STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315375	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hills Center for Rehabilitation and Healing	497 MT Prospect Ave Newark, NJ 07104

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 3 of 4 residents (Resident #47, 63 and 64) observed for incontinence care on 1 of 2 units (4th-floor Nursing Unit).This deficient practice was evidenced by the following:On 7/31/25 at 8:15 AM, the surveyor completed an incontinence tour on the 4th floor Nursing Unit and observed the following:1. On 7/31/25 at 8:25 AM, the surveyor, accompanied by the Licensed Practical Nurse/ Unit Manager, observed Resident #64 in bed. The LPN/UM exposed Resident #64's incontinence brief, and the surveyor observed that it was saturated with urine. The LPN/UM confirmed that the brief was saturated with urine.A review of Resident #64's admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to, diabetes mellitus and dementia. A review of Resident #64's Quarterly Minimum Data Set (MDS), an assessment tool dated 7/15/25, revealed Resident #64 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated Resident #64 had a moderate cognitive impairment. The MDS further revealed that the resident was dependent on staff for personal hygiene, and he/she was always incontinent of bowel and bladder.A review of Resident #64's Individualized Care Plan (CP) initiated on 1/22/23 and revised on 4/16/25 had a focus area that included the resident was at risk for development of a pressure ulcer due to decreased mobility and incontinence with interventions that included but were not limited to; provide incontinent care every 2 hours.2. On 7/31/25 at 8:30 AM, the surveyor, accompanied by LPN/UM, observed Resident #63 in bed. The LPN/UM exposed Resident #63's incontinence brief, which was saturated with urine and feces. The surveyor observed that the sheets were soiled with a brown substance. The LPN/UM confirmed that the brief was saturated with urine and feces and that the sheets were soiled. A review of Resident #63's admission Record revealed Resident #63 was admitted to the facility with diagnoses which included but were not limited to, diabetes mellitus and dementia.A review of Resident #63's quarterly MDS, dated [DATE], revealed Resident #63 had a BIMS score of 0 out of 15, which indicated a severe cognitive impairment. The MDS further revealed that the resident was dependent on staff for toileting and was always incontinent of bowel and bladder. A review of Resident #63 CP initiated on 12/21/22 and revised on 4/15/25 had a focus area that included the resident was at risk for the development of a pressure ulcer due to decrease mobility and incontinence with interventions that included but were not limited to; provide routine incontinent care.3. On 7/31/25 at 8:40 AM, the surveyor, accompanied by the LPN/UM, observed Resident #47 in bed. The LPN/UM exposed Resident #47's incontinence brief, which was saturated with urine and feces. The LPN/UM confirmed that the brief was saturated with urine and feces.A review of Resident #47's admission Record revealed the resident was admitted to the facility with diagnoses that included but were not limited to diabetes mellitus and a urinary tract infection.A review of Resident #47's Quarterly MDS dated [DATE] revealed Resident #47 had a BIMS score of 6 out of 15, which indicated Resident #47 had a severe cognitive impairment. The MDS further revealed that the resident required staff assistance for personal hygiene, and he/she was always incontinent of bowel and bladder.A review of Resident #47's CP initiated on 1/22/23 and revised on 2/25/25, had a focus area that included that the resident was at risk for a pressure ulcer development related to immobility and incontinence with interventions that included to always keep skin dry by providing incontinent care every shift and as needed. On 7/31/25 at 8:50 AM, during an interview with the surveyor, the LPN/UM was not sure what the facility policy was on providing incontinence care but confirmed that the CNAs on the 11-7AM shift should provide incontinence care before the end of the shift between 5 AM-7 AM. On 7/31/25 at 8:58 AM, during an interview with the surveyor, the Assistant Director of Nursing (ADON) stated that she was not sure of the facility's policy on incontinence care but confirmed that best practice would be to provide incontinence care every two hours and when needed.The CNAs assigned to the above residents on the 11-7 AM shift were unavailable for interviews.On 8/4/2025 at 10:00 AM, the survey team discussed the above observations and concerns with the MDS coordinator/ Acting DON. The Acting DON confirmed that incontinence care should be provided every 2-3 hours. A review of the facility's Activities of Daily Living (ADL) policy dated as reviewed 5/2025 reflected.the purpose of this policy is to establish guidelines for providing comprehensive assistance with ADLs to residents or patients. It aims to ensure that each individual's basic needs are met while promoting dignity, independence, and comfort monitor for signs of incontinence and ensure the use of