. iii. Several key options for identifying date collect, analyze, and apply the QAPI process are the following examples; .15. Antibiotics, 17. Infections rates, 18. Infection Control Compliance. NJAC 8:39-33.1(a)(b)

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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. 41858 Based on observation, interview, and a review of facility documentation, it was determined that the facility failed to ensure laundry staff had the proper personal protection equipment (PPE) necessary to handle linens to prevent the spread of infection. This deficient practice was evidenced by the following: On 02/20/25 at 2:34 PM, the surveyor toured the laundry room with the Director of Nursing (DON), the Chief Nursing Officer (CNO) and the Director of Housekeeping (DH). The surveyor observed 3 dryers in use and clean linens, which included patient johnny coats (hospital gowns), folded on a table. The tour continued into to the washing machine side. The surveyor observed empty linen carts. The surveyor did not observe any PPE. The surveyor asked the DH the process for sorting dirty laundry. He stated staff sorted the laundry by wearing gloves and a patient gown. He explained staff came in from the dryer side with the gown. He took the surveyor back to the dryer side and showed the surveyor the short-sleeved hospital gown. He stated staff wore the gown and then put it in the laundry when they were done with it. The surveyor asked if that was acceptable protection? The DH responded yes but the CNO responded, no it is not, it should be a PPE gown. The CNO verified that the staff should be wearing a long-sleeved disposable PPE gown for protection. The DON, CNO, and DH all acknowledged there were no PPE gowns available on the dryer side or the washer side. On 2/21/25 at 1:09 PM, the surveyor made the Licensed Nursing Home Administrator, the DON, and the Administrator in Training aware of the above findings in the presence of the survey team. A review of the facility's policy Linen Handling for Nursing Personnel revised 9/20/24 revealed Policy: To ensure the safety of residents and staff the facility will ensure proper handling of linen. A review of the facility's undated policy Personnel Linen Handling for Residents on Isolation revealed Policy: To ensure the safety of residents and staff the facility will ensure proper handling of linen for residents on Isolation. Objectives: To prevent the spread of communicable and infectious diseases through laundry and linen handling .Procedures: 6. The laundry staff personnel will perform hand hygiene the donn (put on) PPE (personal protective equipment) (gown, gloves) to handle contaminated linen. NJAC 8:36-19.4 (a) (b) (c)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 Based on interviews and review of facility documents, it was determined that the facility failed to maintain an ongoing review for their Antibiotic Stewardship (AS) Program. This deficient practice was evidenced by the following: On 2/20/25 at 1:54 PM, the surveyor interviewed the Chief Nursing Officer (CNO), who stated she was the acting Infection Preventionist (IP) since the last one had recently resigned. She stated she attended the quarterly Quality Assurance & Performance Improvement (QAPI) meeting and reports on infection control. The surveyor requested to review the AS. The CNO requested the Director of Nursing (DON) to join the meeting. At 2:19 PM, the DON joined the interview with 2 Antibiotic Stewardship binders, 2024 and 2025. The CNO stated the facility uses McGeer's Criteria (a set of guidelines used to define and diagnose healthcare associated infections (HIAs) in long-term care Facilities (LTCFs). The surveyor asked to be shown unsampled Resident #15's antibiotic tracking for January 2025. The DON and the CNO reviewed the 2025 binder and acknowledged the resident was not in book .The surveyor asked how are you tracking and ensuring staff are following McGreers, making sure proper tests were done before antibiotics were started, such as an xray or urine culture? The DON and CNO looked in the 2024 binder for December's AS binder and was unable to provide the evidence. The CNO stated that antibiotic monitoring was important because the main purpose was to prevent incorrect use of antibiotic use and resistance. Neither binder was given to the surveyor at that time for review at that time. On 2/21/25 at 10:38 AM, during a follow up meeting with the surveyor, the DON and the CNO, Resident #15's McGreers Criteria check list, dated 1/19/25, was reviewed which revealed the following under the Pneumonia box, All three criteria must be present. -An empty box next to Interpretation of a chest radiograph as demonstrating pneumonia or the presence of a new infiltrate. -An empty box next to At least one of the following respiratory sub-criteria. A check in the circle next to New or increased cough -An empty box next to At least one of the constitution Criteria No circles were checked -Medication/Antibiotics: Amox (amoxicillin) for URI (upper respiratory infection) X-ray neg (negative). -A check in No for Hospital Acquired Infection - A check in Yes for Met Surveillance Criteria -A check in No for reportable to DOH (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Signed by Licensed Practical Nurse. At that time, the CNO stated on 1/19/25 cold symptoms started for Resident #15 and the doctor ordered the antibiotic and ordered an xray. She stated the nurse should have called the doctor and let them know that the resident did not meet the criteria for starting the antibiotic. She further explained that it would be discussed with the medical director if the doctor still wanted to start the antibiotic. She stated that there should be a progress note documenting the time out of antibiotics and what was done. The CNO verified a progress note was not done. On 2/25/25 at 12:48 PM, a review of the facility provided antibiotic stewardship binders for 2024 and 2025. The surveyor reviewed the book which revealed from July 2024 to present, all the data in book for each month was printed on 2/17/25 by the CNO, which was after survey started. On 2/25/25 at 1:05 PM, the surveyor interviewed the DON, who acknowledged the IP surveillance binder had not being updated. On 02/25/25 at 1:21 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) to review the facility's Quality Assurance and Performance Improvement (QAPI). The LNHA reviewed the QAPI sign in sheets for 10/17/24 and verified he did not see where the IP had signed in. The surveyor asked the LNHA to show the AS Information that was reviewed with the committee. The LNHA reviewed the QAPI binder and was unable to locate the AS data, he acknowledged that the other departments information was in the binder. During that meeting, the LNHA verified the IP attended the 1/16/25 meeting, but the LNHA was unable to show the AS information that was reviewed. He stated that usually the AS was printed and reviewed at the meeting. He then added the information could be pulled from the electronic medical record system for tracking. The surveyor made the LNHA aware of the AS binders tracking from July 2024 to present were printed 2/17/25 by the CNO. On 2/21/25 at 1:09 PM, the surveyor made the LNHA, the DON, and the Administrator in Training aware of the above findings in the presence of the survey team. A review of the facility's policy, Antibiotic Stewardship reviewed 9/3/24 revealed. Policy: It is the policy of [NAME] Post Acute Care to implement an Antibiotic Stewardship program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infection, at the same time reducing the possible adverse events associated with antibiotic use. The Core Elements of stewardship .at a minimum, include these basic elements: Leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data .about antibiotic resistance and opportunities for improvement .5. Tracking, a. IP will be responsible for infection surveillance and MDRO (multi-drug resistant organisms) b. IP will collect and review data. 6. Reporting: a. IP and/or other members of the ASP team will review and report findings to facility staff and to QA committee. NJAC 8:39-19.4 (d)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 41858 Based on interviews and review of pertinent facility documents, it was determined that the facility failed to have a designated Infection Preventionist (IP) dedicated solely to the infection prevention and control program (IPCP) and physically worked onsite in the facility. This deficient practice was evidenced by the following: Reference: According to the NJ Executive Directive 21-012 (revised 12/22/22) included The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPCP by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits. According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022, Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating infectious diseases through an effective infection prevention and control program. IP specialized training is required and available. On 2/14/25 at 10:13 AM, during entrance conference, the Licensed Nursing Home Administrator (LNHA) stated that the last IP resigned approximately 2 weeks ago. He stated that facility had an interim Regional Infection Control nurse. A review of the facility provided timeline of IP's revealed the following: IP #1 date of hire (DOH) was 10/16/23 to termination 2/23/24 IP #2 DOH 6/3/24 to termination 7/19/24 IP #3 DOH 8/19/24 to termination 10/11/24 IP #4 DOH 10/29/24 to termination 1/24/25 On 2/20/25 at 1:54 PM, the surveyor interviewed the Chief Nursing Officer (CNO), who stated she was the acting IP, since the last one had recently resigned. She stated she usually came to building 3 times a week for usually 8 hours each time and was in constant communication with the building. She acknowledged that IP's sole responsibility should be full time. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She reviewed the above-mentioned IP timeline and acknowledged the multiple lapses the facility did not have a designated IP, with the longest lapse of 2/24/24 to 6/2/24. She added she was the covering IP during those times but was unable to show accountability for being in the building as the IP during those lapses. The CNO stated, I know we are not in compliance with IP. On 2/21/25 at 1:09 PM, during a meeting with the survey team, the surveyor made the LNHA, the DON, and the Administrator in Training aware of the above findings. A review of the facility's Infection Preventionist Job Description revealed Job Summary: the infection preventionist is responsible for the facility infection prevention and control program (IPCP0, which is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Essential Function: .Maintain current knowledge of federal state, and local regulations and ensure that the facility leader are informed of appropriate issues. Experience: Be qualified by education, training, experience, or certification in infection control. Must work at least part-time at the facility. NJAC 8:39-19.1(b)