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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews and review of pertinent facility documents, it was determined that the facility failed to provide food at a safe and appetizing temperature. The deficient practice was identified for 6 of 6 residents (Residents #1, #19, #20, #29, #69 and #78) that participated in the Resident Council Meeting and was evidenced by the following:On 7/31/25 at 10:30 AM, while participating in Resident council meeting 6 of 6 residents verbalized, they receive food that is cold at meals. On 8/5/25 at 10:15 AM, the surveyor interviewed Unit Manager (UM) for 5th floor. The UM confirmed occasionally residents ask for their food to be heated because it arrived cold. The UM further stated cold food gets heated up on the unit in a microwave. UM stated staff starts passing trays as soon as they are on the floor and acknowledged there are some delays at times getting trays to floor caused by elevators. On 8/5/25 at 10:20AM, the surveyor interviewed CNA #1. CNA#1 verbalized that residents complain of cold food sometimes and stated the elevators slow down the food arrival time and sometimes we are busy and food gets passed out slowly. On 8/5/2025 at 10:25 AM, the surveyor interviewed CNA #2. CNA#2 stated that residents get cold food a lot. CNA#2 verbalized she heats trays up for residents almost every day and stated the elevator causes big delays and we only have one working elevator for a long time now. On 8/5/2025 at 10:40AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Acting Director of Nursing (DON) to discuss concerns including food temperature and both acknowledged food temperature and tray delivery delay issues. Both acknowledged residents should receive foods at appropriate temperatures. NJAC 8:39-17.4(a)2, (e)

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident's dietary preferences were consistently implemented and followed for 6 of 6 residents (Resident #2, #8, #25, #69, #94, and #116) reviewed for dietary preferences during meal observations. This deficient practice was evidenced as follows:1. On 7/30/25 at 12:17 PM, the surveyor was observing the lunch meal on 4th floor unit. The surveyor observed Resident #69's tray, per the tray ticket, Resident #69 was supposed to receive coffee, strawberry short cake and health shake supplement, all three items were missing from the tray. 2. On 7/30/25 at 12:23 PM, the surveyor was observing the lunch meal on 4th floor unit. The surveyor observed Resident #25's tray, per the tray ticket, Resident #25 was supposed to receive sour cream and diet health shake supplement, both items were missing from the tray. 3. On 7/30/25 at 12:29 PM, the surveyor was observing the lunch meal on 4th floor unit. The surveyor observed Resident #116's tray, per the tray ticket, Resident #116 was supposed to receive coffee and strawberry short cake, both items were missing from the tray.4. On 7/30/25 at 12:33 PM, the surveyor was observing the lunch meal on 4th floor unit. The surveyor observed Resident #94's tray, per the tray ticket, Resident #94 was supposed to receive pot roast, bread and health shake supplement, all three items were missing from the tray.5. On 7/30/25 at 12:39 PM, the surveyor was observing the lunch meal on 4th floor unit. The surveyor observed Resident #2's tray, per the tray ticket, Resident #2 was supposed to receive coffee and sour cream, both items were missing from the tray. 6. On 7/30/25 at 12:45 PM, the surveyor was observing the lunch meal on 5th floor unit. The surveyor observed Resident #8's tray, per the tray ticket, Resident #8 was supposed to receive double portions protein, tea, sour cream, and gravy, all four items were missing from the tray.1. On 7/30/25 at 12:50 PM, the surveyor reviewed the electronic medical record (E-mar) for Resident #69. A review of Resident #69's Face sheet (FS) (an admission summary) was admitted to the facility with diagnoses that included but were not limited to encephalopathy, hypothyroidism, and acute kidney failure.A review of the Quarterly MDS, (an assessment tool used to facilitate care management) dated 7/15/25, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident's cognition is intact.A review of the Physician Order (PO) summary revealed a PO dated 1/22/24, Health Shake three times a day for malnutrition.A review of Resident #69's care plan (CP) revealed a nutrition CP with an initiation date of 10/25/24, the intervention portion of the CP revealed two nutrition interventions, Provide, serve diet as ordered with an initiation date of 3/1/25 and Provide and serve supplements as ordered: Health Shakes as ordered, with an initiation date of 3/1/25.2. On 7/30/25 at 12:55 PM, the surveyor reviewed the E-mar for Resident #25. A review of Resident #25's FS was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease, hypothyroidism, and type 2 diabetes mellitus.A review of the annual MDS, dated [DATE], reflected a BIMS score of 6 out of 15, indicating Resident #25 had severe cognitive impairment.A review of the PO summary dated 7/16/25, identified an order with an original date of 7/16/25, Regular diet, Easy to chew texture, and Thin liquid consistency.A review of Resident #25's CP revealed a nutrition CP with an initiation date of 1/17/25, the intervention portion of the CP revealed three nutrition interventions all with 2/11/25 initiation dates, Provide, serve diet as ordered, Provide fortified foods as indicated, and Provide supplements per orders.3. On 7/30/25 at 1:00 PM, the surveyor reviewed the E-mar for Resident #116. A review of Resident #116's FS was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure with hypoxia, atrial fibrillation, and essential hypertension.A review of the quarterly MDS, dated [DATE], reflected a BIMS score of 14 out of 15, indicating Resident #116 had intact cognition.A review of the PO summary dated 12/2/24, identified an order with an original date of 3/3/24, No Added Salt (NAS), Regular texture, and Thin liquid (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	consistency.A review of Resident #116's CP revealed a nutrition CP with an initiation date of 12/9/24, the intervention portion of the CP revealed two nutrition interventions first with an initiation date of 3/25/24, Honor food preferences and a second with an initiation date of 3/6/25 Provide, serve diet as ordered.4. On 7/30/25 at 1:05 PM, the surveyor reviewed the E-mar for Resident #94. A review of Resident #94's FS was admitted to the facility with diagnoses that included but were not limited to subacute osteomyelitis left femur, encephalopathy, and essential hypertension.A review of the quarterly MDS, dated [DATE], reflected a BIMS score of 6 out of 15, indicating Resident #94 had severely impaired cognition.A review of the PO summary dated 4/25/25, identified two orders, one with an original date of 4/24/25, Regular diet, Easy to Chew texture, and Thin liquid consistency, and a second order with an original date of 5/29/24, Health Shake two times a day for supplement. A review of Resident #94's CP revealed a nutrition CP with an initiation date of 1/22/24, the intervention portion of the CP revealed two nutrition interventions both with initiation dates of 1/22/25, Provide, serve diet as ordered and Provide supplements of Health shake 4 ounce twice per day.)5. On 7/30/25 at 1:10 PM, the surveyor reviewed the E-mar for Resident #2. A review of Resident #2's FS was admitted to the facility with diagnoses that included but were not limited to iron deficiency anemia, type 2 diabetes mellitus, and major depressive disorder.A review of the quarterly MDS, dated [DATE], reflected a BIMS score of 9 out of 15, indicating Resident #2 had moderate cognitive impairment.A review of the PO summary dated 6/25/25, identified an order, original date of 3/5/25, Regular diet, Regular texture, and Thin liquid consistency. A review of Resident #2's CP revealed a nutrition CP with an initiation date of 12/2/24, the intervention portion of the CP revealed a nutrition intervention with initiation date of 3/5/25, Provide, serve diet as ordered.6. On 7/30/25 at 1:15 PM, the surveyor reviewed the E-mar for Resident #8. A review of Resident #8's FS was admitted to the facility with diagnoses that included but were not limited to sepsis, peripheral vascular disease and acute kidney failure.A review of the admission MDS, dated [DATE], reflected a BIMS score of 14 out of 15, indicating Resident #8 cognition is intact.A review of the PO summary dated 6/1/25, identified an order, with an original date of 4/24/25, LCS (Low Concentrated Sweets) diet, Regular texture, Thin consistency, Double portion. A review of Resident #8's CP revealed a nutrition CP with an initiation date of 5/22/25, the intervention portion of the CP revealed two nutrition interventions both with initiation dates of 5/22/25, Provide double portion protein at all meals, and Provide, serve diet as ordered.On 7/30/25 at 1:30 PM, the surveyor conducted an interview with the Registered Dietitian (RD) who stated they have not completed tray accuracy audits, but agreed they need to be done to ensure tray accuracy.On 7/30/25 at 1:40 PM, the surveyor conducted an interview with the Food Service Director (FSD) who stated, the kitchen staff needs to have the tray double checked before going up to the units and he needs to perform more tray accuracy audits.On 7/31/25 at 12:36 PM, the surveyor met with the LNHA and acting Director of Nursing (DON) to review areas of concern found during the survey. The LNHA stated the tray accuracy concerns will immediately be addressed.On 8/4/25 at 11 AM, the DON provided the surveyor a facility policy titled, Meal Pass with a reviewed dated of 5/2025. Under the description portion of the policy it states, Meal Services .3. Staff must check the meal ticket upon removing tray from food truck and ensure that items on the meal ticket are present on the tray.On 8/5/25 at 12:27 PM, the survey team met with the LNHA and DON for the exit conference. No further information provided by the facility staffNJAC - 17.4(a)1, (e)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness.This deficient practice was observed and evidenced by the following:On 7/29/25 at 9:37 AM, the surveyor in the presence of the Food Service Director (FSD) toured the kitchen and observed the following: 1. In the bread storage area, the surveyor observed one loaf of sliced white bread, one loaf of sliced whole wheat bread, one bag of 12 hotdog buns, and one loaf of rye bread all opened and without open/use by labels. The FSD stated they use the manufacturers use by dates.2. On a dry storage shelf the surveyor observed an open bag of penne pasta with an open date of 3/26/25 without a use by label. The FSD stated open pasta can be used for 90 days after opening and further acknowledged the pasta was past the 90 days from opening.3. On the Chef preparatory table, the surveyor observed three opened containers of seasoning: 16 ounce (oz) granulated garlic, 5 oz Italian seasoning, and 16 oz red pepper flakes. All seasonings had been opened and were missing open/use-by labels. The FSD stated the seasoning should have been labeled and were discarded.4. The surveyor observed a dietary aide (DA#1) without their hair fully restrained under a hairnet. DA#1 stated they had not realized some of their hair was no longer restrained and put on a new hairnet.5. The dual ovens were observed with a black colored burnt debris on the bottom area. The FSD stated the ovens are cleaned weekly but could not stated why the debris was present. 6. The surveyor observed on the top of the standing steamer a sticky grease like substance was present. The FSD stated the steamer is cleaned weekly but could not state why the grease like substance was present. 7. On the ice machine vent the surveyor observed a dust like debris. Per the FSD the ice machine vent is cleaned weekly but could not state why the debris was present.8. In the walk-in refrigerator the surveyor observed a dust like debris on the interior fans and wrapped sliced America cheese without an open/use-by label. The FSD stated all items should be labeled and the cheese was On 7/30/25 at 11:15 AM, during the follow up kitchen the surveyor observed the following.9. As the chef was taking food temperatures of the tray line the surveyor observed, the chef place the food thermometer into a full tray of broccoli past the metal probe where the broccoli was touching the plastic portion, thereby contaminating the broccoli. Per interview the chef stated they had not realized the plastic had touched the broccoli. Per the FSD the broccoli would need to be disposed of. During further observation the chef contaminated a full tray of roasted potatoes and a 1/4 tray of mashed potatoes by place the plastic portion of the food thermometer into the food. All food was disposed of by the FSD. The FSD stated all staff would be re-in-serviced on taking food temperatures.On 7/30/25 the Licensed Nursing Home Administrator (LNHA) provided the surveyor with multiple facility kitchen policies. The facility policy titled Storage of non-Perishable Goods with a reviewed date of 5/2025 revealed under the policy interpretation and implementation section, 6. Dry goods (i.e. cereal, grains_ shall be stored for a period not to exceed three months. The Kitchen Cleaning Equipment policy with a reviewed date of 5/2025 revealed under the policy interpretation and implementation section, 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions.Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions. The Employee Hygiene policy with a reviewed date of 5/2025 revealed under the policy interpretation and implementation section, 10. Hairnets or caps and beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Policy for labeling and dating of food items not provided after surveyor request.On 7/31/25 at 12:36 PM, the surveyor met with the LNHA and acting Director of Nursing (DON) to review areas of concern found during the survey. The LNHA stated all kitchen concerns will immediately be addressed.On 8/5/25 at 12:27 PM, the surveyor team met with the LNHA and DON for the exit conference. No further information provided by the facility staffNJAC 8:39-17.2(g)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the dumpster and surrounding area free of garbage and debris.This deficient practice was observed and evidenced by the following:On 7/29/25 at 9:37 AM, the surveyor in the presence of the Food Service Director (FSD) toured the kitchen and garbage area; and found the following. There was garbage debris that included food wrappers, food containers, cups, gloves, paper products, and plastic utensil around the dumpster and surrounding areas. The FSD stated that the area should have been cleaned by the maintenance and dietary departments.On 7/30/25 at 1:00 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a facility policy titled, Disposal of Refuge with a reviewed date of 5/2025. Under the interpretation and implementation section of the policy revealed, 4. Outside dumpsters or compactors provided by waste management services will be kept closed and free of surrounding debris.On 7/31/25 at 12:36 PM, the surveyor met with the LNHA and acting Director of Nursing (DON). The LNHA stated the garbage area concerns would immediately be addressed.On 8/5/25 at 12:27 PM, the surveyor met with the LNHA and DON for exit conference, no further pertinent information provided.NJAC 8:39-19.7

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, record review and review of facility policies it was determined that the facility failed to a.) ensure residents with significant weight changes (a weight change of 5% in 30 days and/or 10% in 180 days) were addressed by the Registered Dietitian (RD#1) in a timely fashion and b.) ensure that a resident was weighed weekly in accordance with physician's orders and facility policy. This deficient practice was identified for 2 of 2 residents (Resident #8 and #64) reviewed for significant weights changes. The deficient practice was evidence by the following:1. On 7/29/25 at 11:18 AM, the surveyor interviewed Resident #64 in their room. Resident #64 stated they are on a pureed diet and had lost weight over the past year, but unable to state how much. A review of Resident #64 Face Sheet ((FS) an admission record) revealed that the resident had diagnosis that included but were not limited to unspecified protein-calorie malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things), type 2 diabetes mellitus (a condition in which the body cannot use insulin correctly and sugar builds up in the blood), and anxiety disorder Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/15/25 reflected a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating Resident #64 had moderate cognitive impairment. Review of the weights from the electronic medical record (EMR) revealed:7/24/24: 86.7 pounds (Lbs.) 7/7/25: 86.0 Lbs.7/3/25: 84.7 Lbs.6/26/25: 84.2 Lbs.6/17/25: 84.0 Lbs.4/11/25: 102.2 Lbs. A review of the RD#1's nutrition progress notes (NPN) for Residents #64 in the electronic medical record revealed the following had two LATE ENTRY (Any documentation that is recorded in the medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) designation which indicates the notes were not written on the effective date (Date of service): 1. NPN with an effective date of 6/19/2025, but with a created date of 7/22/2025. Per the RD#1's NPN, dated 6/19/2025, the RD recommended Mighty Shakes 4 ounce (oz) twice per day. 2. NPN with an effective date of 6/23/2025, but with a created date of 7/22/2025. On 7/30/25 at 11:45 AM, the surveyor interviewed RD, who stated they are the Regional RD and has been covering the building until the facility is able to hire a part-time RD, currently she is in the building 3 times per week. Per the RD, residents are weighed upon admission, re-admitted , monthly, and weekly weights are completed for residents per RD discretion. RD acknowledged Resident #64's June weight loss note was backdated from 7/22/25, and the recommended intervention of Mighty Shakes could not have been entered at that time, but Resident #64 had those supplements already in place. On 7/31/25 at 12:36 PM, the surveyor met with the Licensed nursing Home Administrator (LNHA) and acting Director of Nursing (DON) to review areas of concern found during the survey. The LNHA stated they would look into the RD#1's documentation. On 8/4/25 at 11:35 AM, the acting DON provided the surveyor with a facility policy titled, Nutritional Assessment/ Documentation, with a reviewed date of 5/2025. Under the description portion of the policy it revealed, 1. The Dietitian, in conjunction with the nursing staff and healthcare practitioners, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will conduct a nutritional assessment for each resident upon admission and as indicated by a change on condition that places the resident at risk for impaired nutrition. 2. A review of Resident #8 FS revealed that the resident had diagnosis that included but were not limited to Diabetes, Cellulitis of left lower extremity (an infection of tissue) and stage II pressure ulcer (a wound with partial thickness loss of skin affecting the epidermis and the dermis) of the left heel. Review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated A review of the Physician Order Summary (POS) revealed an order dated 7/1/25 with a start date of 7/7/25 to weigh resident weekly on Mondays for four weeks. The dates for the four weekly orders were: 7/7/25, 7/14/25, 7/21/25 and 7/28/25. A review of the weight Review of the weights from the electronic medical record (EMR) revealed the recorded weight was 169.2 pounds on Thursday 7/24/25. On 8/5/25 at 9:15 AM the surveyor interviewed the 5th floor Unit Manage (UM), who stated that on Monday's the RD would provide a list of residents who had orders to be weighed. The UM further stated that the Certified Nursing Assistants (CNA) and the nurses on the unit would obtain the weights and would return the list to the RD. The UM also stated that the weights are then recorded by the RD into the medical records. On 8/5/25 at 9:40 AM, the surveyor interviewed the RD who stated Resident #8 had an order for weekly weight to start on 7/725 for four weeks. The RD acknowledged that one weight was documented for the four-week period. She further stated that she does not document on every weight and acknowledged that the weekly weighs should be entered in the residents' medical records. The RD acknowledged that the weekly weights should have been obtained and documented weekly as ordered for the entire four-weeks ordered by the physician. The RD confirmed there was no documentation of the weights stating, I don't document follow up on every weight. the RD further stated that weekly weights should be entered every week if the weekly weight data and review documentation should be entered for every week. RD confirmed that the floor nurses and staff do not enter the weights before she reviews them to prevent inaccurate weights from being entered in health records and she does not enter them or follow up to see they are entered into the residents' records. On 8/5/25 at 12:27 PM, the survey team met with the LNHA and DON for the exit conference. No further information provided by the facility staff NJAC 8:39-27(a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure sufficient and competent staff were available to provide appropriate incontinence care to dependent residents. This deficient practice occurred for 3 of 4 residents reviewed for sufficient staffing (Resident # 47, #63, and #64) and was evidenced by the following:Refer to F677Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/1/21: (1) One Certified Nurse Aide (CNA) to every eight residents for the day shift. (2) One direct staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and (3) One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the two weeks of staffing from 7/13/25 through 7/26/25 prior to the standard survey of 8/5/2025 revealed the facility was deficient in staffing hours as evidenced by the following: For the 2 weeks of staffing prior to the survey from 07/13/2025 to 07/26/2025, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows:-07/17/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs.-07/20/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. For the week of Complaint staffing from 08/25/2024 to 08/31/2024, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -08/25/24 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs.-08/26/24 had 4 CNAs for 107 residents on the day shift, required at least 13 CNAs.-08/27/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs.-08/30/24 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs.-08/31/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs.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 (LPN/UM) 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 the 11-7:00 AM, Certified Nursing Assistant (CNA) assignment sheet revealed that the 4th-floor nursing unit had a census of 60 Residents with 4 assigned CNAs. The CNA had an assignment of 15 residents on that 11-7 AM shift.2. On 7/31/25 at 8:30 AM, the surveyor, accompanied by the LPN/UM, observed Resident #63 in bed. The LPN/UM exposed Resident #63's incontinence brief, which was saturated with urine and feces. The LPN/UM confirmed that the brief was saturated with urine and feces. The CNA had an assignment of 15 residents on that 11-7 AM shift.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. The CNA had an assignment of 15 residents on that 11-7 AM shift. 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 11-7 AM shift should provide incontinence care before the end of the shift between 5 AM-7AM. The LPN/UM was not sure what the CNA to resident ratio was on the 11-7 AM shift.The CNA assigned to the above residents on the 11- 7:00 AM shift were unavailable for interviews. On 8/5/25 at 10:25 AM, during an interview with the surveyor, the staffing coordinator confirmed that on 7/30/25, during the 11:00 PM-7:00 AM (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shift the census on the 4th floor nursing unit was 60 and that the CNAs had 15 residents on each of their assignments. The staffing coordinator stated that she was aware of the 1 CNA to 14 resident ratio for the night shift. On 8/5/25 at 10:38 AM, the survey team discussed the above observations and concerns with the MDS coordinator and Licensed Nursing Home Administrator (LNHA).A review of the facility's Activities of Daily Living (ADL) policy, revised July 2024, reflected that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. A review of the facility's Staffing Policy reviewed 5/2025 reflected .To ensure the facility complies with New Jersey state law regarding minimum staffing levels and maintains appropriate direct care staff ratios to ensure quality care and resident safety .NJAC 8:39-5.1 (a), 27.1 (a), 27.2 (h)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 7/30/25 and 7/31/25, the surveyor observed three (3) nurses administer medications to six (6) residents. There were 25 opportunities, and six (6) errors were observed which calculated to a medication administration error rate of 24%. The deficient practice was identified for two (2) of six (6) residents, (Resident #16 and #89), that were administered medications by two (2) of three (3) nurses that were observed.The deficient practices were evidenced by the following:1). On 7/30/25 at 8:48 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN#1) in the room of Resident #16. The surveyor observed LPN#1 informing Resident #16 that she would be administering the resident's medications. The surveyor observed the resident who was in their bed and just finished eating breakfast.On 07/30/25 at 8:52 AM, the surveyor observed LPN#1 preparing to administer nine (9) medications to Resident #16 which included one (1) tablet Carvedilol 6.25 mg (medication for lowering blood pressure), one (1) tablet of Levocarnitine 330 mg (to prevent and treat low blood levels of carnitine),one (1) tablet of Hydralazine 25 mg (medication for lowering blood pressure), one (1) Vitamin C 500 mg (supplement), two (2) chewable tablets of Aspirin 81 mg (coronary artery disease), Combigan eye drops (glaucoma), Dorzolamide eye drops (glaucoma), one tablet of [NAME]-Vite (supplement) and one tablet of Apixaban 5 mg (coronary artery disease). The surveyor observed LPN #1 entered the resident's room. LPN#1 one told the surveyor that the resident receives two eye drops and both drops are instilled into the resident's left eye. The surveyor observed LPN#1 instill one drop of Combigan into the resident's left eye (ERROR #1). She then told the surveyor she had to wait 15 minutes before administering Dorzolamide eye drops. LPN#1 was then observed to attempt to administer all of Resident #16's by mouth medications, and at that time the surveyor stopped LPN#1 and asked her to leave the room with all of the resident's medications. The surveyor and LPN#1 reviewed the resident's medications and at that time, LPN#1 acknowledge that she put two Aspirin 81 mg chewable tablets into the medication cup instead of one tablet (Error #3) . LPN#1 also acknowledge that she placed a Vitamin C 500 mg tablet into the medication cup instead of Vitamin C 250 mg (Error #4).The surveyor then observed LPN#1 disposing medication into a drug disposal system (drug buster) and then reprepared all the medications for administration. LPN #1 was then observed going back to Resident #16's room and administering the resident's medication. LPN #1 was then observed instilling 1 drop of Dorzolamide eye drops to the resident's left eye (error #2).After medication administration, the surveyor in the presence of LPN#1 reviewed Resident #16's Electronic Medication Administration Record (e-MAR) which revealed that Resident #16 had a physician's order for Combigan ophthalmic (eye) drops with a direction to instill 1 drop to both eyes twice daily and a physician's order for Dorzolamide ophthalmic drops with a direction to instill 1 drop in both eyes twice daily.At that time, LPN#1 acknowledge that she should have instill 1 drop in both eyes for both the Combigan and Dorzolamide eye drops.A review of the admission Record (an admission summary) reflected that Resident #16 was admitted to the facility with diagnoses that included but not limited to; hypertension (a condition in which the force of the blood against the artery walls is too high), type II diabetes(a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure).A review of the quarterly Minimum Data Set, an assessment tool used to facilitate the of care, dated 05/08/25, reflected that the resident's cognitive skills for daily decision-making score was 15 out of 15, which indicated that the resident's cognition was cognitively intact.A review of the July 2025 Physician's Orders (PO) revealed a Physician's Order dated 11/05/24, for Combigan Ophthalmic solution 0.2%-0.5% (Brimonidine Tartrate-Timolol Maleate) Instill 1 drop both eyes two times a day for (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glaucoma (pressure in the eye) and a PO dated 06/18/25 for Dorzolamide HCL solution 2% Instill 1 drop in both eyes two times a day for glaucoma, a PO dated 11/5/24, for Aspirin 81 mg oral chewable, give 1 tablet by mouth in the morning for Coronary Artery Disease (CAD), and a PO dated 11/5/24, for Ascorbic Acid Oral tablet 250 mg (Vitamin C), give 1 tablet by mouth one time a day for supplement.A review of the July 2025 EMAR revealed a PO dated 11/05/24, for Combigan Ophthalmic Solution 0.2-0.5% (Brimonidine Tartrate-Timolol Maleate), Instill 1 drop in both eyes two times a day for glaucoma and PO dated 06/18/25 for Dorzolamide HCL 2%, Instill 1 drop in both eyes two times a day for glaucoma, a PO dated 11/5/24, for Aspirin 81 mg oral chewable, give 1 tablet by mouth in the morning for Coronary Artery Disease (CAD), and a PO dated 11/5/24, for Ascorbic Acid Oral tablet 250 mg (Vitamin C), give 1 tablet by mouth one time a day for supplement.2). On 07/31/25 at 8:30 AM, the surveyor while observing medication administration pass, observed a Registered Nurse (RN#1) entered Resident #89 who was eating breakfast, that she was going to take the resident's vitals and administer their medications.On 07/31/25 at 8:32 AM, the surveyor observed RN#1 preparing to administer five (5) medications to Resident #89 which included one (1) tablet of aspirin 81 mg chewable (coronary artery disease), one (1) tablet Januvia 50 mg (medication to lower blood sugar), Ferrous Sulfate 325 mg (anemia), Metformin 500 mg tablet(medication to lower blood sugar), and Metoprolol 25 mg tablet (blood pressure medication). The surveyor observed RN#1 preparing the resident's medications for administration. She told the surveyor that the resident is administered their medications crushed and in apple sauce. The surveyor observed RN#1 crush each medication including Januvia 50 mg and Ferrous Sulfate 325 mg and place each medication in a separate medication cup with apple sauce. The surveyor then observed RN#1 enter Resident #89's room and administered the resident their medications, which included Januvia 50 mg (Error #5) and Ferrous Sulfate 325 mg (Error #6).The surveyor reviewed Resident #89's medical records.A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; type II diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), syncope and collapse (fainting, or a sudden temporary loss of consciousness) and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete painful blockage).A review of the Annual Minimum Data Set, an assessment tool used to facilitate the management of care dated 07/23/25, reflected that the resident's cognitive skills for daily decision-making score was 7 out of 15, which indicated that the resident' had severe cognitive impairment.A review of the July 2025 Order Summary Report (physician's order sheet) (OSR) revealed a physician's order (PO) dated 12/28/23, for Januvia 50 mg (Sitagliptin Phosphate) by mouth one time a day and an PO dated 02/27/25, for Ferrous Sulfate oral tablet 325 (65 Fe) MG (Ferrous Sulfate) give 1 tablet by mouth one time a day for supplement.A review of the July 2025 electronic medication administration record (eMAR) revealed a PO dated 12/28/223, for Januvia 50 mg (Sitagliptin Phosphate) by mouth one time a day and an PO dated 02/27/25, for Ferrous Sulfate oral tablet 325 (65 Fe) MG (Ferrous Sulfate) give 1 tablet by mouth one time a day for supplement with both medications having a plotted time of 9 AM.A review of the Manufacturer's Specifications for both Januvia and Ferrous Sulfate revealed the following:-Januvia should be swallowed whole. The tablets must not be split, crushed, or chewed before swallowing.-Ferrous Sulfate should not be crush, chew or break apart.On 07/31/25 at 09:00 AM, the surveyor in the presence of the RN#1 reviewed Resident#89's physician's orders and there were no instructions on the e-MAR instructing the nurse not to crush Januvia and Ferrous Sulfate. The surveyor in the presence of RN#1 reviewed Resident #89's Januvia medication card which contained no auxiliary label not to crush Januvia.At that time, the surveyor interviewed RN#1 who stated that she was not aware that both Ferrous Sulfate and Januvia couldn't be crush. She further stated if she was aware that both Januvia and Ferrous Sulfate couldn't be crush that she would not crush those two medications.On 7/31/25 at 1:15 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator (LNHA) and the Minimum Data Set (MDS) coordinator who (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was covering for the Director of Nursing.No further information was provided.On 8/5/25 at 8:50 AM, the surveyor interviewed the CP via a telephone interview who acknowledge that both Ferrous Sulfate and Januvia should be taken whole and should not be crushed or split. She stated that crushing both medications won't affect the activity or the distribution of the medication or harm the resident. The CP stated that the recommendation not to crush both Januvia and Ferrous sulfate was due to bitter taste or causing discoloration of teeth. She felt it was not necessary to make this recommendation when it won't affect the way the medication works or harm a resident.A review of the facility's policy for Medication Administration that was dated 6/2025 and was provided by the LNHA revealed the following: 3. Reads medication order on electronic Medication Administration Record (e-MAR). 4. Removes medication from resident's drawer in the medication cart.Checks name of residentChecks name of drugChecks strength/dose of drugFrequency given. 5. Checks medication order again. Compares e-MAR to blister pack to ensure it reads the same. NJAC 8:39-11.2(b), 29.2(a)(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and other facility documentation, it was determined that the facility failed to a.) maintain a sanitary clean environment; b.) minimize the potential spread of infection to residents during medication administration for 1of 3 nurses observed during medication pass on 1 of 2 nursing units and c.) follow the Centers for Disease Control recommendations and guidelines for Hand Hygiene for 3 of 3 staff members.This deficient practice was evidenced by the following. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24, Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 07/30/25 at 8:52 AM, during medication administration observation the surveyor observed a Licensed Practical Nurse (LPN#1) preparing Resident #16's medications which included two (2) eye drops, Combigan and Dorzolamide Ophthalmic drops. After preparing all the medications, the nurse told the surveyor that she will be applying a pair of gloves to administer the resident's eye drops. The surveyor observed LPN#1 cleaning her hands with a hand sanitizer and then putting on her a pair of gloves. The surveyor then observed the LPN #1 while wearing the pair of gloves touching the lid of a trash bin that was attached to the medication cart. LPN#1 was then observed entering Resident #16's room and placing the resident's medications on the overbed table. The surveyor observed LPN#1 without performing hand hygiene and changing her gloves, touched the resident's bed and headrest. The surveyor observed LPN#1 with the same pair of gloves instilled 1 drop of Combigan eye drops to Resident #16's left eye and then wipe the eye with a tissue. At that time, the surveyor interviewed LPN#1 who acknowledge that after touching the trash bin and the resident's bed she should have removed her gloves, performed hand hygiene and then reapplied gloves before instilling an eye drop and then wiping the resident's eye with a tissue paper. 2. On 7/30/25 at 9:41 AM, during medication administration observation, the surveyor observed LPN#1 cleaning her hands with a hand sanitizer and then putting on a pair of gloves. The surveyor observed LPN#1 cleaning a blood pressure monitor, a pulse ox, and a thermometer with a disinfectant wipe. After allowing them to dry, the surveyor observed LPN#1 without removing her gloves and performing hand hygiene take Resident #54's vitals. At that time, the surveyor interview LPN#1 who acknowledge that after cleaning the blood pressure monitor, pulse ox, and the thermometer, she should have removed her gloves and perform hand hygiene. She further stated that after performing hand hygiene she should have reapply her gloves and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then took Resident #54's vitals. On 07/31/25 at 1:00 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator (LNHA) and the Minimum Data Set (MDS) coordinator who was the acting Director of Nursing for this survey. A review of the facility's policy titled Handwashing/Hand Hygiene with a review date of 5/2025 and was provided by the LNHA revealed the following: 6. In most situations, the preferred method of hand hygiene is an alcohol-based rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: Before and after direct contact with residents Before donning sterile gloves Before performing any non-invasive procedures Before preparing or handling medications Before handling clean or soiled dressing, gauze pads, etc Before moving a contaminated body site to a clean body site during resident care After contact with a resident's intact skin After handling used dressing, contaminated equipment, etc After contact with objects (e.g medical equipment) in the immediate vicinity of the resident After removing gloves 2. On 7/30/25 at 8:54 AM, Surveyor #1 (S#1) toured the laundry area in the presence of the Director of Maintenance and Housekeeping (DMH). Both S#1 and the DMH observed the following: -Next to the dirty area of the laundry room was the washer area and the DMH stated that it was considered a clean area. Upon entry, there were three folding tables, the 1st two tables with folded clean residents' clothes and towels uncovered, at the end of the 3rd table was the big electric fan blowing air towards uncovered clothes and towels. The electric fan observed with heavy accumulation of blackish substances, which the DMH stated they were heavy accumulation of dust. Below the table was a small electric fan blowing air with accumulations of dust. -At the back of the big electric fan were metal racks with folded clean towels, linens, and blankets, and they were all uncovered. The other back side were rehabilitation (rehab) supplies and equipment (wheelchair, walkers, positioning equipment) heavily covered with dust (grayish substances). Above were pipes with heavy accumulation of grayish substances and the DMH stated should have been cleaned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that same time, the DMH was unable to state when the last time was it was cleaned and there was no accountability log. He stated it was the responsibility of the maintenance people to clean the area. He also stated that the clean supplies should have been covered. The laundry area at that time was left unattended. On 7/30/25 at 9:14 AM, both S#1 and the DMH toured the 4th floor unit shower room. Both S#1 and the DMH observed the door was left open, the Certified Nursing Aide (CNA) entered the room, and performed handwashing in the sink. The CNA, while washing her hands stated that there were no soap and paper towels, and the water accumulated in the sink. The DMH stated that the sink was clogged and should have been fixed. He further stated that he would ask Housekeeper to put soap and paper towels. At that same time, both S#1 and the DMH observed the left side of the shower room, there were two big plastic bags of garbage on the floor next to the three compartment bins, and the lids were left open. The DMH stated that the bags of garbage should have been disposed properly in one of the three compartment bins and the lids should have been closed. On 7/30/25 at 10:09 AM, S#1 in the presence of the Minimum Data Set Coordinator/Registered Nurse (MDSC/RN) interviewed the Infection Preventionist/RN (IP/RN). The IP/RN informed S#1 that she was responsible for infection control, ensuring hand hygiene, infection control protocols were followed, education of staff, immunizations of residents and staff, and antibiotic stewardship. She stated that part of her responsibility also was to do daily rounds in the unit, including shower rooms, and residents' room, and monthly rounds for the laundry area. She further stated that she ensure that all areas were clean and with enough supplies. At that same time, S#1 notified the IP/RN and the MDSC/RN of the above findings and concerns with laundry area, shower room on the 4th floor, and hand hygiene of the CNA. The IP/RN stated that the garbage should not be on the floor, it should be inside the three compartment bins, and lids should be down to cover the bins. She further stated that there should be soap and paper towels for the staff to be able to perform appropriate hand hygiene. A review of the facility's Laundry and Linen Policy with a reviewed date of 5/2025, that was provided by the MDSC/RN, revealed, under purpose.this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. A review of the facility's Handling of Linens Policy with a reviewed date of 5/2025, that was provided by the MDSC/RN, revealed, under purpose.the facility will ensure that all linens are handled, stored, processed and transported so as to prevent the spread of infection. A review of the facility's Cleaning a Resident's Room Policy with a reviewed date of 5/2025, that was provided by the MDSC/RN, revealed, under Important things to remember.2. Never: d. Place soiled items (example garbage) directly on the floor. On 7/31/25 at 1:30 PM, the survey team met with the MDSC/RN and the LNHA, and S#2 notified them of the above findings and concerns. 3. On 7/31/25 at 8:25 AM, during the incontinence tour on the 4th floor nursing unit, the surveyor observed the Licensed Practical Nurse/Unit Manager (LPN/UM) enter Resident 64's room and perform hand hygiene. The LPN/UM applied soap and immediately placed his hands under the stream (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of running water without first lathering and applying friction. The LPN/UM used the same paper towel he dried his hands with to turn off the faucet. The LPN/UM put on gloves and exposed Resident #63's brief, which was saturated with urine. The LPN/UM removed his gloves, applied soap, and immediately placed his hands under the stream of running water without first lathering or applying friction. The LPN/UM dried his hands and used the same paper towel to turn off the faucet. On 7/31/25 at 8:30 AM, the LPN/UM entered Resident #63's room and performed hand hygiene. The LPN/UM applied soap and immediately placed his hands under the stream of running water without lathering and applying friction. The LPN/UM dried his hands and used the same paper towel to turn off the faucet. The LPN/UM put on gloves and exposed Resident #63's brief, which was saturated with feces and urine. The LPN/UM removed his gloves, applied soap, and immediately placed his hands under the stream of running water without first lathering or applying friction. The LPN/UM dried his hands and turned off the faucet with the same paper towel. On 7/31/25 at 8:32 AM, the Certified Nursing Assistant (CNA #1) assigned to Resident #63's care entered the room and performed hand hygiene. The surveyor observed the CNA applied soap and lathered her hands for 6 seconds outside the stream of running water, then placed her hands under water. On 7/31/25 at 8:40 AM, the LPN/UM entered Resident #47's room. The LPN/UM applied soap and immediately placed his hands under the stream of running water without lathering or applying friction. The LPN/UM dried his hands and with the same paper towel turned off the faucet. The LPN/UM put on gloves and exposed Resident #47's brief, which was saturated with feces and urine. The LPN/UM removed his gloves, applied soap, and immediately placed his hands under the stream of running water without first lathering and applying friction. The LPN/UM dried his hands and turned off the faucet with the same paper towel. On 7/31/25 at 8:45 AM, during an interview with the surveyor, the LPN/UM stated he thought that as long as he washed his hands for 20 seconds, it didn't matter whether it was outside or under the stream of water. On 7/31/25 at 8:55 AM, during an interview with the surveyor, CNA #1 stated that she was educated by the Assistant Director of Nursing (ADON) to wash and lather her hands outside the stream of water for 20 seconds. CNA #1 could not speak to why she only lathered for 6 seconds outside the stream of water. On 7/31/25 at 8:58 AM, during an interview with the surveyor, the ADON stated she was the facility's educator and that she instructed all staff on how to perform hand hygiene properly, which included applying soap and lathering their hands outside the stream of water for a minimum of 20 seconds. On 8/4/25 at 10:00 AM, the surveyor discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA) and MDS coordinator, who confirmed that hand hygiene included lathering and applying friction for at least 20 seconds out of the stream of water. NJAC 8:39-19.4(a)(1),(m)

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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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and a review of pertinent facility documents, it was determined that the facility failed to treat each resident with respect and dignity in a manner that promotes their quality of life. The deficient practice and violation of privacy were identified for 3 of 28 residents (Resident #70, #71 and Resident #123) reviewed for residents' rights and was evidenced by the following: On 7/30/25 at 11:30 AM, the surveyor was interviewing Resident #70. At that time, the surveyor observed a maintenance worker enter the room without knocking or announcing themselves. The maintenance worker opened a step ladder and inspected the privacy curtain and then exited the room.On 7/30/25 at 11:40 AM, the surveyor observed the same maintenance worker enter the room of Resident #71, without knocking, waiting for permission or introducing themselves before entering the room.At that time, the surveyor interviewed the maintenance worker who stated that they should have knocked, announced themselves and attempted to get permission before entering the room. On 7/30/25 at 11:45 AM, the surveyor interviewed the 5th floor Registered Nurse/Unit Manager (RN/UM) who stated that all staff should knock, announce themselves, and state the purpose for entry into any resident's room. On 7/30/25 at 12:13 PM, the surveyor observed two transport ambulance personnel pushing a stretcher, enter Resident #123's room. Neither person was observed to knock, announce themselves, or state their purpose upon entering the room. At that time, the surveyor interviewed the ambulance personnel, who stated that they did not knock or announce themselves before entering the room, and both acknowledged that they should have.On 7/30/25 at 12:25 PM, the surveyor interviewed the 5th floor UM, who stated that outside contractors should respect the policies of the facilities, knock and announce themselves before entering a resident's room.On 7/30/25 at 12:37 PM, the surveyor interviewed the Director of Maintenance (DOM), who stated that all staff are expected to knock before entering a resident's room and then wait to receive permission from the resident before entering.On 7/30/25 at 1:45 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that all employees and contractors must knock and announce themselves before entering a resident's room. No further information was provided. NJAC 8:39-27.1 (a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner for a.) 1 of 2 Nursing Units reviewed for environment; b.) ensure clean linens were provided daily for 6 of 6 residents who attended the resident group meeting (Resident #1, 19, 20, 29, 69 and 78); c.) ensure equipment was kept in a clean, sanitary manner for 2 of 2 residents, (Resident #113 and #70) and e). ensure privacy curtains were clean and in working order for 2 of 2 Residents (Resident #47 and #13)). This deficient practice was evidenced by the following: 1. On 7/30/25 at 9:14 AM, Surveyor #1 (S#1) and the Director of Maintenance and Housekeeping (DMH) toured the 4th floor unit and observed the following: The clean linen room was observed with the door closed, upon entry there was a metal rack uncovered with clean folded towels. On top was a vent with heavy accumulation of grayish substance and the ceiling tile with dried brownish discoloration. The DMH stated that the heavy accumulation of grayish substance was dust and the last time it was cleaned was beginning of March this year. He further stated that there was no specific timeframe when to clean the vent but when it was dirty it should have been reported to the Maintenance department and to be cleaned. On that same date and time, the DMH informed S#1 that it was not cleaned because they were doing some projects. He also stated that the ceiling tile where the vent had a dried brownish discoloration was from the condensation from the vent. The shower room door was left open, upon entry there were 6 and 1/2 missing tiles and broken tiles on the floor. The DMH stated he was aware of concerns with missing and broken tiles in the 4th floor unit shower room a month ago and had not had a chance to fix it. The shower curtain with missing hooks, the exhaust on the ceiling, and vent with accumulation of blackish substances. The DMH stated they were accumulations of dust. At that same time, the Certified Nursing Aide (CNA) entered the shower room and performed handwashing in the sink. Both S#1 and the DMH observed water accumulation in the sink, and the DMH stated that the sink was clogged and should be fixed. The two shower cubicles vents were heavily covered with dust and the DMH stated that they should have been cleaned daily. The DMH was unable to state the last time it was cleaned, there was no accountability log. The DMH stated that the housekeepers knew it should be cleaned daily. On 7/30/25 at 9:25 AM, both S#1 and the 4th floor Licensed Practical Nurse/Unit Manager (LPN/UM) went to Resident room [ROOM NUMBER] (RR#416) and observed privacy curtains with missing hooks. The resident's closet in the 1st bed observed the 1st drawer with chipped wood and the light was busted. The LPN/UM stated it should have been fixed. The toilet room vent with heavy accumulation of grayish substances, which the LPN/UM claimed it was dust, and should have been cleaned. At that same time, both S#1 and LPN/UM observed the shade blind was broken and the windowsill with accumulation of blackish substances, which the LPN/UM claimed should have been cleaned. The air-conditioning (aircon) system was blowing air, inside was observed individual packets of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	handwipes, dust accumulations, and dried brownish items. The LPN/UM stated that those brownish items were dried leaves. On 7/30/25 at 9:35 AM, both S#1 and the LPN/UM went to RR#431, observed privacy curtains with missing hooks, the floor with brownish discoloration, and dust. Both S#1 and LPN/UM also observed the aircon with dried brownish discoloration on top and accumulation of dust. The LPN/UM stated that the floor and aircon should have been cleaned. On that same date and time, outside RR#431, in the hallway, both S#1 and the LPN/UM observed the vent with heavy accumulation of dust, and LPN/UM stated it should have been cleaned. On 7/30/25 at 9:39 AM, S#1 interviewed the Housekeeping Staff (HS) assigned in the 4th floor unit in the presence of the DMH. The HS informed S#1 that it was her responsibility to maintain the cleanliness of the unit, that included mopping the floor, cleaning the tables, resident's toilet rooms, and shower room daily. At that same time, the HS informed S#1 that she did not have a chance to check the shower room yet today. She further stated that she was aware of the privacy curtains in resident rooms with missing hooks but did not report it to anyone. On 7/30/25 at 10:09 AM, S#1 in the presence of the Minimum Data Set Coordinator/Registered Nurse (MDSC/RN) interviewed the Infection Preventionist/RN (IP/RN). The IP/RN informed S#1 that part of her responsibility also was to do daily rounds in the unit, including shower rooms, resident rooms, and monthly rounds for the laundry area. She further stated that she ensured that all areas were clean and with enough supplies. At that same time, S#1 notified the MDSC/RN who was covering for the Director of Nursing (DON), in the presence of the IP/RN the above findings and concerns. The IP/RN had no answer as to why the above concerns were not identified during her routine rounds. A review of the facility's Cleaning a Resident's Room Policy with a reviewed date of 5/2025, that was provided by the MDSC/RN, revealed, under policy: to ensure that all residents' rooms are cleaned on a regular basis. Under procedure, daily cleaning, 1. Using a clean cloth treated with an appropriate disinfectant or dusting utensil: a. [NAME]/high dust all appropriate surfaces including, but not limited to: i. vents,.windowsills.c. clean floors.e. inspect privacy curtains. Replace curtains that are soiled or damaged. On 7/31/25 at 1:30 PM, the survey team met with the MDSC/RN and the Licensed Nursing Home Administrator (LNHA), and Surveyor #2 notified them of the above findings and concerns. 2. On 7/30/25 at 9:00 AM, during a tour of the 5th floor Nursing unit, two alert and oriented unsampled residents (who wished to remain anonymous) stated that they were not provided clean towels or wash cloths daily and that the Certified Nursing Assistants (CNAs) often used their top sheets to dry them after bathing. They both stated that they received clean gowns daily. On 7/31/25 at 9:05 AM, during an interview with the surveyor, the CNA (CNA #1), who was assigned to the 4th floor nursing unit, stated that 5 out of 7 days, she was unable to provide fresh clean towels or wash clothes to her residents. CNA #1 stated that she had brought it to the attention of the Director of Nursing (DON) and the nurses on the 4th floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/25 at 9:10 AM, during an interview with the surveyor, CNA #2 stated that there were not enough towels or washcloths for the residents, and that when towels were unavailable, she used the top sheets to dry the residents after their showers and bed baths. On 7/31/25 at 9:12 AM, during an interview with the surveyor, CNA #3 stated that she did not have enough towels or washcloths for the residents on her assignment and sometimes needed to use their top sheets to dry them. On 7/31/25 at 9:15 AM, during an interview with the surveyor, CNA #4 stated she often was unable to provide fresh, clean linens to the residents on her assignment. She stated that she had notified DHK with no resolution. On 7/31/25 at 9:30 AM, during an interview with the surveyor, the CNA (CNA #5) stated that when she notified the Housekeeping staff that she needed more linens, the response was that there were no clean towels or washcloths available. CNA #5 further stated that the facility was always running out of paper towels. On 7/31/25 at 10:30 AM, during the resident council meeting, 6 out of 6 alert and oriented residents (#1, #19, #20, #29, #69, #78) chosen by the facility to attend the meeting stated that they did not receive clean towels and or washcloths daily. They further stated that the top sheets were not changed often. On 7/31/25 at 11:00 AM, during an interview with the surveyor, the Director of Housekeeping/ Maintenance (DHK) stated that he did not keep a record of PAR levels or the number of linens ordered and had no idea of how much linen the facility had. The DHK stated that every resident should be provided with 3 towels per shift. He further confirmed that the CNAs often told him that they were short and needed more, but he stated that the CNAs hoarded the linens and more were not always available. The DHK showed the surveyor the emergency linen supply closet. DHK confirmed that there should be enough emergency supplies for 3 days .Facility Census was 106. The surveyor and DHK observed that there were no fitted sheets and no top sheets. There were three boxes of towels, each containing 60 towels. The facility had a total of 180 towels for 106 residents. Additionally, there was one box with 10 dozen (120) washclothes. The surveyor observed 3 boxes of disposable wipes, which the DHK stated that the facility no longer used. The DHK acknowledged that he did not have 3 days' supplies of emergency linens. On 7/31/25 at 11:15 AM, during an interview with the surveyor, the Housekeeper/porter stated that the CNAs would notify him a few times a week that they were short and needed more linens, but they were not always available. They would be in the washer and dryer. He further stated that he would be unable to provide additional linens. The surveyor asked the porter if he had notified the DHK that there were not enough linens. The [NAME] replied that the DHK was aware. On 7/31/25 at 12:35 PM, the survey team discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA) and Minimum Data Set (MDS) coordinator/Acting Director of Nursing. (ADON) [NAME] Sanguan. The ADON stated that he would get back to me regarding facility policy on linens provided to the residents and PAR levels. On 8/4/25 at 2:30 PM, during an interview with the surveyor, Resident #1 stated that she only received one towel for the entire week. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 7/31/25 at 8:45 AM, the surveyor and the LPN/UM entered room [ROOM NUMBER] and observed that the privacy curtain for Resident #47 was heavily soiled with a brown substance across the bottom section of the curtain. The LPN/UM confirmed that the curtain should have been replaced as the residents should be provided a clean environment. On 7/31/25 at 8:52 AM, during an interview with the surveyor, the Housekeeping aide stated that when she saw a soiled curtain, she would report it to the Director of Housekeeping (DHK), but had not realized the curtain was soiled. On 8/4/25 at 10:00 AM, the survey team met with the LNHA and MDS coordinator to discuss the above observations and concerns. A review of the facility's Linen policy reviewed 5/2025 reflected .The purpose of this policy is to ensure that all residents in the facility receive adequate, clean, and well-maintained linens. Establishing proper linen par levels will help maintain a consistent and efficient supply of linen for daily use while minimizing waste and shortages .Policy .The facility will maintain an appropriate par level of linens to ensure that each resident has access to sufficient and appropriate clean linens (e.g., bed sheets, towels, pillowcases, incontinence products) at all times. Linen par levels will be established based on resident census, facility needs, and infection control protocols . Linen Par Level: The ideal quantity of linen items needed to meet daily demand and allow for turnover without running short .This includes the standard linens provided for each resident, as well as an additional inventory to account for laundry processing time, emergencies, or high usage. Par Level Calculation: The quantity of linen required for daily usage, factoring in the number of residents, laundry processing time, and anticipated fluctuations (e.g., seasonal changes, special needs) . A review of the facility's Terminal Cleaning policy reviewed 5/2025 reflected .It is the policy to ensure that all resident rooms, treatment areas, and common areas are thoroughly and effectively cleaned and disinfected . Medical Equipment Cleaning: Clean and disinfect all non-disposable resident care equipment such as .PEG tube feeding stands . 4. On 7/30/25 at 9:30 AM, during medication administration the surveyor observed a Certified Nursing Assistant (CNA#1) in the process of starting morning care for Resident #13. The surveyor observed CNA #1 attempting to close the privacy curtain which could only close halfway. The surveyor observed the curtain not attached to multiple rings which connects the privacy curtain to the rail . The surveyor interviewed CNA #1 after she completed morning care. CNA#1 told the surveyor that she's been working at the facility for around one month and the curtain has been that way since she started. On 7/30/25 at 9:45 AM, the surveyor interviewed the resident's nurse, Licensed Practical Nurse (LPN#1). LPN#1 stated that the resident's curtain has been broken for a long time and the facility were aware that the curtain was broken. She was unable to tell the surveyor why the privacy curtain was not fixed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/25 at 1:15 PM, the surveyor presented the above concern to the Licensed Nursing Home Administrator (LNHA) and the Minimum Data Set (MDS) coordinator who was the acting Director of Nursing. 5. On 7/30/25 at 9:00 AM, during a tour of the 5th floor nursing unit, two unsampled residents (who wished to remain anonymous) stated that they didn't receive clean towels or wash cloths daily. The residents further stated that the Certified Nursing Assistants (CNAs) often used their top sheets to dry them after bathing. On 7//31/25 at 10:30 AM, the surveyor conducted the Resident group meeting with 6 residents. All 6 of 6 residents stated that they were not provided with clean towels or washcloths daily and further stated that their sheets were not changed very often. On 8/4/25 at 2:30 PM, during an interview with the surveyor, Resident #1 stated that they only received one towel for the entire week and that their sheets were not changed often. 6. On 7/29/25 at 11:39 AM, the surveyor observed in the room of Resident #113, a Tube Feeding Pump (delivers liquid nutrition through a flexible tube into the stomach). The surveyor observed that the pump and the pole was soiled with yellow and brown substances. The surveyor further observed the floor behind the head of the bed was heavily soiled with yellow brown substance. The oxygen concentrator (a medical device that provides supplemental oxygen) that was also in the room was observed to have had splatters of a substance and a layer of dust. On 7/30/25 at 8:45 AM, the surveyor observed in Resident #113's room a Tube Feeding Pump (delivers liquid nutrition through a flexible tube into the stomach). The surveyor observed that the pump was soiled with yellow and brown substances, and the pole was heavily soiled with dark brown and yellow substances. there was a NC oxygen tubing connected to the concentrator not in use and not stored in a plastic bag. On 7/31/25 at 9:30 AM, the surveyor showed the Registered Nurse (RN) assigned to Resident #113 the soiled Tube Feeding Pump and Pole. The RN stated that Resident #113 no longer used the pump and that it should have been removed from their room. The RN acknowledged that the pump and pole were soiled. The surveyor asked the RN who was responsible for cleaning the pump and pole. The RN replied that she was not sure. 7. On 7/29/2025 at 10:30 AM, the surveyor observed the enteral feeding pump and pole of Resident #70's were splattered with light brown dried substance. The legs of the pole were also heavily crusted with thick reddish-brown substance. On 7/30/2025 at 12:30 PM The Surveyor made a second observation of Resident #70's enteral feeding pump and the pole the pump was mounted to remained splattered with light brown dried substance. The legs of the pole remained heavily crusted with thick reddish-brown substance. On 8/4/2025 at 1:40 PM, the survey team met with the LHNA and DON for the exit conference. No further pertinent information provided. NJAC 8:39-31.4(a)(b)(f) NJAC 27.1 (a)

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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. **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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 appropriate hygiene products. NJAC 8:39-27.1 (a), 27.2 (h)

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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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide a safe smoking environment for 2 of 2 residents (Resident #3 and #72). This deficient practice was identified in the smoking area by the entrance to the facility, and was identified by the following:On 7/29/25 at 9:15 AM, the surveyor observed that the area near the facility's covered entryway had extinguished cigarettes on the ground in several areas. The surveyor observed that there were no receptacles or ashtrays in the area to safely extinguish cigarettes. The surveyor also observed that there were no fire extinguishers or fire blankets.1. On 7/29/25 at 10:50 AM, the surveyor observed Resident #3 in their room. The alert and oriented Resident stated that he/she was an independent smoker, and the facility staff permitted him/her to keep their cigarettes and lighters locked in their top drawer.On 7/30/25 at 11:00 AM, the surveyors observed Resident #3 in the portico near the front entrance smoking a cigarette. The surveyors observed extinguished cigarettes on the ground in several areas. The surveyor asked Resident #3 if this area was designated for smoking. The Resident replied that the staff told him/her that this was where she/he was permitted to smoke. The surveyor asked the resident where he/she extinguished and discarded the leftover portion of the cigarette (butt). The resident replied that he/she extinguished it on the outside of the trash can and then threw the butt into the trash can.The surveyor reviewed the medical record for Resident #3.A review of the admission Record reflected Resident #3 was admitted to the facility with diagnoses that included but were not limited to; seizures and hemiplegia (partial paralysis on one side of the body) and hemiparesis (weakness) following cerebrovascular disease (stroke).A review of the admission Minimum Data Set, an assessment tool dated 6/21/25, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS further assessed under section J that the resident was not currently using tobacco. A review of Resident #3's Care Plan Report had a focus area that included: the resident is a known smoker with the goal that the resident will smoke safely within the designated smoking area x 90 days initiated on 6/18/25 and revised on 7/2/25 with interventions that included but were not limited to; review the smoking policy with the resident as needed. A review of the Smoking Regulation Agreement signed and dated 6/15/25 reflected.[Resident #3] is aware of the smoking rules and has been informed and accompanied to the designated smoking area. residents who smoke are permitted to smoke, must do so off premises in a public domain.I understand that it is my responsibility to keep all matches/lighters secured in a locked drawer in my room or secured on my person. A review of Resident #3's Smoking assessment dated [DATE] reflected. Resident demonstrates an accurate understanding of smoking policy and guidelines.2. On 08/5/2025 at 9:15 AM, the surveyor observed Resident #72 smoking in the area by the facility entrance. During an interview with the surveyor, Resident #72 stated that he/she was admitted to the facility about a year ago. Resident #72 stated that he/she was informed at that time that this was the designated smoking area and that he/she had been smoking in this space since admission. He/she further stated that there used to be a bucket with sand to extinguish the cigarette butts, and now there is an ashtray. The resident further stated that when there was no bucket or ashtray, he/she extinguished them on the ground. The surveyor observed that there were no fire extinguishers or fire blankets in the area. The surveyor reviewed the medical record for Resident #72.A review of the admission Record reflected Resident #72 was admitted to the facility with diagnoses that included but were not limited to; depression, anxiety, and chronic obstructive pulmonary disease (a lung disease).A review of the most recent Minimum Data Set, dated [DATE], revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. The MDS further assessed under section J that the resident was currently using tobacco. A review of Resident #72's Care Plan Report had a focus area (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that included: resident is a known smoker and smokes daily initiated 11/7/24 with the goal that the resident will smoke safely within the designated smoking area x 90 days initiated on 12/2/24 and revised on 3/21/25 with interventions that included but were not limited to review smoking policy with resident as needed and allow resident to smoke in designated smoking area with supervision as needed. A review of Resident #72's Smoking assessment dated [DATE] reflected.Resident demonstrates an accurate understanding of smoking policy and guidelines.On 8/5/25 at 9:30 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) the Smoking Regulation Agreement for Resident #72. No Smoking Regulation Agreement was provided for Resident #72.On 7/30/25 at 11:10 AM, during an interview with the surveyors, the receptionist confirmed that there was no fire extinguisher in the front lobby. On 7/30/25 at 12:00 PM, during an interview with the surveyor, the LNHA stated that the designated smoking area was located off to the side near the building's entrance. The surveyor asked the LNHA where the residents were supposed to extinguish their cigarette butts. The LNHA replied, In the ashtray. The surveyor informed the LNHA that no ashtrays were observed on 7/29/25 or 7/30/25. The LNHA replied, Someone must have stolen it. The surveyor asked the LNHA if there was a fire extinguisher in the area. The LNHA replied that she would have to get back to the surveyor. On 7/31/25 at 12:35 PM, the surveyor discussed the above observation and concerns with the LNHA and MDS coordinator. The LNHA stated that the facility was smoke-free and that residents needed to go off the premises if they wanted to smoke.On 7/31/25 at 1:15 PM, the surveyor observed two unsampled residents smoking in the area near the facility entrance. The surveyor observed there were no receptacles or ashtrays for the residents to safely extinguish their cigarette butts, and there were no fire extinguishers.On 8/4/25 at 8:10 AM, the surveyor observed by the facility entrance a large bucket filled with sand and several cigarette butts. At that time, the surveyor observed the Director of Housekeeping (DHK) /maintenance used a dolly to remove the large bucket and replace it with a green ashtray.On 8/4/25 at 8:20 AM, during an interview with the surveyor, the DHK stated that he had gone to the Home Depot to get the bucket and sand this weekend. He just got the ashtray today, so he was replaced it with the sand bucket. The DHK further stated that the area where he placed the ashtray was, in fact, the designated smoking area. The DHK acknowledged that the facility was responsible for providing a safe smoking environment. Specifically, it should have had an ashtray receptacle so that residents could safely extinguish and dispose of their cigarettes, and a fire extinguisher in the designated smoking area. A review of the facility's undated Smoking Policy reflected.In accordance with New Jersey state law, this center shall maintain a smoke-free environment. Residents, visitors, and employees are prohibited from smoking within the building, including the center's parking area, delivery area, and portico covered entryway. Residents and visitors wishing to smoke shall be directed to do so off premises on the public domain.such as a sidewalk.NJAC 8:39-31.6(e)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure a urinary drainage bag was secured in a manner to prevent contamination, infection control, and to enhance dignity for 1 of 1 resident reviewed for urinary catheter care.The deficient practice was evidenced by the following: On 8/4/25, at 9:45 AM, the surveyor observed Resident #113's urinary drainage bag not in a privacy bag and visible from the hallway. A review of Resident #113's admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; urinary retention, chronic obstructive pulmonary disease, and gastrostomy status (a feeding tube inserted through the abdominal wall into the stomach to deliver nutrition). A review of the current Order Summary Report and transcribed onto the Treatment Administration Record (TAR) reflected a physician order to check urinary catheter (a flexible, plastic tube inserted into the bladder to drain urine) for proper placement, provide urinary care, record urine output at the end of each shift and maintain in privacy bag every 8 hours. A review of Resident #113's admission Minimum Data Set (MDS), an assessment tool, dated 7/24/25 reflected the resident had a severely impaired cognition. Section H of the assessment revealed the resident had an indwelling catheter. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, initiated on 7/18/25, that the resident has a foley catheter for urinary retention with interventions that included but were not limited to; cover drainage bag with privacy cover at all times. On 8/4/25 at 9:45 AM, during an interview with the surveyor, the Registered Nurse (RN) stated that she was unsure whether the urinary drainage bag should be secured in a privacy bag for infection control prevention and dignity. On 8/4/25 at 10:00 AM, the survey team discussed the above observations and concerns with the MDS coordinator and the Licensed Nursing Home Administrator (LNHA). The MDS coordinator confirmed that the urinary drainage bag should be stored in a privacy bag for infection control and dignity. A review of a facility policy, Catheter Care, Urinary dated as reviewed 5/2025, revealed.cover urinary drainage bags with privacy covers. N.J.A.C. 8:39-27.1 (a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure oxygen nasal cannula tubing was stored in accordance with infection control measures for 1 of 1 residents (Resident #113) reviewed for Oxygen Therapy. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 7/29/25 at 11:39 AM, the surveyor observed in Resident #113's room an oxygen concentrator, not in use, soiled with a brown and yellow substance and covered with dust.On 7/30/25 at 8:45 AM, the surveyor observed in Resident #113's room an oxygen concentrator soiled with a brown and yellow substance covered with dust and a Nasal Cannula Oxygen tubing connected to the concentrator, not in use, not stored in a plastic bag. A review of Resident #113's admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath) and gastrostomy status (a feeding tube inserted through the abdominal wall into the stomach to deliver nutrition). A review of the current Order Summary Report revealed a Physician Order (PO) dated 7/17/25 and transcribed onto the Treatment Administration Record (TAR) to give 3 liters per minute (lpm) of oxygen via nasal cannula, check saturation (the amount of oxygen in the blood) every shift. A review of Resident #113's admission Minimum Data Set (MDS), an assessment tool, dated 7/24/25, reflected that the resident had severely impaired cognition. Section O of the assessment revealed the resident received respiratory treatments, which included oxygen therapy. A review of the resident's individual comprehensive care plans (CP) revealed that no care plan had been initiated for oxygen therapy. On 7/31/25 at 9:30 AM, during an interview with the surveyor, the Registered Nurse assigned to Resident #113's care stated that the oxygen tubing should be stored in a plastic bag for infection control prevention. On 8/4/25 at 10:00 AM, the survey team discussed the above observations and concerns with the MDS coordinator and the Licensed Nursing Home Administrator (LNHA). The MDS coordinator confirmed that when the oxygen tubing was not in use, it should be stored in a plastic bag for infection control measures. A review of a facility policy, Oxygen Administration dated as reviewed 5/2025, revealed.the purpose of this procedure is to provide guidelines for safe oxygen administration.review the resident's care plan to assess for any special needs of the resident.store tubing that is not in use in plastic bags. NJAC 8:39-19.4(a); 27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that medication was administered according to the physician's order (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in one (1) of six (6) residents (Resident #16) during medication observation pass. The deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 7/30/25 at 8:48 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN#1) in the room of Resident #16. The surveyor observed LPN#1 informing Resident #16 that she would be administering the resident's medications. The surveyor observed the resident in bed eating breakfast.On 07/30/25 at 8:52 AM, the surveyor observed LPN#1 preparing to administer nine (9) medications for Resident #16 which included Carvedilol 6.25 mg (medication for lowering blood pressure), Levocarnitine 330 mg tablet (to prevent and treat low blood levels of carnitine), Hydralazine 25 mg tablet (medication for lowering blood pressure), Vitamin C 250 mg tablet (supplement), Aspirin 81 mg (coronary artery disease), Combigan Ophthalmic (eye) drops (glaucoma), Dorzolamide Ophthalmic (eye) drops (glaucoma), [NAME]-Vite (supplement) and Apixaban 5 mg (coronary artery disease). The surveyor observed LPN #1 during medication administration observation instilling 1 drop of Combigan eye drops and 1 drop of Dorzolamide eye drops into the resident's left eye.After LPN#1 administered Resident #16's medications the surveyor reviewed the physician orders for both the Dorzolamide and Combigan eye drops with LPN#1. The surveyor in the presence of LPN#1 inspected the pharmacy packaging for both Combigan and Dorzolamide Ophthalmic drops. The surveyor observed a label with administration directions for Dorzolamide Ophthalmic drops to instill 1 drop to the left eye twice daily. The pharmacy label was dated 6/10/25. A review of the Combigan Ophthalmic drops revealed a label with administration directions to instill 1 drop to both eyes twice daily. After reviewing the packaging for both eye drops the surveyor in the presence of LPN#1 reviewed Resident #16's Electronic Medication Administration Record (e-MAR) which contained a physician's order for Combigan Ophthalmic drops to instill 1 drop to both eyes twice daily and a physician's order for Dorzolamide Ophthalmic drops to instill 1 drop in both eyes twice daily.At that time, the surveyor interviewed LPN #1 who acknowledge that both Dorzolamide and Combigan Ophthalmic drops should have been instill into both eyes. LPN#1 acknowledge that she was following the instructions of the pharmacy label and should have follow the instructions on the EMAR. LPN#1 further stated that the incorrect directions on the pharmacy label was confusing and had a potential to cause an error. She stated that whenever the instructions on the pharmacy label are different from the order on the EMAR, she should verify the order with the physician. A review of the admission Record (an admission summary) reflected that Resident #16 was admitted to the facility with diagnoses that included, but were not limited to; hypertension (a condition in which the force of the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood against the artery walls is too high), type II diabetes(a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). A review of the quarterly Minimum Data Set, an assessment tool, dated 05/08/25, reflected that the resident's cognitive skills for daily decision-making score was 15 out of 15, which indicated that the resident's cognition was intact.A review of the July 2025 Physician's Orders (PO) revealed a PO dated 11/05/24, for Combigan Ophthalmic solution 0.2%-0.5% (Brimonidine Tartrate-Timolol Maleate) Instill 1 drop both eyes two times a day for glaucoma (pressure in the eye) and a PO dated 06/18/25 for Dorzolamide HCL solution 2% Instill 1 drop in both eyes two times a day for glaucoma.A review of the July 2025 EMAR revealed a PO dated 11/05/24, for Combigan Ophthalmic Solution 0.2-0.5% (Brimonidine Tartrate-Timolol Maleate), Instill 1 drop in both eyes two times a day for glaucoma, and a PO dated 06/18/25 for Dorzolamide HCL 2%, Instill 1 drop in both eyes two times a day for glaucoma. On 07/31/25 at 1:00 PM, the surveyor discussed the above concerns with the facility administration team that consisted of the Licensed Nursing Home Administrator (LNHA) and the Minimum Data Set (MDS) coordinator, who was the acting Director of Nursing.There was no additional information provided.A review of the facility's policy for Medication Administration dated 6/2025, which was provided by the LNHA revealed the following: 3. Reads medication order on electronic Medication Administration Record (e-MAR). 4. Removes medication from resident's drawer in the medication cart.Checks name of residentChecks name of drugChecks strength/dose of drugFrequency given. 5. Checks medication order again. Compares e-MAR to blister pack to ensure it reads the same.NJAC 8:39-11.2 (b), 29.2 (d)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities in the resident's medical record to the facility staff and attending physician. This deficient practice was identified for one (1) of six (6) residents observed during medication administration pass, (Resident #89) for medication management and was evidenced by the following: On 07/31/25 at 8:30 AM, during medication administration pass the surveyor observed a Registered Nurse (RN#1) entered into Resident #89 room. The resident was observed sitting up in bed and eating breakfast.RN #1 informed the resident that she would be taking their vitals and then would be administering their medications.On 7/31/25 at 8:32 AM, the surveyor observed RN#1 preparing to administer five (5) medications for Resident #89 which included aspirin 81 milligram (mg) chewable tablet (coronary artery disease), Januvia 50 mg (medication to lower blood sugar), Ferrous Sulfate 325 mg (anemia), Metformin 500 mg tablet (medication to lower blood sugar), and Metoprolol 25 mg tablet (blood pressure medication). The surveyor observed RN#1 preparing the resident's medications for administration. She told the surveyor that the resident is administered their medications crushed and in apple sauce. The surveyor observed RN#1 crush each medication including Januvia and Ferrous Sulfate and place each medication in a separate medication cup with apple sauce. The surveyor then observed RN#1 enter Resident #89's room and administered the resident their medications which included Januvia 50 mg and Ferrous Sulfate 325mg.The surveyor reviewed Resident #89's medical records.A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; type II diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), syncope and collapse (fainting, or a sudden temporary loss of consciousness) and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete painful blockage).A review of the Annual Minimum Data Set, an assessment tool used to facilitate the management of care dated 07/23/25, reflected that the resident's cognitive skills for daily decision-making score was 7 out of 15, which indicated that the resident' had severe cognitive impairment.A review of the July 2025 Order Summary Report (physician's order sheet) (OSR) revealed a physician's order (PO) dated 12/28/23, for Januvia 50 mg (Sitagliptin Phosphate) by mouth one time a day and an PO dated 2/27/25, for Ferrous Sulfate oral tablet 325 (65 Fe) MG (Ferrous Sulfate) give 1 tablet by mouth one time a day for supplement. A review of the July 2025 electronic medication administration record (eMAR) revealed a PO dated 12/28/2023, for Januvia 50 mg (Sitagliptin Phosphate) by mouth one time a day and an PO dated 2/27/25, for Ferrous Sulfate oral tablet 325 (65 Fe) MG (Ferrous Sulfate) give 1 tablet by mouth one time a day for supplement with both medications having a plotted time of 9 AM.A review of the Manufacturer's Specifications for both Januvia and Ferrous Sulfate revealed the following:-Januvia should be swallowed whole. The tablets must not be split, crushed, or chewed before swallowing.-Ferrous Sulfate should not be crush, chew or break apart.A review of the Consultant Pharmacist (CP) Monthly Reports from dated 5/1/25 through 7/31/25 indicated that the CP reviewed the medication regimen for Resident #89 with no recommendation that both Ferrous Sulfate and Januvia can't be crush. They were also no recommendation making the physician or nurses aware that these two medications were not recommended to be crushed by the manufacture.On 7/31/25 at 9:00 AM, the surveyor in the presence of the RN#1 reviewed Resident#89's physician's orders and they were no instructions on the e-MAR instructing the nurse not to crush Januvia and Ferrous Sulfate. The surveyor in the presence of RN#1 reviewed Resident #89's Januvia medication card which contained no auxiliary label not to crush Januvia.At that time, the surveyor interviewed RN#1 who stated that she was not aware that both Ferrous Sulfate and Januvia couldn't be crush. She further stated if she was aware that both Januvia (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Ferrous Sulfate couldn't be crush that she would not crush those two medications.On 7/31/25 at 1:15 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator (LNHA) and the Minimum Data Set (MDS) coordinator who was covering for the Director of Nursing. No further information was provided.On 8/5/25 at 8:50 AM, the surveyor interviewed the CP via a telephone interview who acknowledge that both Ferrous Sulfate and Januvia should be taken whole and should not be crushed or split. She stated that crushing both medications won't affect the activity or the distribution of the medication or harm the resident. The CP stated that the recommendation not to crush both Januvia and Ferrous sulfate was due to bitter taste or causing discoloration of teeth. She felt it was not necessary to make this recommendation when it won't affect the way the medication works or harm a resident.A review of the facility's policy for Medication Administration Guidelines undated, which was provided by the MDS coordinator included the following: 17. Observe for medications suitable and unsuitable for crushing. Stickers on blister packs will state Do Not Crush to indicate that the medication cannot be crushed. A review of the Consultant Pharmacist responsibilities that was undated and provided by the MDS coordinator revealed the following: Consultant Pharmacist would assure duration of therapy (adequate therapy) and Manufacturer's Recommendations.On 8/4/25 at 1:40 PM, the survey team met with the LNHA and DON for exit conference, no further pertinent information provided. NJAC 8:39-29.3

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to properly dispose of medications which was observed for one (1) of three (3) nurses during medication administration pass. This deficient practice was evidenced by the following:On 7/30/25 at 8:48 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN#1) in the room of Resident #16. The surveyor observed LPN#1 informing Resident #16 that she would be administering the resident's medications. The surveyor observed the resident in bed and eating breakfast.On 07/30/25 at 8:52 AM, the surveyor observed LPN#1 preparing to administer nine (9) medications to Resident #16 which included Carvedilol 6.25 mg (medication for lowering blood pressure), Levocarnitine 330 mg tablet (to prevent and treat low blood levels of carnitine), Hydralazine 25 mg tablet (medication for lowering blood pressure), Vitamin C 250 mg tablet (supplement), Aspirin 81 mg (coronary artery disease), Combigan eye drops (glaucoma), Dorzolamide eye drops (glaucoma), [NAME]-Vite (supplement) and Apixaban 5 mg (coronary artery disease). The surveyor observed LPN#1 during medication preparation added two (2) Aspirin 81 mg chewable tablets instead of one tablet into the medication cup. The surveyor also observed LPN #1 adding a Vitamin C 500 mg tablet instead of a Vitamin C 250 mg tablet into the medication cup.The surveyor stopped LPN#1 just before she was going to administer the medications to Resident #16. The surveyor asked LPN#1 to leave the resident's room with all of the resident's medications. The surveyor informed LPN#1 of the observations and asked for her to take out a bottle of Vitamin C 500 mg and a bottle of Aspirin 81 mg chewable tablets from the medication cart, so that she could identified the tablets. The surveyor observed LPN#1 pour two tablets of Aspirin 81 mg chewable tablets from a stock bottle and put them on a tissue paper. LPN#1 was observed handling these two tablets while reviewing the medications. LPN#1 acknowledge that she accidently added two Aspirin 81 mg chewable tablets to the medication cup. At that time, the surveyor observed LPN#1 pick up the tissue paper that contained the two Aspirin tablets and was going to throw them into the trash bin that was attached to the medication cart. At that time, the surveyor stopped LPN#1 and asked her if that was the proper way to dispose medications. LPN#1 stated that all medications should be dispose in a Drug Buster (medication disposal system) and that medication should not be dispose in a trash bin. The surveyor then observed LPN#1 remove a Drug Buster from her medication cart and dispose the two Aspirin tablets and all the medications that were in the medication cup. The surveyor then observed the nurse re-prepared all of the resident's medications for medication administration.On 7/31/25 at 1:00 PM, the surveyor discussed the above concerns with the Licensed Nursing Home Administrator and the Minimum Date Set (MDS) Coordinator who was covering for the Director of Nursing who was on vacation.No further information was provided by the facility.A review of the facility's policy titled Medication Return and Disposal of Medications Non-Controlled that was dated 05/2025 and was provided by the LNHA indicated the following: Policy: Medications that cannot be returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by the resident, and/or medications left by residents upon discharge) shall be destroyed If a dose of a non-controlled prescription medication is refused, spit out and/or dropped during medication pass, the facility will utilized Drug Buster to dispose of said medication. When container is filled per manufacturer's instructions, it will be disposed of in a med room trash and replaced with a new Drug Buster container.NJAC: 8:39-29.4 (a) (h) (d)