STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315374	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DE LA Salle Hall	810 Newman Springs Rd Lincroft, NJ 07738

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 observations, interviews, and review of facility provided documents, it was determined that the facility failed to maintain proper kitchen sanitation practices by keeping the kitchen door closed and consistently recording water temperatures and chemical sanitizer levels, to prevent the potential development of food borne illness. This deficient practice was evidenced by the following:On 5/12/26 at 5:23 PM, during the initial tour of the facility, the surveyor walked past a door to the kitchen which was completely open to a hallway used by residents, staff, and/or visitors. The surveyor observed a staff member in the kitchen putting food onto plates. A sign on the open door indicated to keep the door closed at all times. The surveyor observed the door was held open by a magnet attached to the bottom of the door. On 5/12/26 at 5:25 PM, the surveyor toured the kitchen with the cook, who acknowledged the kitchen door to the hallway should have been closed. The cook stated he prepared the food and plated it for dinner for the residents, and another staff member used that door to take meal trays to the units, and then would bring the trays back and wash the dishes. The surveyor observed a dishwasher which the cook stated was a high-temp dishwashing machine (a type of dishwasher that uses extremely hot water during its wash and rinse cycles to clean and sanitize dishes more effectively than standard dishwashers), and a 3-bay sink (3 deep sinks specifically designated and labeled for washing, rinsing, and sanitizing, used for pots and other items that were hand washed). The dishwashing machine and 3-bay sink were currently not being used. On 5/13/26 at 10:20 AM, the surveyor toured the kitchen with the Director of Dining Services (DDS) in the presence of the Regional Director. The DDS confirmed the dishwashing machine was high-temp, and the staff running the machine checked the water temperatures at least 3 times a day. The Regional Director added that the water temperatures were checked before starting to wash dishes after each meal. The DDS stated she checked the log each evening to confirm there were no issues with the function of the machine. The DDS provided a clipboard with temperature log sheets for each month, for the surveyor to review. In the presence of the DDS and Regional Director, the surveyor observed the log sheet for May 2026. The DDS asked the cook if he checked the water temperatures yesterday, and he replied that he forgot. The DDS asked the server/utility staff member (Server #1), who was currently running the dishwasher, if he checked the water temperatures this morning. He stated he checked the temperatures and stated they were 155 degrees Fahrenheit (155 F) for the wash and 182 F for the rinse. He acknowledged he wrote the temperatures in the space for 5/12 breakfast and stated he should have written them on the 5/13 breakfast space. In the presence of the surveyor and the Regional Director, the DDS acknowledged that the dishwashing machine water temperatures had not been logged for 5/11 dinner, and 5/12 breakfast, lunch, and dinner. At that time, the surveyor, in the presence of the DDS and the Regional Director, observed the log sheet for May 2026 for the 3-bay sink. The DDS stated the temperature of the water for washing, and the chemical levels for sanitizing, were checked before the pots were washed after each meal. There were blank spaces on 5/11 dinner time, and 5/12 breakfast, lunch, and dinner times, and 5/13 breakfast time. The DDS asked Server #1 if he checked the water temperature and chemical levels in the 3-bay sink that morning. Server #1 acknowledged he did but did not log the results. On 5/14/26 at 8:49 AM, the surveyor observed the (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	door to the kitchen completely open to the hallway used by residents, staff, and/or visitors. The cook in the kitchen acknowledged to the surveyor that the door should have been closed and closed it. On 5/14/26 at 9:07 AM, the surveyor entered the kitchen and observed a rack of utensils next to the high temp dishwashing machine. Server #2 acknowledged the utensils had been washed but she had not yet checked and logged the water temps for the dishwashing machine. She stated the temps were checked by looking at thermometers on top of the machine which indicated the wash and rinse water temperatures. Server #2 stated she checked the 3-bay sink water temperature and sanitizer level this morning but had not logged it yet. Server #2 acknowledged the reason for checking water temperatures and sanitizer levels was to be sure the dishes were all cleaned properly. Server #2 returned the rack of utensils to the area with the dirty dishes. She acknowledged she needed to check the temperatures for the water in the dishwashing machine and re-wash the utensils. Server #2 provided the log sheets to the surveyor for March 2026, April 2026, and May 2026. The surveyor observed several blank spaces on each month's log sheets, in addition to those noted above, for the dishwashing machine and the 3-bay sink, as follows: Dishwashing machine blank spaces: 3/21 breakfast3/31 dinner4/23 lunch4/27 dinner4/28 breakfast, lunch and dinner4/29 breakfast, lunch, and dinner4/30 breakfast and lunch 3-bay sink blank spaces:3/31 dinner4/9 lunch4/16 lunch4/27 dinner4/28 breakfast, lunch, and dinner4/30 breakfast, lunch, and dinner4/30 breakfast and lunch On 5/14/26 at 11:38 AM, the surveyor met with the DDS, in the presence of the Administrator, to present the above concerns. The Administrator acknowledged the surveyor's findings. The DDS acknowledged it was important to check the water temperatures and sanitizer levels to ensure proper sanitation of kitchen dishes and utensils. She acknowledged the temperatures, and sanitizer should have been checked and logged before washing the dishes from breakfast, lunch, and dinner every day. The DDS acknowledged the log sheets were important because if the temperatures or sanitizer were out of acceptable range, she checked them again and notified the maintenance department if the machines were not working properly. The DDS acknowledged that even if her staff visually checked the temperatures and sanitizer levels, if it was not logged there was no evidence of proper cleaning or sanitation for her to review. On 5/14/26 at 1:53 PM, the survey team met with the Administrator and the Director of Nursing who acknowledged the surveyor's above concerns regarding the dishwashing machine, the 3-bay sink, and the kitchen door propped open to the hallway. On 5/15/26 at 8:58 AM, the surveyor observed the door to the kitchen completely open to the hallway used by residents, staff, and/or visitors. There were no staff in the kitchen visible to the surveyor from the doorway. On 5/15/26 at 9:57 AM, the survey team met with the Administrator and the Director of Nursing. The Administrator acknowledged he observed the kitchen door open to the hallway this morning and acknowledged it must be kept closed because the kitchen is a hazardous area, in addition to many other reasons the door shouldn't be left open. The Administrator did not provide any further information. A review of the facility provided job description titled Dishwasher reflected a summary: Maintains china/dishes, pots, pans, trays, kitchen, work areas, equipment and utensils in clean and orderly and sanitary condition. One of the essential duties and responsibilities reflected.Maintain and track temperatures and chemical (sanitizer) levels as outlined by provided standards. Let supervisor know in a timely manner if levels are off. A review of the facility provided job description titled Cook reflected an essential duty and responsibility: Perform job safely while maintaining a clean and safe work environment and following correct procedures at all times. A review of the facility provided job description for the DDS, titled Chef Manager, reflected key responsibilities including maintains sanitation of equipment, supplies, and utensils. and supervise hourly food service associates. A review of the facility provided policy with the subject: Food and supply storage, revised 1/26, reflected All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The procedures included.Restrict access to storage areas to only those associates whose job responsibilities require them to retrieve items from these areas. NJAC 8:39-17.2(g), 19.7(d)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to complete reference checks on new hires. This deficient practice was identified for 4 out of 14 employees (Employee #3, #4, #7, and #9) hired since the last Department of Heath recertification survey date of 12/31/24.On 5/12/26 at approximately 5:45 PM, during the entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA), all newly hired employee files for active and inactive employees from 12/31/24 to the current date. A review of the employee personnel files revealed the following:For Employee #3, an Activities Staff with a date of hire (DOH) of 3/19/25, there was no evidence of a reference check prior to the start of employment.For Employee #4, a Certified Nursing Assistant with a DOH of 10/19/25, there was no evidence of a reference check prior to the start of employment. For Employee #7, an Activities Staff with a DOH of 3/21/25, there was no evidence of a reference check prior to the start of employment.For Employee #9, a Registered Nurse with a DOH 12/23/25, there was no evidence of a reference check prior to the start of employment. On 5/14/26 at 12:47 PM, the LNHA and Director of Nursing (DON) were made aware of the above concerns regarding reference checks for newly hired employees.On 5/14/26 at 1:06 PM, the surveyor interviewed the Business Office Manager who stated that she was responsible for employee reference checks. She stated that during the initial interview the employee would provide references for whom they would like the facility to contact. She further stated that the importance of the reference checks was because it was a state guideline. She then stated that a reference inquiry should be completed prior to their date of hire.On 5/15/26 at 9:54 AM, the survey team met with the LNHA and the DON. The LNHA acknowledged the reference checks that were not completed and further stated reference checks should be completed prior to hire. The LNHA then stated, we could do better with employee files.The facility had no additional information to present for the above concerns.A review of the facility's Abuse policy, revised 10/2022 revealed .The facility will not knowingly employ any individual who has a history of abusing other persons. Potential employees and volunteers shall be screened thoroughly through structured interviews, personal and employment reference checks, criminal background checks and contact with State licensing boards and registries, when applicable. NJAC 8:39-9.3(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, review of the medical record and other facility documentation, it was determined that the facility failed to ensure a resident's care plan, who was a known high fall risk and had sustained multiple falls, maintained documentation of the falls. This deficient practice was identified for 1 of 2 residents (Resident #7) reviewed for falls and accidents and was evidenced by the following:On 5/12/2026 at 6:24 PM, during initial tour, Resident #7 was observed in bed. The resident stated they had a fall in the past but couldn't remember when. The surveyor reviewed the electronic medical record (EMR) for Resident #7. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified macular degeneration (an eye disease that affects central vision, meaning people can't see things directly in front of them), heart failure (a chronic condition where the heart cannot pump enough oxygen-rich blood to meet the body's needs) and unspecified hearing loss.A review of the annual Minimum Data Set (MDS), an assessment tool dated 11/21/25, revealed the resident had a Brief Interview for Mental Status of 11 out of 15, indicating the resident was moderately cognitively impaired. A further review of the MDS revealed the resident had a fall since admission/entry.A review of the individual comprehensive care plan (ICCP) revealed a focus of High risk for falls r/t (related to) Confusion and macular degeneration, Date Initiated: 11/13/2024, Revision on: 11/28/2025. Further reveal of the ICCP, did not reveal the resident had an actual fall. A review of the progress notes revealed the following:On 10/16/2025 at 9:54 PM, Nurse's Note text: CNA (Certified Nursing Aid) reported to this writer that resident was sitting on buttocks with both feet extended between recliner and bed.On 12/31/2025 at 6:57 AM, Nurse's Note text: entered room to give AM meds (medications). Resident noted sitting on floor next to bed. fully clothed slippers on. On 1/14/2026 at 7:35 PM, Nurse's Note Text: Called to the room by the LPN (Licensed Practical Nurse). Resident was located on the floor, next to bed, on left side. Resident is awake and alert with baseline confusion but easily redirected.Care plan updated.A review of the Morse Fall Scale documents revealed the following:Effective date: 10/17/25 at 11:05 PM; Score: 50; Type: Post FallEffective dated: 12/31/25 at 7:00 AM; Score 90; Type: Post FallEffective date: 1/14/25 at 7:10 PM; Score 80; Post FallFurther review of the Morse Fall Scale documents (a tool for assessing a patient's likelihood of falling) revealed Section G. Scoring: Morse Fall scoring: High Risk 45 and higher. On 5/14/2026 at10:59 AM, the surveyor interviewed Registered Nurse (RN) #1, who stated he was Resident #7's assigned nurse. He stated the resident was a fall risk and had a fall but was unsure of the date. He stated the purpose of the care plan was to make sure needs are met. RN #1 stated a fall should be in the care plan and should include the date of the fall and any interventions. He accessed the EMR, in presence of surveyor, and reviewed the care plan. He was unable to locate the actual falls. During the interview, the Director of Nursing (DON) came over to assist RN #1 in finding the documentation of the actual falls. She was unable to, at that time. On 5/14/2026 at11:13AM, the DON accessed the EMR on her computer, in the presence of the surveyor. She stated Resident #7 had a history of falls and should have an actual care plan for falls. The DON stated if you select the H(history) on the care plan for High risk for falls you would see the resident has a fall 10/16/25. She was unable to locate the falls from 12/31/25 and 1/14/26 on the care plan. The DON stated the purpose of the care plan was to provide a plan for care. She stated it would be important to keep the falls on the care plan so we (the facility staff) know not to do the same thing (interventions) over again. The DON stated the MDS coordinator takes things off the care plan after 6 months. The DON stated she had to check with the MDS coordinator for the falls.On 5/14/2026 at 1145 AM, during a follow up interview, the DON stated the care plan was updated at the time of the falls for Resident #7. She stated you had to click resolved to see the actual falls. The DON showed the surveyor in the EMR, which showed the fall from 10/16/25, 12/31/25 and 1/14/26 had been on the care plan but were all resolved on 2/2/2026. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated she told the MDS coordinator she wanted to go back to the old way on the care plan where we keep the dates of the actual falls. On 5/14/2026 at 1:53 PM, in the presence of the survey team, the Licensed Nursing Home Administrator and the DON were made aware of the above concerns.A review of facility policy Assessing Falls and Their Causes updated 4/19/2026, revealed Purpose: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall.Preparation: 1. Review the resident's care plan to assess for any special needs of the resident.A review of facility policy Care Plans-Comprehensive updated 6/19/25, revealed Policy Interpretation and Implementation .7. The comprehensive, person-centered care plan: .d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. NJAC 8:39-27.1 (a)