STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315372	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White House Healthcare and Rehabilitation Center	560 Berkeley Avenue Orange, NJ 07050

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, record review, and policy review, the facility failed to ensure the kitchen was maintained in a sanitary manner, putting 147 residents who received meals from the kitchen (12 residents received nutrition via feeding tubes) out of 159 total residents at potential risk for foodborne illness. Specifically, failures included: improper freezer temperatures, a lack of functioning thermometers in the refrigerators/freezers, improper concentration of sanitizer solutions, uncleanable surfaces due to rust, not labeling foods removed from original packaging with the identification of the contents, unclean microwaves in the pantries, improperly maintained equipment such as refrigerators in the nursing pantries, an ice machine was unclean on the inside box where ice was made and stored, and tray line food holding temperatures were outside of safe temperature ranges.Findings include: Review of the facility's undated Food Receiving and Storage revealed, Foods shall be received and stored in a manner that complies with safe food handling practices . Danger zone means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow rapid growth of pathogenic microorganisms that can cause foodborne illness . Food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times. When food is delivered to the facility it is inspected for safe transport and quality before being accepted . Refrigerated/frozen storage . foods are stored at or below 41 F, unless otherwise specified by law . Refrigerated foods are dated and monitored so they are discarded . Frozen foods are maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing . Foods and Snacks Kept on Nursing Units - All food items to be kept at or below 41 F are placed in the refrigerator located at the nurse's station and dated . All foods belonging to residents are labeled with the resident's name, the item and the 'use by' date . Refrigerators must have working thermometers and are monitored for temperature according to state- specific guidelines . Review of the undated Utensil Washing Instructions for San-IT sanitizer revealed, sanitize by: immersing utensil for (2) minutes in solution of 1 oz. of San-It sanitizer per 4 gallons of water, to achieve 200 PPM of quat [quaternary ammonia]. No upper limit for concentration in PPM was noted on the instructions. 1. The initial kitchen tour was conducted on 09/02/25 from 11:03 AM through 12:03 PM with the Dietary Manager (DM). The following concerns were noted: a. In the three-sink pot washing area of the dairy kitchen, scrubbies for washing pots and pans were stored directly on top of the grease trap surface which was completely rusted. b. The temperature of the chest freezer in a room off the dairy kitchen had individual serving sized packages of ice cream. The internal temperature of the freezer was 10 degrees F. The ice cream containers were soft to touch, verified by the DM. c. The bottom shelf of the stainless-steel cart in the dairy kitchen was covered in rust. The DM stated the staff primarily used the cart to store racks for the hot food cart, which were in place on the rusted surface. d. The internal temperature of the cook's reach in refrigerator in the dairy kitchen was 43 degrees F. Sandwiches, soda, and fruit salad were stored within. e. In the dish room of the meat kitchen, there was a section of baseboard of approximately two feet long that had pulled away from the wall and was lying on the floor with accumulated dust/dirt on top of it.f. The first sink (used for holding the wash solution) of the three-sink pot washing system in the meat kitchen had two (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	metal bumps sticking up approximately one inch above the surface of the bottom of the sink and the seams of the interior edges of the sink (where the walls and bottom of the sink connected) had been repaired with a bumpy metal material. These surfaces contained rust and black residue. The DM verified the rust and black residue could not be removed when cleaning the sink. g. The top horizontal surface of the grease trap in the dishwashing room in the meat kitchen was rusted. Scrubbies used for washing dishes/pans were stored directly on the rusted surface. h. The reach in refrigerator in the meat kitchen contained multiple bags of frozen meats that had been removed from the original packaging (boxes). The bags of meat were dated with a use by date; however, the identity of the frozen meats was not recorded on the bags. There was a bag with meat patties; however, the type of meat was not documented and could not be determined. The DM stated he thought it was a bag of veal patties. There was a bag of what appeared to be unidentifiable meat nuggets. The DM stated the cook told him it was chicken. i. The shelf under the steam table in the meat kitchen was completely rusted. Nothing was stored on the shelf at the time.j. A bucket of wiping rag sanitizer solution in use in the meat kitchen was tested for concentration of the sanitizer. The DM used a quaternary ammonia test strip and the concentration read 100 parts per million (PPM). The DM stated he wanted it to be at a concentration of at least 150 PPM and preferably 200 PPM to effectively sanitize kitchen surfaces. The DM stated he was not sure what the recommended PPM should be for this specific product. The DM stated the bucket was mixed that morning at around 9:00 AM. The DM showed the surveyor the quaternary ammonia-based product San It in a one-gallon jug. The DM stated the sanitizer came from a local vendor. The DM stated he would get manufacturer information that documented the desired concentration in PPM. k. Most of the boxes of frozen meat (at least 20) stored in the walk-in freezer in the meat kitchen had deteriorated and collapsed, were crushed, and were no longer intact. There were multiple rips, tears, and holes in the cardboard boxes and the boxes were melded together with ice. The DM stated this was a result of the defrost cycle and occurred when the foods thawed during defrosting. The DM stated he had talked to the maintenance staff about this and they told him the freezer was working properly. The thermometer read 5 degrees F. Foods were frozen to touch at this time.l. The thermometer in the walk-in refrigerator in the meat kitchen read 12 degrees F. The DM stated the thermometer was not working and verified refrigerator temperatures should be around 40 degrees F. m. A chest freezer was located in the hallway into the kitchen area. There were two bags of meat removed from the original boxes. One bag contained breaded patties, and the DM stated it was breaded fish. There was no label to identify the contents. The second bag contained nuggets, and the DM stated it was fish nuggets; however, there was no label identifying the contents. 2. A tour of four nursing pantries located on One South, One North, Two South, and Two North was made with the DM on 09/02/25 from 12:08 PM - 12:22 PM. Each pantry contained refrigerators, microwaves, and food storage areas. Concerns were found in three of the four pantries:a. Observation in the One South Pantry refrigerator revealed the internal thermometer read 50 degrees F. Snacks and beverages were contained in the refrigerator. The DM verified the temperature should be 41 degrees or less and that the door could not be completely closed due to the seal that was no longer adhered to the door. The entire length of the rubber seal at the top of the refrigerator door was no longer affixed to the top of the door creating a gap. b. Observation of the Two South Pantry refrigerator revealed the temperature of one of the two refrigerators in the room was 50 degrees F. The DM stated the thermometer might not have been working properly. There was a freezer compartment above the refrigerator that contained popsicles. There was excessive ice built up several inches thick on the interior. The log for recording temperatures did not include recording the freezer temperatures; only refrigerator temperatures were recorded. The microwave oven interior surface contained areas of an unknown black residue. The DM stated it did not look good.c. Observation in the Two North Pantry revealed the microwave contained grey residue on the interior surface and a large brown spill covered the bottom of the microwave floor. The DM verified it was not clean. In the refrigerator there as a package of food that the DM stated was a resident's food container; it had no label with the resident's (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	name/room or expiration date. There was a second container with a resident's food with a name and date of 07/26/25. The DM stated it should have been discarded by nursing staff after three days. 3. A follow up observation of the kitchen and pantries was conducted on 09/04/25 from 9:54 AM through 11:15 AM. a. Dietary Aide (DA)1 was at the entry to the walk-in freezer in the meat kitchen. The freezer door was open, and there was a 55-gallon garbage can near the door that was filled with deteriorated boxes of meat that were now soggy and wet. DA1 stated he was throwing away the boxes that were busted. The temperature of the walk-in freezer was 40 degrees. The DM stated the freezer went up to 20 degrees on defrost, it dripped, and then the boxes got wet. b. The top surface of the booster continued to be rusted. The DM verified that was where scrubbies for washing dishes/pots were often stored. The DM verified that rusted surface was not a cleanable surface. c. A bucket of wiping rag sanitizer solution, mixed and in use, was tested for concentration using a test strip. The concentration was greater than the top threshold of the test strip and was over 400 PPM. The DM stated he was not sure if the concentration of sanitizer was too high as he did not have the manufacturer's information. d. In the kitchen dish, the section of baseboard of approximately two feet long that had pulled away from the wall and was lying on the floor with accumulated dust/dirt on top of it, remained in place. The DM stated he had not noticed this previously but would report it to the maintenance department.e. The first sink of the three-sink pot washing system in the meat kitchen continued to have two metal bumps sticking up above the surface of the bottom of the sink and the seams of the interior edges of the sink continued to have a bumpy metal material. These surfaces contained rust and black residue. The DM stated this pot washing sink was used for washing pots/pans the dinner meal each day and agreed the surface was not cleanable due to the rust and black substance. f. The ice machine located in the basement in the employee lounge, used by the dietary staff had gray/brown residue on the wall of the interior surface that was directly above the ice in the bin. The DM took a paper towel and wiped the substance off, verifying the surface was not clean and the ice could be contaminated. The Brown/grey residue was observed on the paper towel. The DM stated the Maintenance department was responsible for cleaning the ice machine. g. An observation of tray line holding temperature for lunch was conducted (at 10:36 AM). Concerns were noted with three foods: The mashed potatoes were 127 degrees F; the coleslaw was 52 degrees F, and the three-bean salad was 52 degrees F. DA2 measured the temperatures and verified what they were stating the cold foods should be cold enough. DA2 stated the cold foods should be at 30 degrees F and the hot foods should be at 160 degrees F. The pan of mashed potatoes were in a steam table pan on top of another steam table pan that was in a bath of water on the stove. There was no direct means to keep the potatoes hot. h. Inspection of the microwaves and refrigerators in Two South Pantry and Two North Pantry revealed new microwaves had been purchased. A new refrigerator had also been purchased for the One South Pantry. i. On 09/04/25 at 11:08 AM, upon return from the nursing pantries to the kitchen, the tray line meal service was being conducted with residents' plates being served up and loaded into the carts. The DM stated the hot food temperatures should be 165 degrees on the tray line and verified cold food temperatures should be 41 degrees or less. The DM measured the temperature of the mashed potatoes at 11:15 AM and they were 132 degrees F. The DM verified they were not hot enough. The DM measured the temperature of the coleslaw and three bean salad and they were both 50 degrees F, which he stated was not cold enough. 4. During an interview on 09/04/25 at 8:43 AM, Administrator 1 stated they had fixed everything identified during the initial kitchen tour and had purchased a new refrigerator and microwaves. Administrator 1 stated he was not aware of the issue with the deteriorating boxes in the meat freezer. During an interview on 09/04/25 at 4:37 PM, Administrator 1 stated they did not have records for work orders and repairs in the kitchen which had been requested. He stated the department heads went over everything in morning meetings and some things got fixed and did not get documented. The Administrator stated there were maintenance books that staff could document issues needing repair. During an interview on 09/05/25 at 11:03 AM, the Maintenance Director stated there was a maintenance communication book used to (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	alert him of needed repairs. He stated staff also called him and paged him if repairs were needed. The Maintenance Director stated there was no formal system for documenting issues and repairs. The Maintenance Director stated maintenance staff also did rounds and fixed things as they saw them. The Maintenance Directors stated he was aware of the base board that had pulled away from the wall in the dish room. The Maintenance Directors stated a freezer had been replaced. The Maintenance Director stated the walk-in freezer was working perfectly. He stated the defrost cycle created condensation and that was why water dripped. The Maintenance Director stated he was aware of the booster surfaces being rusted. The Maintenance Director stated the ice machines were cleaned every month, which involved dumping the ice, shutting off the ice machine, and cleaning it. The Maintenance Director stated the ice machine had just been cleaned on Monday and stated he had not noticed any residue on the interior walls. The Maintenance Director stated the maintenance staff serviced the dietary stainless-steel carts; however, was not aware of the rusted bottom shelf. During an interview on 09/05/25 at 11:42 AM, the Registered Dietitian (RD) stated she did not have oversight responsibility in the kitchen and did not routinely do kitchen sanitation inspections. The RD stated she was not aware of the rusted surfaces in the kitchen. The RD stated sanitizer solutions should be mixed according to the appropriate concentration. The RD stated staff should monitor refrigerator and freezer temperatures. The RD verified there were no labels on the bags on meat in the reach in refrigerator on 09/02/24 specifying what was in the bag. The RD stated hot food holding temperatures should be 165 degrees F and cold food should be under 40 degrees F. NJAC 8:39-17.2(g)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to allow one out of 33 sampled residents (Resident (R)15) to exercise her right to go to the day room to attend activities. R15 was not allowed to co-mingle with other residents in the activity room after she sustained an infection. R15 was currently on enhanced barrier precautions which did not dictate that the resident could not leave her room and attend activities in the day room or socialize there. This created the potential for R15 to experience isolation and the inability to enjoy previous activities in which she had participated.Findings include: Review of the facility's Resident Rights Policy policy, dated 06/2025, revealed, . All residents in this facility have rights guaranteed to them under Federal and State law, and by this facility's personnel . The residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . To meet with members of and take part in activities of social, commercial, religious and community groups . Review of the facility's Enhanced Barrier Precautions policy, dated 08/2022, revealed, . Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents . The use of EBPs does not impose limitations on group activities or room restrictions for residents . Review of R15's undated admission Record, located in the Electronic Medical Record (EMR) under the Profile tab, revealed R15 was admitted to the facility on [DATE]. Diagnoses included dementia. Review of R15's most current Activity Assessment, dated 05/27/23 and located in the EMR under the Assessment tab, revealed R15 participated in self-directed activities and group activities. R15's favorite activities included, [R15] enjoys going to church, listening to gospel & oldies music, and looking at magazines. Review of R15's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/08/24 and located in the IQIES portal, revealed R15 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of three out of 15. Review of R15's Infection Note, dated 02/04/25 and located in the EMR under the Progress Notes tab, revealed R15 tested positive for candida auris on this date and contact isolation precautions were initiated. Review of R15's Orders tab in the EMR, located under the Resident tab, revealed on 05/29/25 R15 was placed on EBP and contact precautions were discontinued. Review of R15's Care Plan, dated 03/06/25 and located in the EMR under the Care Plan tab, revealed a focus area of [R15] needs individualized activity visits to provide physical, social, mental, and sensory stimulation. [R15] needs to be kept within specific areas during specific times due to diagnosis of C. Auris. The goal was, [R15] will respond to 1:1 [one to one] activity visits evidenced by conversing, smiling, and participating with staff Xs [for] 90 days. Interventions were, Provide 1:1 room visits consisting of auditory, olfactory, and tactile stimulation for peer interaction and socialization. Label resident's name on zip lock bag containing magazines and tactile materials. Keep zip lock bag in specific area away from other residents. Wear gloves during 1:1 visits when providing tactile stimulation due to resident's dx. [diagnosis] of C. Auris. Review of quarterly Recreation Progress Notes prior to R15 becoming infected with candida auris in February 2025, revealed she enjoyed socializing with other residents and staff as well as participating in group activities as follows: Review of a Recreation Progress Note, dated 09/05/24 and located in the EMR under the Progress Notes tab, revealed, [R15] . continues to enjoy strolling down two north hallway conversing with staff and peers, and participating in light exercise, sing-along, music events and reminiscing activities. Rec [recreation] staff will continue to encourage and invite to small group activities for socialization . Review of a Recreation Progress Note, dated 12/05/24 and located in the EMR under the Progress Notes tab, revealed, . She continues to enjoy strolling down two north hallway conversing with staff and peers and participating in light exercise, sing-along, music events and reminiscing activities. Rec. [recreation] staff will continue to encourage and invite to small group (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities for socialization . Review of R15's activity participation 1:1 Room Visits record, from 08/01/25 through 09/04/25, revealed R15 received 1:1 visits only and did not participate in any group activities. Observations during the survey revealed R15 was lying in bed in her room each time she was checked: On 09/02/25 at 4:22 PM, R15 was lying in bed on her back, under the covers, awake with her eyes open. The signage attached to the doorway of her room indicated she was on enhanced barrier precautions. On 09/03/25 at 10:11 AM, R15 was lying in bed under the covers, with her eyes closed. On 09/03/25 at 3:14 PM, R15 was lying in bed under the covers, with her eyes closed. On 09/04/25 at 9:25 AM, R15 was lying in bed under the covers, and was awake. She motioned the surveyor over and made hand gestures and spoke but her words could not be understood. She was not able to communicate her needs. On 09/04/25 at 4:50 PM, R15 was lying in bed under the covers and was awake. On 09/05/25 at 9:48 AM, R15 was lying in bed under the covers and was awake. On 09/05/25 at 11:03 AM, R15 was lying in bed under the covers and was awake. During an interview on 09/04/25 at 9:40 AM, Certified Nursing Assistant (CNA) 2 stated R15 was dependent on staff for care and could at times communicate basic needs such as that she was wet or she pointed to the television to have staff turn it on. CNA2 stated R15 got out of bed at times and into a wheelchair and was placed in the hallway near the entrance to the room. CNA2 stated activity staff came to the room to do activities with the resident but she did not go to the activity/day room on the unit to participate in group activities due to her infection. CNA2 verified R15 had attended group activities prior to being placed on infection control precautions. During an interview on 09/04/25 at 2:08 PM, Licensed Practical Nurse (LPN) 2 stated R15 had gone to the hospital for a gastrostomy tube replacement and tested positive candida auris in the hospital. LPN2 stated R15 was currently on enhanced barrier precautions. LPN2 stated R15 could sit in the hallway outside her room but she could not go to the dayroom for activities because she would touch everything and she carried the candida auris on her skin. During an interview on 09/05/25 at 8:56 AM, the Activity Director (AD) and Activity Aide (AA) were interviewed. The AD stated the residents who had candida auris had special activity programs due to not being able to go to group activities. This included provision of an activity bag with R15's name that remained in her room which contained magazines and musical props. The AA stated R15 was severely cognitively impaired and she provided 1:1s in the resident's room. The AA stated R15 was not allowed to leave the room. The AA and AD stated R15 participated in and enjoyed group activities prior to contracting candida auris. The AA and AD stated R15 had been on 1:1 visits in her room since she became infected with candida auris (February 2025). During an interview on 09/05/25 at 9:14 AM, the Infection Preventionist (IP) stated the hospital had contacted the facility with the positive candida auris result for R15 in early February 2025. The IP stated at first R15 was on contact precautions and then it was changed to enhanced barrier precautions after being provided with information from the state and the Center for Disease Control recommended contact or enhanced barrier precautions. The IP stated R15 was allowed to come out of her room once on enhanced barrier precautions and she was not prohibited from attending group activities. The IP stated he had trained staff in this. The IP stated once a person had the candida auris infection, it could not be eliminated but could be managed with hand washing and disinfecting surfaces. The IP stated if R15 was not allowed to come out of her room, there would be a physician's order which indicated this but there was no order. During an interview on 09/05/25 at 5:35 PM, the Director of Nursing (DON) stated R15 was allowed to go out of her room. She stated enhanced barrier precautions did not prohibit R15 from going to common areas such as the day room for activities. The DON stated she had occasionally seen R15 in her wheelchair out in the hallway near the nursing station and stated the resident enjoyed talking with staff when out of the room. NJAC 8:39-4.1(a)NJAC 8:39-27.1(a)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one resident and family member out of 32 sampled residents (Resident (R)103) were invited to the quarterly care plan meeting. The facility's practice did not include inviting residents or families to quarterly care plan meetings. This created the potential for residents/families to lack information regarding care and services provided and lack the opportunity to provide input into care provided.Findings include: Review of the facility's Care Planning - Interdisciplinary Team policy, dated 03/2022, revealed, . Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT) . The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan . Review of R103's undated admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R103 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (ischemic stroke) and vascular dementia. Family Member (F)1 was documented as being R103's Responsible Party and Emergency Contact #1. Review of R103's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/12/25 and located in the EMR under the MDS tab, revealed R103 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of the MDS tab in the EMR, located under the Resident tab, revealed R103 had three MDS assessments completed following her admission to the facility (admission MDS with an ARD of 02/09/25, a Significant Change MDS with an ARD of 05/12/25 and a Quarterly MDS with an ARD of 08/12/25). Review of the IDCP (Interdisciplinary Care Plan) Meeting/Care Plan Conference Record, dated 02/03/25 and located under the Assessment tab, revealed a care plan meeting was held in conjunction with the Initial MDS review and indicated F1 was invited to and attended the meeting in person. Review of the IDCP Meeting/Care Plan Conference Record, dated 05/05/25 and under the Assessment tab, revealed the care plan meeting was held in conjunction with the Significant Change MDS review and indicated F1 had been invited to the meeting and attended the meeting via phone call. Review of the IDCP /Care Plan Conference Record, dated 08/04/25 and under the Assessment tab, revealed the care plan meeting was held in conjunction with the Quarterly MDS review. The question that asked whether the resident/designated representative was invited to participate in the care plan meeting was marked No. The question that read, Resident/designated representative attended the meeting was marked No. During an interview on 09/02/25 at 2:38 PM, F1 stated he had attended one care plan meeting since R103 was admitted to the facility. F1 stated he was R103's emergency contact and decision maker. F1 stated he did not feel he was well informed regarding R103's current medical condition, care, or of her current psychological state. R103 was present during the interview; however, the resident was confused and did not respond to or participate in the conversation. During an interview on 09/04/25 at 1:09 PM, the Social Service Director (SSD) stated she and the Minimum Data Set Coordinator (MDSC) were responsible for setting up care plan meetings and inviting residents and families to the meetings. The SSD stated they invited residents and families/responsible parties to care planning meetings that corresponded with the Initial, Annual, and Significant Change MDS assessments; however, residents, families, and responsible parties were not invited to care plan meetings that corresponded with quarterly MDS reviews. During an interview on 09/05/25 at 10:42 AM, the MDSC stated residents and families were notified of care plan meetings prior to the scheduled meetings. The MDSC stated families were called. The MDSC stated residents and families/responsible parties were invited to the initial, significant change, and annual care plan meetings; however, they were not invited to the quarterly care plan meetings. During an interview on 09/05/25 at 5:36 PM, the Director of Nursing (DON) verified that residents/families/responsible parties were not invited to care plan (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meetings that corresponded with quarterly MDS reviews. The DON stated residents and families were invited to care plan meetings that corresponded with initial, significant change, and annual MDSs. The DON stated she was not aware of the requirement to invite residents/families to all care plan meetings, which included quarterly MDS reviews. NJAC 8:39-4.1(a)NJAC 8:39-11.2(e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315372	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White House Healthcare and Rehabilitation Center	560 Berkeley Avenue Orange, NJ 07050

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure written notice of the facility's bed hold policy and/or transfer notices that contained all necessary information were provided to three of four residents and/or representatives (Resident (R) 1, R22, and R7) reviewed for transfer notices out of a total sample of 32. This failure had the potential for the resident and/or representative not to have knowledge of where and why a resident was transferred, how to appeal the transfer, or to be knowledgeable of the facility's bed hold policy. Findings include: Review of the facility's undated policy titled, Bed-Holds and Returns revealed, . Written information will be given to the residents and the resident representatives that explains in detail:b. The reserve bed payment policy as indicated by the state plan (Medicaid residents),The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond thestate bed-hold period (Medicaid residents); andd. The details of the transfer (per the Notice of Transfer).4. Medicaid residents who exceed the state's bed hold limit and/or non-Medicaid residents who request abed-hold are responsible for the facility's basic per diem rate while his or her bed is held . 1. Review of R1's admission Record, located under the Profile Tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses that included essential (primary) hypertension. On 09/01/25 at 9:30 AM, R1 was observed being transferred to the hospital due to hypertension. The resident was not provided a written copy of the facility's bed hold policy. Review of R1's Progress Note, dated 09/01/25 at 1:21 PM and located in the EMR under the Progress Notes tab, revealed R1 was transferred to the hospital due to hypertension on the day shift. Review of R1's EMR revealed no documented evidence R1 or the resident representative was provided with a written transfer or bed hold notice. During an interview on 09/01/2025 at 10:20 AM, Licensed Practical Nurse (LPN) stated that she was not aware of any paperwork for a bed hold notice. LPN2 stated she was only aware of the papers to be sent to the hospital with a resident, which included the diagnoses, medication list, and why the resident was being sent to the hospital. During an interview on 09/03/2025 at 3:24 PM, the Administrator stated that R1 was sent out to hospital emergently, and they could not give R1 the bed hold papers. During an interview on 09/04/2025 at 11:25AM, LPN1 and LPN2 both stated that there was no written bed hold notice to give to residents on transfer. They stated they were to notify the Administer when residents were sent out. 2. Review of R22's admission Record, located under the Profile Tab of the EMR, revealed R22 was admitted to the facility on [DATE] with diagnoses that included hypertension, abnormalities of gait and mobility, and depression. Review of R22's Progress Note, dated 05/28/25 at 1:25 PM and located under the Progress Notes tab of the EMR, revealed R22 was transferred to the hospital due to hypertension. Review of R22's EMR revealed no documented evidence R22 or any resident representative was provided with a bed hold notice at the time of transfer. During an interview on 09/04/2025 at 11:25AM, LPN1 and LPN2 both stated that there was no written bed hold notice to give to residents on transfer. They stated they were to notify the Administer when residents were sent out. Both stated there was no paperwork that they had ever given residents as they were transferred from the facility. 3. Review of R7's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R7 was originally admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, type 2 diabetes mellitus, asthma, adjustment disorder with depressed mood, and dialysis-dependent end-stage renal disease. Review of R7's Progress Notes tab of the EMR revealed on 07/16/2025, at approximately 3:20 AM, R7 was observed to be breathing with accessory muscles. The resident was assessed, and as needed (PRN) oxygen was administered via nasal cannula at 2 liters per minute (LPM), as oxygen saturation was reported at 88%. Monitoring continued, and the resident's physician was notified. Due to no improvement in the resident's condition, the physician issued orders to (continued on next page)

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	315372	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer R7 to the emergency department (ED). According to facility documentation, the family was notified, and written documentation was provided to the resident at the time of transfer and mailed to the resident's representative. A review of the transfer notice provided by the Administrator revealed that it did not include the reason for the transfer, the location of the transfer, the resident's appeal rights, or the contact information for the ombudsman. During an interview on 09/05/2025 at 1:34 PM, the Administrator confirmed that the document is given to the resident at the time of transfer and mailed to the representative. When asked about the missing elements in the transfer notice, he stated that the facility provides its contact information for residents or their representatives to reach out with any questions or concerns. NJAC 8:39-4.1(a)31,31NJAC 8:39-5.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one out of one sample residents reviewed for range of motion (ROM) (Resident (R) 58) out of a total sample of 32 residents, had an elbow splint/hand roll applied in accordance with physician's orders. This created the potential for R 58 to experience a worsening of her contracted left arm/hand.Findings include: Review of the facility's Resident Mobility and Range of Motion (ROM) policy, dated 07/2017, revealed, . Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM . Review of the R58's admission Record, located in the Electronic Medical Record (EMR) under the Profile tab, revealed R58 was admitted to the facility on [DATE]. Diagnoses included hemiplegia (partial or total paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (ischemic stroke) affecting left non-dominant side. Review of R58's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/11/25 and located in the EMR under the MDS tab, revealed R58 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of eight out of 15. R58 was not coded as exhibiting any rejection of care during the assessment period. R58 was impaired in ROM to the upper extremity and lower extremity on one side. R58 required substantial assistance with toileting hygiene, tub/shower transfer, partial moderate assistance with dressing, rolling left and right, sitting to lying, lying to sitting on bedside, and sitting to standing. Review of the physician Order Summary Report, active through 09/05/25 and located in the EMR under the Orders tab, revealed an order for, Splint device: apply to left hand and elbow AM when out of bed and remove when in bed PM, initiated on 07/18/25. Review of the Rehab Department Discharge Request & RNP [Restorative Nursing Program] Referral Form, dated 07/16/25 and provided by the facility, revealed the recommendation for, Splinting/bracing: Resident will tolerate hand splint & elbow splint on left UE [upper extremity] to be applied in the morning when the resident got out of bed and in the evening when she went to bed. Review of the Care Plan, dated 07/17/25 and located in the EMR under the Care Plan tab, revealed a focus area of Resident is on Nursing Restorative Program: AM: Assistance with Splint or brace - resident will tolerate hand splint and elbow splint on left upper extremity initiated on 07/17/25. The goal was, Resident will maintain her/his current level of function through the review period. Interventions were:- Allow/provide rest periods between exercises, ambulation.- Encourage/assess resident in performing nursing restorative program:Assistance with Splint or brace - resident will tolerate hand splint and elbow splint onleft upper extremity.- Monitor for any deterioration in goals, inform and refer to rehab as needed forevaluation and treatment as needed.- Promptly notify the nurse if any changes are observed.- Staff to examine body parts carefully each time post ROM for changes such asswelling, redness, break in skin and promptly inform the nurse.Review of the POC [Plan of Care] Response History report for Nursing Restorative Program: Assistance with splint or brace - resident will tolerate hand splint and elbow splint on left upper extremity, from 08/06/25 through 09/05/25 and located in the EMR under the Tasks tab, revealed no documented evidence R58's splint was not applied on:08/06/25 - 08/14/2508/16/25 - 08/17/2508/19/25 - 08/24/2508/29/25 - 09/01/25. The form included a column for refusals. No refusals were documented on the form. Observations during the survey revealed R58 was not wearing the left hand/elbow splint when she was up and out of bed during the day as follows: On 09/02/25 at 4:39 PM, R58 was up sitting in her wheelchair in the day room. Her left hand was observed to be contracted into a fist. R58 stated she had a splint but was not wearing it. On 09/03/25 at 10:00 AM R58 was sitting in her wheelchair in the day room without the splint/hand roll in place. On 09/03/25 at 3:08 PM, R58 was sitting in her room in her wheelchair without the splint in place. On 09/04/25 at 9:17 AM, R58 was sitting in the day room without the splint/hand roll in place. On 09/04/25 at 2:06 (continued on next page)

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	315372	A. Building B. Wing	09/05/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, R58 was sitting in the day room without the splint/hand roll in place. On 09/04/25 at 4:47 PM, R58 was sitting in the day room without the splint/hand roll in place. During an interview on 09/04/25 at 1:56 PM, Certified Nursing Assistant (CNA)1 stated R58 was paralyzed on one side and required a lot of assistance with ADL care. CNA1 stated R58 had a splint and roll for her palm she was supposed to wear; however, she did not always want to wear it. CNA1 stated she offered to apply the splint for R58 in the mornings. CNA1 stated she asked R58 this morning; however, R58 did not want to wear it. CNA1verified that R58 had not worn the hand splint at all today during day shift. CNA1 stated she would let the nurses know if R58 did not want to wear it. During an interview on 09/04/25 at 2:19 PM, Licensed Practical Nurse (LPN)2 stated R58 was alert with confusion and forgetfulness and was dependent on staff for activities of daily living (ADLS). LPN2 stated staff had to apply R58's elbow splint and hand roll. LPN2 stated R58 was supposed to wear the splint and hand roll during the day. LPN2 stated, For the most part, she will wear it. LPN2 stated she had not been informed that R58 had not been wearing the splint. LPN2 stated therapy staff applied the splint and they worked with R58 daily. During an interview on 09/05/25 at 8:45 AM, the Director of Rehab (DOR), an Occupational Therapist (OT), stated R58 had been recently receiving physical therapy (PT) and occupational therapy but had been discharged to the restorative nursing program. The DOR stated R58 should be wearing the left elbow splint and hand roll when she was up and out of bed during the day. The DOR stated the Restorative Aide (RA) was the main person who applied the splint and hand roll; however, the RA was not working today. The DOR stated application of the splint was important to keep R58's contractures from worsening. During a follow up interview on 09/05/25 at 10:08 AM, the DOR stated R58's elbow splint had been washed yesterday and left to air dry. The DOR stated it was still wet. Registered Nurse (RN)3 joined the conversation and stated R58 was known to remove her splint after it was applied. RN3 stated there was documentation on one day (08/25/25) that R58 had removed her splint. RN3 stated the documentation over the past three days showing R58's splint had been applied was documentation for that point in time and R58 may have had the splint on when the record reflected it had been applied. RN3 verified the splint had not been applied on 09/04/25 because it was being washed and had not been applied today yet because it was still wet. During a follow up interview on 09/05/25 at 12:11 PM, the DOR stated he had just applied R58's elbow splint and hand roll. The DOR stated R58 smiled and presented no problem when he applied the splint and hand roll. During an interview on 09/05/25 at 5:10 PM, the Director of Nursing (DON) stated the Restorative Aide was responsible for applying R58's splint. The DON stated it was supposed to be applied in the morning and taken off at night and should be documented under Tasks. The DON stated it should be applied daily and if the resident refused, the refusal should be documented under Tasks. NJAC 8:39-27.1(a)

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	315372	A. Building B. Wing	09/05/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to ensure laboratory results were followed up on in a timely manner for one of three sampled residents (Resident (R) 58) reviewed for a urinary tract infection (UTI) out of a total sample of 32. R58's Urinalysis and Culture and Sensitivity (C & S) results revealed she may have had a urinary tract infection. There was no documentation of follow up indicating the Physician was notified of the results and no documentation of whether the physician wanted to treat the infection until the surveyor asked about it nine days later. This created the potential for R58 to experience a UTI without treatment. Findings include: Review of the facility's Lab and Diagnostic Test Results - Clinical Protocol, dated 11/2018, revealed, . 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility . Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors) . Options for Physician Notification - 1. A physician can be notified by phone, fax, voicemail, e-mail, mail, pager or a telephone message to another person acting as the physician's agent (for example, office staff). A. Facility staff should document information about when, how and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record . Physician Responses 1. Time frames - A physician will respond within an appropriate time frame, based on the request from nursing staff and the clinical significance of the information. A. A physician should respond within one hour regarding a lab test result requiring immediate notification, and by the end of the next office day to a non-emergency message regarding non immediate lab test notification with a request for response . b. If the Attending or Covering Physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance . Review of R58's undated admission Record, located in the Electronic Medical Record (EMR) under the Profile tab, revealed R58 was admitted to the facility on [DATE]. Diagnoses included hemiplegia (partial or total paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (ischemic stroke) affecting left non-dominant side. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/11/25 and located in the EMR under the MDS tab, revealed R58 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of eight out of 15. Review of a Nursing Progress Note, dated 08/24/25 and located in the EMR under the Progress Notes tab, revealed, . Resident alert with confusion and forgetfulness all ADL's [activities of daily living] care rendered, resident c/o [complain] that she has a towel in her diaper, resident daughter's visited and noted care given to their mom and saw that their (sic) were no towel place in her diaper. [Attending Physician] was called ordered for resident to have U/A [urinalysis] and C/S [culture and sensitivity] done. All orders was (sic) carried out . Review of a Nursing Progress Note, dated 08/25/25 at 7:41 AM and located in the EMR under the Progress Notes tab, revealed, . Urine specimen obtained, contaminated. All shift to follow/up. Resident slept at long interval throughout the night, easily aroused. No acute distress noted. No c/o urinary pain or discomfort. PO [by mouth] fluids encouraged, Afebrile [no fever] T [temperature] 98.0. Left in bed resting, call bell placed within reached (sic). fall/safety precaution maintained . Review of a Nursing Note, dated 08/25/25 at 11:53 PM and located in the EMR under the Progress Notes tab, revealed, . Urine specimen collected and is on 1south fridge . Review of the Urine Culture Result, with a specimen date of 08/25/25 at 6:00 AM, a result date of 08/28/25 at 10:02 AM, and located in the EMR under the Results tab, revealed the (continued on next page)

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	315372	A. Building B. Wing	09/05/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean catch urine was positive for Escherichi A Coli (E Coli) and Aerococcu S Urinae and these were abnormal results. Under Details, the following was documented, 10,000 - 50,000 CFU/mL Escherichia coli (Abnormal) *** Probable ESBL (Extended Spectrum Beta-Lactamase) producing organism . 50,000 - 100,000 CFU/mL Aerococcus urinae (Abnormal) *** Susceptibility testing not routinely performed on this isolate . Review of the Urinalysis Lab Results Report, with a collection date of 08/26/25 at 7:34 AM, a reported date of 08/26/25 at 11:06 AM, and located in the EMR under the Results tab, revealed abnormal results including turbid urine, trace ketones, trace protein, positive nitrite, large leukocyte Esterase, white blood cells in the urine/uL 297.5, casts Urine/uL 2.16, and bacteria urine/uL 7058.4. There was one Urinalysis found in the R58's EMR; there was no documentation on the report of the urine sample being contaminated. Review of the Progress Notes section (which included Physician Notes) from 08/25/25 after 11:53 PM through 09/04/25 at 3:25 PM showed no further documentation related to whether the second urine specimen was sent to the lab, what the results were, whether the physician was contacted about the results, or what the physician's decision was regarding treating the abnormal results of the Urinalysis and C & S, etc. Review of the Order Summary Report, current as of 09/06/25 and located in the EMR under the Orders tab, revealed no antibiotic had been prescribed following the abnormal lab results. During an interview on 09/04/25 at 2:19 PM, Licensed Practical Nurse (LPN) 2 stated R58 was dependent on staff for activities of daily living and was alert but forgetful. LPN2 stated the C & S was collected 08/25/25 and reported to the facility on [DATE]. LPN2 stated the C & S results were abnormal, indicating a potential UTI. LPN2 stated once the lab results were received, the next step was to for nursing staff to contact the doctor and them him/her know what the results were. LPN2 reviewed R58's EMR and verified there was no documented follow up after the urine sample was collected on 08/26/25. LPN2 verified there was no documentation to show the physician had been notified and what his/her decision was regarding treatment and no documentation on the UA or C & S that the urine specimen was contaminated. LPN2 stated she would have to follow up to find out what happened. During an interview on 09/05/25 at 9:44 AM, Registered Nurse (RN) 3 stated R58 stated on 08/24/25 she had a towel in her private parts and her family took her to the bathroom, but there was nothing there. The resident's physician was contacted, and he ordered a urinalysis and culture and sensitivity to rule out a urinary tract infection. RN3 stated it was difficult to get a urine sample from R58 on the day shift so the next shift was asked to obtain it. RN3 stated the C & S results came back on 08/25/25. RN3 stated the results were reported to the Infection Control Physician and he declined prescribing an antibiotic because R58 was asymptomatic. RN3 stated the resident's Attending Physician who had ordered the UA and C & S had been called this morning (09/05/25) to notify of the results. RN3 indicated this information was now documented (on 09/04/25 and 09/05/25 following the surveyor's inquiries) in progress notes. During an interview on 09/05/25 at 5:19 PM, the Director of Nursing (DON) stated the typical process for labs included collecting the urine, placing the sample in the 1 south refrigerator, the sample being collected the next day. The DON stated the results were auto populated in the computer system the next day. The DON stated that typically the Nurse Practitioner (NP) would review the results for labs on a daily basis from Monday through Friday and would make a recommendation regarding treatment. The DON stated both the nurse and NP should write a progress note and she verified that this had not been done. The DON verified there was one urinalysis report and it did not indicate the urine specimen was contaminated. The DON stated it was a possibility that the laboratory notified the facility by phone indicating the result was contaminated and did not upload the contaminated result. The DON stated the Urinalysis dated 08/26/25 was probably the second result. The DON stated R58 did not exhibit symptoms of a UTI currently and did not require treatment. The DON stated it was difficult to get nurses to document adequately in the EMR. NJAC 8:39-35.2(d)11

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	315372	A. Building B. Wing	09/05/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one of one sampled resident (Resident (R)103) reviewed for dental services out of a total sample of 32 was scheduled for dental services within three days and in accordance with facility policy after her dentures were lost on 05/25/25.Findings include: Review of the facility's undated Dental Services policy revealed, . Routine and 24-hour emergency dental services are available to meet the resident's oral health service in accordance with the resident's assessment and plan of care . Dentures will be protected from loss or damage, to the extent practicable, while being stored . If dentures are damaged or lost, residents will be referred for dental services within 3 days . Review of R103's undated admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R103 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (ischemic stroke) and vascular dementia. Family Member (F)1 was documented as being R103's Responsible Party and Emergency Contact #1. Review of the undated Census tab in the EMR under the Resident tab revealed R103's primary payer source was Medicaid. Review of R103's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/25 and located in the EMR under the MDS tab, revealed R103 was not edentulous. Review of R103's quarterly Minimum Data Set (MDS), with an ARD of 08/12/25 in the EMR under the MDS tab revealed R103 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of a Quarterly Nutrition Review dated 05/12/25, in the EMR under the 'Progress Notes tab revealed R103 was prescribed a regular, mechanical soft texture diet. Review of a Nursing Progress Note, dated 05/07/25 and located in the EMR under the Progress Notes tab, revealed, . Resident denture found. Resident noted removing denture from mouth and keeping it in her hand/sometimes she has it wrapped in a tissue on the bedside table. RP [Family Member (F)1] made aware of found denture, as per RP [Responsible Party] he will talk to resident about her behavior of removing dentures . Review of a Nursing Progress Note, dated 05/26/25 and located in the EMR under the Progress Notes tab, revealed, . Resident missing her denture as of 05/25/25. Son is aware . Review of a Nursing Progress Note, dated 05/29/25 and located in the EMR under the Progress Notes tab, revealed, . Resident denture still missing. Resident noted with good PO [by mouth] intake during meals with no difficult [sic]. On dental consult for next visit . Review of a Nursing Progress Note, dated 08/08/25 and located in the EMR under the Progress Notes tab, revealed, . Resident's son expressed concern of mother's upper denture and claimed that his mother is on the list to be seen by dentist . Review of social service Progress Notes, from 02/04/25 through 09/05/25, revealed no mention of R103's denture being lost or the status of her dental appointment. Review of the email from the Dentist to the facility, dated 09/04/25 and provided by the facility, revealed R103 was on the dental list to be seen on 09/09/25 for Initial impressions for dentures. The email indicated the visit had been originally scheduled for 09/03/25; however, the visit had been cancelled. During an interview on 09/02/25 at 2:59 PM, F1 stated R103 lost her dentures after coming to the facility. F1 stated R103 removed her dentures and placed them on her meal tray resulting in the dentures being lost a couple of times, then being found, and then being lost permanently. F1 stated the facility had not found the dentures after the last time they were lost. F1 stated he had been told the facility would follow up but had not heard anything about R103 being scheduled to see the dentist. During a follow up interview on 09/05/25 at 3:14 PM, F1 stated he thought R103 lost her dentures permanently around the end of May 2025, stating, They have been missing quite a while. F1 stated he felt like it had been too long for R103 to wait to see the dentist. F1 stated he had not been updated regarding when she was scheduled for a dental appointment. During observations on 09/02/25 at 3:01 PM and 09/04/25 at 9:12 AM, R103 did not have upper dentures/teeth. During an interview on 09/04/25 at 12:54 PM, the Registered Dietitian (RD) stated R103 was on a mechanical soft diet due to her denture being lost. The RD reviewed the (continued on next page)

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	315372	A. Building B. Wing	09/05/2025

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Notes in the EMR and stated the dentures had been missing since 05/25/25. The RD stated the Assistant Administrator was responsible for scheduling dental visits. During an interview on 09/04/25 at 2:29 PM, Licensed Practical Nurse (LPN) 2 stated R103 was on the list to see the dentist and she should have been seen yesterday (on 09/03/25) but the dentist did not come to the facility. LPN2 showed the surveyor the list posted at the nursing station and it documented R103's name and that she was scheduled as a new patient exam. During an interview on 09/04/25 at 1:09 PM, the Social Service Director (SSD) stated missing dentures were discussed in the morning department head meetings. The SSD stated if a resident who was on Medicaid lost their dentures, she recommended replacement of the dentures. The SSD stated replacing the dentures was important because loss of dentures could affect the resident's nutritional status. The SSD stated the Registered Dietitian would be immediately notified to address necessary diet texture changes while the dentures were lost. The SSD stated the resident would be put on the list to see the dentist so new dentures could be made. The SSD stated the facility put interventions in place once dentures were received to ensure they were not lost again. The SSD stated the status of obtaining dentures should be documented in the medical record under progress notes. The SSD reviewed R103's Progress Notes and stated R103 was on consultation for the next week to be seen by the dentist in a noted dated 05/29/25; however, she did not see anything else in the record showing what occurred since that time. The SSD stated there was a dental list maintained by the Assistant Administrator. The SSD stated the dentist came to the facility once or twice a month. The SSD stated there was a consultation record in the hard chart that documented dental visits. The SSD reviewed R103's hard chart and stated there was no consultation record showing she had been scheduled for or seen by the dentist since admission. During an interview on 09/05/25 at 3:07 PM, Assistant Administrator (AA)2 stated R103 had a history of wrapping her dentures up and they had been lost more than once. AA2 stated he thought R103's dentures had been found after they were lost on 05/25/25 and it was a later date when they were permanently lost. AA2 stated there was no documentation after 05/25/25 showing R103's had been found and then lost for good at a later date (other than 05/25/25), but he thought the date when the dentures were lost for good occurred after 05/25/25. AA2 stated R103 would have been scheduled earlier to see the dentist if she had lost her dentures on 05/25/25 as the dentist came to the facility on a monthly basis. AA2 stated R103 was scheduled to be seen by the dentist on 09/03/25; however, the dentist did not come on that date and it would be rescheduled. NJAC 8:39-15.1