STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Rehabilitation & Health Care Center	129 Morris Turnpike Newton, NJ 07860

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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. 39399 Based on observation, interview, record review, it was determined that the facility failed to maintain dignity during mealtime for a resident who needed assistance with eating. This deficient practice was observed for 2 of 5 second floor dining room residents reviewed, Resident #10 and Resident #24 and was evidenced by the following: 1. On 3/4/24 at 12:16 PM, the surveyor observed Resident #10 in the second floor dining room seated in a Broda chair (chair that provides safe, comfortable long-term seating that can reduce the number of falls for residents) being fed their lunch. The surveyor observed that the resident's hospice Certified Nursing Aide (CNA) was standing behind the resident while reaching over the resident's right side to feed them. The surveyor interviewed the hospice CNA on 3/4/24 at 12:21 PM who stated, she was aware that any staff should be seated in eye to eye level while feeding any resident. The hospice CNA further stated that it was not appropriate to stand while feeding. A review of the Admission Record for Resident #10 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Aphasia; Cerebral Infarction; and Atrial Fibrillation. A review of the Resident #10's Significant Change in Status MDS, an assessment tool used to facilitate the management of care, dated 12/20/23, reflected that Resident #10 had a BIMS score of 99 out of 15, indicating severely impaired cognition. The MDS further reflected that the resident required partial/moderate assistance for eating. 2. On 3/4/24 at 12:16 PM, the surveyor observed Resident #24 in the second floor dining room seated in a wheelchair being fed their lunch. The surveyor observed that the Certified Nurse Aide #1 (CNA #1) was standing over the resident while feeding them. The surveyor interviewed CNA #1 on 3/4/24 at 12:55 PM who stated that all staff should be seated next to the resident while assisting them during feeding time. CNA #1 further stated that she was aware that she was standing while feeding the resident and shouldn't be. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission Record for Resident #24 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Vascular Dementia, Alzheimer's Disease and Abnormal weight loss. A review of Resident #24's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/24/24, reflected that Resident #24 had a Brief Interview for Mental Status (BIMS) score of 99 out of 15, indicating severely impaired cognition. The MDS further reflected that the resident required supervision or touching assistance for eating. Review of the Feeding Policy did not have any direction related to the appropriate way to feed a resident. On 3/11/24 at 3:30 PM, the Licensed Nursing Home Administration and the Interim Director of Nursing were made aware of the surveyor's dining observation. They both agreed that the CNA's should be seated next to the resident when feeding. N.J.A.C. 8:39-4.1(a)12

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 31656 Based on observation, interview, and record review, it was determined that the facility staff failed to follow acceptable standards of clinical practice for 1. not accurately documenting the resident's refusal of a medication, 2. not adequately documenting in the Administration Record to indicate that the daily weights were done according to physician's order (PO) to 2 of 16 residents reviewed, Resident #11 and Resident #18. This 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 or 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. 1. On 3/8/24 at 8:06 AM, the State Surveyor observed the start of medication pass with the Licensed Practical Nurse (LPN#1) on the 3rd floor. On 3/8/24 at 8:16 AM, LPN#1 entered the room belonging to Resident #19. Resident #18 was cheerful and identified the medication in the cup as 2 gelcaps of (Colace) Docusate Sodium 100 mg to LPN#1. Resident #18 explained that she didn't need the Colace 100 mg last night, so she saved it to give to the nurse in the morning. The surveyor reviewed the March 2024 Physician Orders (PO) which included an order for Colace 100mg give 2 capsules (200 mg) daily at bedtime for constipation HOLD for LBM (loose bowel movement). This was first ordered by the Physician for Resident #18 on 2/8/24. Review of the March 2024 electronic medication administration record (eMAR) revealed that the Colace 100 mg was scheduled to be administered at 9:30 PM. Review of the documentation on 3/7/24 of the eMAR provided a nurse's signature expressing that the Colace was administered to Resident #18 at 9:30 PM. On 3/8/24 at 12:00 PM, the surveyor discussed the situation with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA stated that the administering nurse should always wait until the medication is swallowed or refused by the resident and document accurately on the eMAR. The LNHA continued explaining that if the medication is refused by the resident, it should be documented that way. 39399 2. On 3/6/24 at 10:07 AM, the surveyor reviewed the March 2024 PO form that reflected an order dated 4/30/23 under Monitoring to Weigh resident every day at 7:00 AM before breakfast. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the form titled Resident Medication Administration Record (RMAR) for January 2024 showed a PO to Weigh resident every day at 7:00 AM before breakfast. The PO also indicated that nurses had to sign and document the weight of the resident. The surveyor observed that for the month of January 2024 RMAR , the nurse's failed to document that the weight was obtained for 23 out of 31 days. A review of the February 2024 RMAR revealed that the nurses failed to document that the weight was obtained for 10 out of 29 days. The surveyor interviewed the Registered Nurse (RN) #1 who was assigned to Resident #11 could not explain why the administration RMAR were blank, not signed daily and weights were not documented. A review of the facility's Policy and Procedure titled, Weight and Weight change Management revealed under procedure #4. All weights (daily, weekly, monthly) are to be documented in the electronic medical record or appropriate designated form. On 3/11/24 at 3:30 PM, the surveyor discussed this issue related to the missing signatures as well as required weights with the LNHA and Interim DON. There was no additional information provided. NJAC 8:39 - 27.1

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46049 REPEAT DEFICIENCY Based on observation, interview, and record review it was determined that the facility failed to provide care and services consistent with professional standards of practice for a resident with a pressure ulcer. This deficient practice was identified in 1 of 2 residents, Resident #1, reviewed for pressure ulcer care and prevention. The deficient practice was evidenced by the following: On 3/4/24 at 11:25 AM, the surveyor observed Resident #1 lying in bed in their room. Resident #1 was alert, verbally responsive, and conversant. Resident #1 stated they had a wound on their backside that was treated daily by the nurses and a wound doctor would visit weekly. On 3/7/24 at 10:06 AM, the surveyor observed Licensed Practical Nurse (LPN) #2 provide wound treatment to Resident #1's sacral wound. LPN #2 provided the surveyor a copy of the resident's treatment order. The physician order dated 1/11/24 read, Cleanse Sacral Wound and R [right] Buttocks with NS [normal saline] apply Triad to peri wound Medihoney, to Calcium Alginate Cover with large foam dressing BID [two times a day]. On 3/7/24 at 10:11 AM, the surveyor observed LPN #2 remove the old dressings from the sacral wound and a left upper buttock wound. LPN #2 sprayed wound cleanser to the resident's wounds, then used an ABD [Abdominal] gauze pad (used to absorb discharges from abdominal and other heavily draining wounds) and patted the wound site areas. LPN #2 did not use normal saline to cleanse the wound as documented in the physician's order. On 3/7/24 at 10:16 AM, the surveyor observed LPN #2 apply a small, bordered dressing to the left upper buttock wound. LPN #2 then applied a calcium alginate dressing with medihoney to the sacral wound bed and covered it with a large, bordered dressing. On 3/7/24 at 10:25 AM, the surveyor interviewed LPN #2 about the wound treatment observation and order. LPN #2 acknowledged that the physician's order was to be followed and the order should have been clarified with the physician for wound cleanser to be used for the treatment. The surveyor asked LPN #2 about wound cleansing technique. LPN #2 stated she did not see any concern with the method used when cleansing the wound. The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #1 which revealed the following: The Resident Face Sheet (an admission summary) documented Resident #1 had diagnoses that included but were not limited to, pressure ulcer of sacral region, hypertension, anemia, heart failure, and urinary tract infections. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 2/2/24, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 15 out of 15 which indicated that the resident was cognitively intact. The MDS assessment also indicated the resident had a stage 4 pressure ulcer. A review of the electronic treatment administration record (ear) included a physician's order 1/11/24 which read, Cleanse Sacral Wound and R [right] Buttocks with NS [normal saline] apply Triad to peri wound Medihoney, to Calcium Alginate Cover with large foam dressing BID [two times a day]. There were no other treatment orders documented for the resident's wounds. A physician's order dated 7/26/23 read Weekly Skin Assessment .Every week on Monday at 7:00-3:00 pm . A physician's order dated 10/13/2023 read Eval and Treat [wound consulting company] for wound care . A review of wound progress notes by the nurses, did not include assessment or documentation of the wound left upper buttock wound. The wound progress notes dated 2/15/24 and 2/22/24 documented wound location Sacrum and R [right] Buttocks. A review of the additional wound progress notes from March 2024 and February 2024 revealed there was only documentation for the sacral wound and no documentation of any other wounds. On 3/7/24 at 12:00 PM, the Director of Nursing (DON) provided the facility's wound care policy. The surveyor requested from the DON wound consultant documentation for Resident #1, which were not found in the resident's chart. On 3/7/24 at 2:05 PM, LPN #2 provided wound consultant documentation for Resident #1. A review of the physician wound consultant's notes from October 2023 to March 2024 revealed there was no documentation and assessment of the left upper buttock wound. A review of the wound consultant notes from January 2024 to March 2024 revealed there was documentation for the sacral wound. There was no documentation found of any other wounds. On 3/11/24 at 1:35 PM, the surveyor interviewed LPN #2, in the presence of the DON, about Resident #1's current wounds and only documentation for the sacral wound in the medical records. LPN #2 stated the resident's wound was on the right buttocks and there was no wound on the left buttock. The DON stated they would follow up to provide documentation of the resident's wounds and clarify the location of the resident's wounds. LPN #2 provided the contact phone number for the wound consultant physician. On 3/11/24 at 1:52 PM, the surveyor placed a phone call to the wound consultant physician. There was no answer, and a message was left to return a call to the surveyor. The wound consultant physician did not return a call to the surveyor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/24 at 3:17 PM, the surveyor informed the DON, Licensed Nursing Home Administrator (LNHA), and LPN #2 were made aware of the concerns observed during the wound treatment and for the assessment of the resident's wounds. The DON and LNHA stated appropriate wound technique would be for the wound to be cleansed with a gauze from the inner to the outer portion of the wound. The DON acknowledged each wound treatment should have individual treatment orders. The LNHA stated the facility would provide additional information. On 3/12/24 at 12:03 PM, the DON informed the surveyor she assessed Resident #1 with LPN #2 and stated the resident had the stage 4 sacral wound and a left upper buttock wound. The DON stated there was no right buttock wound and the right buttock in the treatment referred to the left upper buttock. The DON could not say if the left buttock wound was previously documented. The DON stated she would provide further information. On 3/12/24 at 12:40 PM, the DON provided a wound progress note dated 3/12/24. The document indicated the left buttock wound onset was on 2/7/24. The DON could not provide a verbal response as to why there was no previous documentation for the resident's wound and how the wound onset was determined to be on 2/7/24. The DON stated she would have to follow up with the nurses to determine what happened to the wound assessment and documentation. There was no additional information was provided by the facility. The surveyor reviewed the facility's policy titled, WOUNDS: PRESSURE ULCERS & ULCERS OF DIFFERENT TYPES, which had an updated date of 2/23/16. Under I. Assess, it read: Assess the individual for pressure ulcers and/or risk of developing pressure ulcers: .3. Weekly if actual ulcer is present to determine staging, effectiveness of current treatment, interventions, and healing process . Under C. Documentation, it read: .Resident with wound: Resident Wound Form, Resident Medical Record, TAR, Resident Plan of Care: to be conducted weekly, at a minimum, and shall include, but not be limited to: .a. location and staging, b. size, c. exudate, d. pain, if present including nature and frequency, e. wound bed, f. description of wound edges and surrounding tissue, g. infections related to ulcer, if applicable; h. dressings and treatment selection; effectiveness; i. general progress toward healing . The surveyor reviewed the facility policy titled Weekly Skin Assessment with a reviewed date of 5/20/23. Under Policy it read, It is the policy of this facility [to] do a weekly skin assessment to ensure that resident skin integrity is intact and to prevent development of pressure any ulcers and detection of any skin condition that jeopardizes the resident's skin integrity. Under Procedure it read, 1. A physician's order will be obtained for all residents for a weekly skin assessment. Weekly skin assessment will be conducted weekly during scheduled shower day by nurse assigned on the resident. Documentation will be by the nurse for any findings in [electronic medical record]. MD will be notified if there are abnormal findings. N.J.A.C. 25.2 (c); 27.1 (a)(e)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39399 NJ00169688 NJ00169710 Based on interview, and record review, it was determined that the facility failed to ensure that Resident #10 who was at risk for falls, accurately investigated the cause of each fall, the prevention of future falls, including a fall that resulted in serious injury. This deficient practice was identified for 1 of 3 residents reviewed for falls. Review of history of falls for Resident #10 revealed that they had 2 falls, on 11/11/23 and 11/13/23 with injuries. A review of the Investigation reports for the falls that occurred on 11/11/23 and 11/13/23, revealed that they did not include possible causes/root cause of the falls. Review of the investigations report supported that there was no appropriate Intervention evaluation or interventions put in place after the resident's falls relating to the resident's involuntary movements. Resident #10's care plan (CP) was not appropriate or specific to the resident's individualized needs including the resident's jerking movements which abetted in causing falls. The surveyor reviewed Resident #10's medical records. On 3/4/24 at 10:59 AM, the surveyor observed Resident #10 in the day room seated in a Broda chair (chair that provides safe, comfortable long-term seating that can reduce the number of falls for residents). A review of the Admission Record for Resident #10 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to Unspecified Convulsions, Hemiplegia and Hemiparesis following Cerebral infarction and Restlessness and Agitation. A review of Resident #10's Significant Change in Status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/20/23, reflected that Resident #10 had a BIMS score of 99 out of 15, indicating a severe impaired cognition. The following were the reported and documented fall incidents: 1. On 11/11/23 at 7:50 PM fall incident report revealed a witnessed fall resulting in minor injuries which included 3 skin tears to the left arm, 2 skin tears to the right arm and bruising noted to right groin and scrape on the knee. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the form titled, Employee/Witness Statement Form documented by Certified Nursing Assistant #4 (CNA #4) stated, was cleaning the resident the resident moved and fell off the side of the bed. On 3/7/24 at 10:45 AM, the surveyor interviewed CNA #1 who was the regular CNA for Resident #10. CNA #1 stated that occasionally when the resident was turned to their side, the resident would develop involuntary spasms/jerky movements. The surveyor asked CNA #1 if there were any documented medical alerts related to Resident #10's occasional spasms/jerky movements in the medical records or CNA tasks to aid the facility staff in taking care of the resident. CNA #1 could not locate any type of medical alert indicating the spasms/jerky movements. A review of the resident's CP activity report titled; Falls revealed that there were no interventions added to address the resident's occasional spasms/jerky movements. On 3/11/24 at 3:30 PM, the survey team discussed the above concerns to the facility's Licensed Nursing Home Administrator, Director of Nursing (DON) and Licensed Practical Nurse #2. The facility could not provide further information. The DON also agreed that the investigation was not thoroughly assessed and evaluated to determine the cause of the fall. 2. On 11/13/23 at 12:45 PM fall incident report revealed an unwitnessed fall resulting in major injury which included laceration to forehead which required hospitalization . A review of the form titled, Incident/Accident Report documented by Licensed Practical Nurse #3 (LPN #3) stated, After resident eat lunch with CNA staff (feeder) and after nurse left the dining room after all residents finished eating, CNA staff starting to pull up all resident from dining room, resident found on the floor and was bleeding from forehead . A review of the staffing for the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -11/12/23 had 5 CNAs for 66 residents on the day shift, required at least 8 CNAs. -11/13/23 had 6 CNAs for 66 residents on the day shift, required at least 8 CNAs. The staffing report revealed that on 11/13/23, the facility was short of CNAs in the day shift. A review of the progress notes dated 11/16/23 and documented by the Certified Occupational Therapy Assistant (COTA) reflected that Resident #10 was screened due to recent falls. The COTA documented, Resident had 2 falls recently. One from bed and another from broda chair. Upon investigation, the resident was left unattended in the dining room with broda chair completely upright instead of reclined. A review of the resident's CP activity report titled; Falls revealed that there were no interventions found indicating that the resident required the use of broda chair when out of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/11/24 at 3:30 PM, the surveyor discussed the above concerns to the facility's Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Licensed Practical Nurse #2. The DON agreed that the investigation was not conducted and assessed thoroughly for the fall incident on 11/11/23. The LNHA stated that the staffing was short on the day of the second fall incident which was 11/13/23. No further information was provided. NJAC 8:39-27.1(a); 31.4(a); 33.1(d)

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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. 39399 Based on observation, interview, and record review, it was determined that the facility failed to: a) ensure appropriate storage of oxygen (O2) equipment in accordance with facility and infection control policies, b) ensure a resident received oxygen as ordered by the physician. This deficient practice was identified in 3 of 3 residents (Resident #11, #12 and #58), reviewed for respiratory care. The deficient practice was evidenced by the following: 1. On 3/4/24 at 11:14 AM, during the initial tour in Resident #11's room, the surveyor observed an oxygen tubing connected to the resident's tracheostomy and oxygen concentrator dated 2/7. The resident was observed with eyes closed with the tracheostomy in place. A review of the Admission Record (AR) for Resident #11 reflected that the resident was admitted to the facility with diagnoses that included but not limited to Chronic Respiratory failure with hypoxia; Respiratory Syncytial virus pneumonia; Sepsis and Anoxic brain damage. A review of the Resident #11's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 1/1/24 reflected that the Brief Interview for Mental Status was not conducted due to the resident being in a vegetative state. A review of the March 2024 Physician's Order (PO) revealed that there was a PO dated 2/7/24 for Oxygen at 5Liters per minute with 28% humidity via tracheostomy mask continuously; change oxygen tubing, humidifier bottle, nebulizer set-up, and bag weekly - label with name and date every Wednesdays 11pm-7am shift. On 3/4/24 at 11:22 AM, Registered Nurse #1 (RN #1) assigned to Resident #11 was brought inside the room and during the interview, RN #1 verified that the date on the tubing were 2/7/24. RN#1 further stated that the oxygen tubing was scheduled to be changed weekly by the night shift (11pm-7am). The surveyor reviewed the facility's Policy and Procedure titled, Oxygen Administration under #4. Nasal Cannula/face mask: Connect tubing to humidifier outlet and adjust liter flow as ordered Nasal Cannula/face mask will be changed by weekly and PRN. 46049 2. On 3/4/24 at 10:47 AM, the surveyor observed Resident #12, resting in bed in their room. Resident #12 opened eyes spontaneously to verbal greeting and provided limited verbal response to the surveyor. Resident #12 was receiving oxygen via a nasal cannula (NC-plastic prongs attached to a tube, inserted into the nostrils that oxygen flows through) which was attached to a concentrator (an oxygen delivery system). The surveyor observed a humidified bottle attached to the concentrator that was dated 2/15/24 and there was no visible date on the nasal cannula. The oxygen concentrator setting was not visible to the surveyor due to position of the equipment at the bedside. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/24 at 12:57 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #2 about Resident #12's oxygen therapy and equipment. LPN #2 stated the resident was ordered to receive oxygen at 2 liters per minute (LPM) continuously. LPN #2 further explained oxygen equipment such as tubing and humidified bottles were changed weekly. LPN #2 accompanied the surveyor to the resident's bedside to check the resident's oxygen equipment and setting on the concentrator. LPN #2 stated the humidified bottle should have been changed and could not speak to why the bottle was not changed. The oxygen concentrator setting was set at 4 LPM. LPN #2 immediately adjusted the setting to 2 LPM and stated the resident should be receiving 2 LPM as per physician's order. LPN #2 could not explain why the resident's oxygen setting was set at 4 LPM and stated the oxygen setting should only be adjusted by the nurse. LPN #2 further stated I did not check it [oxygen setting] this morning and it should be checked at least two times per day. On 3/5/24 at 9:47 AM, the surveyor reviewed Resident #12's electronic medical record (EMR). The Resident AR (a summary of important information about the resident) revealed that Resident #12 was admitted with diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) and Acute Respiratory Failure. A comprehensive Minimum Data Set (MDS), an assessment tool to facilitate care, dated 12/11/23, indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 8 out of 15 which indicated that the resident's had moderate cognitive impairment. Section O of the MDS documented the resident received O2 therapy. A review of the physician's orders and the March 2024 eMAR documented a physician's order dated 11/27/23 which read, Oxygen at 2 L/Min via nasal cannula Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm-11:00 pm; 11:00 pm-7:00 am . A review of the February 2024 electronic treatment record (eTAR) documented an entry for a physician's order dated 11/27/23 which read, Change Oxygen Tubing, Humidifier Bottle (If in use), and Bag Weekly - Label with Name and Date Schedule: Every Week on Wednesday at 11:00 pm-7:00 am . The entry on 2/21/24 was signed as completed by the 11-7 shift nurse and the entry on 2/28/24 was left blank. A review of the March 2024 eTAR documented an entry for a physician's order dated 11/27/23 read, Check Label and Date on Oxygen Tubing and Bag every shift Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm-11:00 pm; 11:00 pm-7:00 am . The entries were signed as completed by the nurses on the eTAR. The entry on 3/2/24 was left blank and not signed. On 3/5/24 at 2:20 PM, the Director of Nursing (DON) provided the facility's oxygen administration policy. A review of the facility policy titled Oxygen Administration with a revised date of March 2023 read under Procedures #3 Humidifiers Bottle: .f. Set the flow meter to the rate ordered by the physician .h. Label humidifier with date and time opened .h. Humidifier bottle will be changed weekly and PRN 11-7 shift . 31656 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 3/11/24 at 1:20 PM, Resident #58 was observed by the surveyor, outside of the room, seated in a wheelchair and self-propelling in the hallway. On 3/11/24 at 1:24 PM, the surveyor inspected Resident #58's room. Inspected resident's room with LPN#3. The surveyor along with LPN#3 identified that the Oxygen (O2) nasal tubing dated 3/5/24, was stored in Resident #58's nightstand drawer, not in bag, along with the resident's call bell. LPN#3 stated that the nasal tubing should be stored in a bag to prevent contamination, not in a drawer with the call bell. Review of the resident's (AR) reflected that Resident #58 was admitted to the facility with medical diagnoses that included but were not limited to Unspecified asthma with acute exacerbation, Pneumonitis due to inhalation of food and vomit and Unspecified Dementia, unspecified severity, with psychotic disturbance. A review of the Quarterly MDS, an assessment tool used to facilitate the management of care, dated 2/20/24 documented that the resident had a BIMS score of 10 out of 15 indicating that the resident had a moderate impaired cognition. Review of the March 2024 eMAR indicated an entry that was signed and completed by the nurse (11PM-7AM) on 3/6/24 reflecting a Physician's order (PO) which began on 8/3/23. The PO explains, Change Oxygen Tubing, Humidifier Bottle (If in use), and Bag Weekly-Label with Name and Date Protocol: Label both bag and tubing with name and date. Review of Resident #58's Care Plan which began 11/20/23, under Respiratory that documents, All shifts will check Oxygen and Nebulizer tubing for date/time every shift: place in plastic bag when not in use. Review of the facility Oxygen Administration: Nasal Cannula or Mask policy updated on 5/16/23 which specifies, Points to Remember: 3. Between use, keep cannula or mask in a clean plastic bag at the machine or draped over regulator on tank. On 3/11/24 at 3:17 PM, the surveyor informed the DON, Licensed Nursing Home Administrator and LPN #2 of the above concerns. The DON stated oxygen tubing change was the responsibility of the 11-7 shift and staff would be provided re-education. There was no additional information provided by the facility. NJAC 8:39-27.1(a) NJAC 8:39-19.4(a)(k)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31656 Based on observation, interview, and record review, it was determined that the facility failed to assure that the physician responsible for supervising the care of residents completed monthly progress notes . This deficient practice continued over several months for 15 of 16 residents reviewed, Resident #18, #19, #58, #117, #10, #20, #38, #56, #61, #64, #42, #50, #1, #12 and #16 reviewed for physician progress notes and current physician orders. This deficient practice was evidenced by the following: 1. On 3/07/24 at 10:41 AM, the surveyor reviewed Resident #18's hybrid medical records. Review of Resident #18's Admission Record (AR) reflected that Resident #18 was admitted to the facility with medical diagnoses that included but were not limited Systemic Lupus Erythematosus, Sepsis, Major Depressive Disorder, Cirrhosis of Liver, and Atherosclerotic Heart Disease of Native Coronary Artery with Unspecified Angina Pectoris Review of the Medical Progress Notes (PN) written by Physician #1, from 2/8/24 to 3/7/24 were held in DRAFT by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. 2. On 3/07/24 at 10:50 AM, the surveyor reviewed Resident #19's hybrid medical records. Review of Resident #19's AR reflected that Resident #19 was admitted to the facility with medical diagnoses that included but were not limited to Lymphedema, Acute Respiratory Failure with Hypoxia, Chronic Kidney Disease and Hypertensive Heart Disease with Heart Failure. Review of the Medical PN written by Physician #1, from 2/9/2024 to 3/7/202 were held in DRAFT by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. 3. On 3/11/24 at 12:28 PM, the surveyor reviewed Resident #58's hybrid closed medical records. Review of Resident #58's AR reflected that Resident #58 was admitted to the facility with medical diagnoses that included but were not limited to Atherosclerotic Heart Disease, Unspecified Heart Failure, Unspecified Dementia with Psychotic Disturbance, Acute Respiratory Failure with Hypoxia, Chronic Kidney Disease and Hypertensive Heart Disease with Heart Failure. Review of the Medical PN revealed that on 9/2023 and 10/2023 there was no evidence of any Physician documentation. The facility could not find the missing Medical PN documented by Physician #2. 4. On 3/07/24 at 11:16 AM, the surveyor reviewed Resident #117's hybrid medical records. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #117's AR reflected that Resident #117 was admitted to the facility with medical diagnoses that included but were not limited to Congestive Heart Failure, Diabetes Mellitus, Unspecified Cirrhosis of liver, Hyperlipidemia, and Hypertensive Heart Disease with Heart Failure. Review of the Medical PN revealed that the 6/6/2023 to 6/30/2023 Medical Progress Notes (PN) were held in DRAFT by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. 39399 5. On 3/06/24 at 1:11 PM, the surveyor reviewed Resident #10's hybrid medical records. Review of Resident #10's AR reflected that Resident #10 was admitted to the facility with medical diagnoses that included but were not limited to Unspecified Convulsions, Hemiplegia and Hemiparesis following Cerebral infarction and Restlessness and Agitation. Review of the Medical PN revealed that from 12/2023 through 2/2024 were missing. The facility could not find the missing Medical PN documented by Physician #2. 6. On 3/11/24 at 1:10 PM, the surveyor reviewed Resident #20's hybrid medical records. Review of Resident #20's AR reflected that Resident #20 was admitted to the facility with medical diagnoses that included but were not limited to Parkinsonism; Dysphagia; Pneumonitis and Chronic Atrial Fibrillation. Review of the Medical PN revealed that the 10/6/23 to 2/27/24 monthly Medical PN were held in DRAFT by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. 7. On 3/6/24 at 10:07 AM, the surveyor reviewed Resident #38's hybrid medical records. Review of Resident #38's AR reflected that Resident #38 was admitted to the facility with medical diagnoses that included but were not limited to Convulsions; Stage 3 Chronic Kidney Disease; Hyperlipidemia and Schizoaffective Disorder. Review of the Medical PN revealed that from 12/2023 through 2/2024 were missing. The facility could not find the missing Medical PN documented by Physician #2. 44605 8. On 3/04/24 at 11:02 AM, the surveyor observed Resident #56 lying in bed in their room. The resident was alert, verbally responsive, and conversant. The surveyor reviewed the hybrid medical records of Resident #56 which revealed the following: The Resident Face Sheet documented that Resident #56 had diagnoses that included but were not limited, parkinsonism, sepsis, acute respiratory failure with hypoxia and chronic obstructive pulmonary disease. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident # 56's hybrid medical records revealed that from 2/9/24 to 3/1/24 monthly Medical Progress Notes (PN) were held in draft in the electronic medical record (EMR), included PPNs that had no information documented within the entry and remained in draft by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. 9. On 3/4/24 at 1:45 PM, the surveyor observed Resident #61 lying in bed in their room. The resident was alert, verbally responsive, and conversant. The surveyor reviewed the hybrid medical records of Resident #61 which revealed the following: The Resident Face Sheet documented that Resident #61 had diagnoses that included but were not limited, unspecified sequelae of cerebral infarction, rheumatoid vasculitis, and acute pulmonary edema. A review of Resident # 61's hybrid medical records revealed that from 2/9/24 to 3/1/24 monthly Medical Progress Notes (PN) were held in draft in the electronic medical record (EMR), included PPNs that had no information documented within the entry and remained in draft by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. 10. On 3/7/24 at 11:26 AM, surveyor reviewed the closed electronic medical record of Resident #64, the resident was admitted on [DATE] and discharged to the hospital on 12/29/23. The electronic medical record revealed the following: The Resident Face Sheet documented that Resident #64 had diagnoses that included but were not limited, unspecified sequelae of cerebral infarction, cellulitis of left lower limb, peripheral vascular disease, and polyneuropathy. A review of Resident #64's hybrid medical records revealed that from 11/21/23 to 12/22/23 monthly Medical Progress Notes (PN) were held in draft in the electronic medical record (EMR), included PPNs that had no information documented within the entry and remained in draft by Physician #1 documenting a letter (Z, C, A) to keep the place. No other information was evidenced in the Medical PN. A review of the facility's policy titled, Medical Service Documentation Policy with a reviewed date of 5/23/2023 under Procedure read: 2. Each resident must be seen by their attending physician or alternate at least once every thirty (30) days. The resident's total program of care, including mediation and treatments is viewed and revised as necessary. A progress note is written and signed by the Attending Physician at the time of each visit and he/she signs all orders . On 3/11/24 at 3:17 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and LPN #2 who were informed of the above concerns for physician progress notes. The LNHA could not speak to why the physicians were not entering their notes when visiting residents in the facility. There was no additional information provided by the facility. 46049 11. On 3/7/24 at 11:05 AM, the surveyor reviewed Resident #42's hybrid medical records. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Resident Face Sheet documented that Resident #42 had diagnoses that included but were not limited, sepsis, type 2 diabetes mellitus, hypertension, chronic kidney disease, heart failure, and osteoporosis. A review of the Medical Progress Notes (PN) written by Physician #1, from 1/24/24 to 3/7/24 were held in DRAFT by Physician #1 documenting a letter (Z, C, A) to keep the place. There was no other information evidenced in the Medical PN. 12. On 3/7/24 at 11:07 AM, the surveyor reviewed Resident #50's hybrid medical records. The Resident Face Sheet documented that Resident #50 had diagnoses that included but were not limited to, sepsis, cystitis, hypertension, dementia, and major depressive disorder. A review of the Medical Progress Notes (PN) written by Physician #1, from April 2023 to February 2024 were held in DRAFT by Physician #1 documenting a letter (Z, C, A) to keep the place. There was no other information evidenced in the Medical PN. On 3/7/24 at 11:55 AM, the survey team interviewed Physician #1 over the phone regarding the medical PN for his residents. Physician stated he visited the residents in the facility and would write the medical PN at a later time. Physician #1 stated the medical PN that were in draft were not completed and the letter in the entry was a place holder to remind him to complete the note after visiting with the resident. Physician #1 acknowledged medical PN should be completed at the time of visiting the resident and available for the resident's medical record. 13. On 3/11/24 at 1:10 PM, the surveyor reviewed Resident #1's hybrid medical records. The Resident Face Sheet documented that Resident #1 had diagnoses that included but were not limited, hypertension, anemia, pressure ulcer wounds, and heart failure. The surveyor with LPN #4 reviewed the resident's paper and electronic medical records. There was no PN found for February 2024 to indicate a face-to-face visit and examination of Resident #1. 14. On 3/11/24 at 1:10 PM, the surveyor reviewed Resident #12's hybrid medical records. The Resident Face Sheet documented that Resident #12 had diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, and Acute Respiratory Failure. The surveyor reviewed the resident's paper and electronic medical records. There were no PN found for February 2024 to indicate a face-to-face visit and examination of Resident #12. 15. On 3/11/24 at 1:10 PM, the surveyor reviewed Resident #16's hybrid medical records. The Resident Face Sheet documented that Resident #16 had diagnoses that included hypertension, anemia, type 2 diabetes mellitus, and peripheral vascular disease. The surveyor reviewed the resident's paper and electronic medical records. There were no PN found for February 2024 to indicate a face-to-face visit and examination of Resident #16. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy titled, Medical Service Documetation Policy with a reviewed date of 5/23/2023 under Procedure read: 2. Each resident must be seen by their attending physician or alternate at least once every thirty (30) days. The resident's total program of care, including mediation and treatments is viewed and revised as necessary. A progress note is written and signed by the Attending Physician at the time of each visit and he/she signs all orders . On 3/11/24 at 3:17 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and LPN #2 who were informed of the above concerns for physician progress notes. The LNHA could not speak to why the physicians were not entering their notes when visiting residents in the facility. There was no additional information provided by the facility. NJAC 8:39-23.2(b)(d)

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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. 31656 Based on observation, interview, and record review, it was determined that the facility failed to ensure that narcotic medication shift to shift sign in and out sheet was accurately signed. This deficient practice was identified for 1 of 3 units inspected during the facility unit inspection process. This deficient practice was evidence by the following: On 3/4/24 at 1:00 PM, the State Surveyor inspected the 2nd floor medication Cart A. During the inspection the State Surveyor reviewed the Narcotic Inventory book. All Narcotics stored in the medication cart were in order and The Narcotic Count shift to shift sign in sheet was found to have empty areas. Review of the Narcotic Count Shift to Shift sign in sheet was found to lack nurse's signatures on 3/1/24 Outgoing Nurse 11:00 PM, 3/3/24 Incoming Nurse 3:00 PM and 3/4/24 Outgoing Nurse 11:00 PM. On 3/4/24 at 1:10 PM, the State Surveyor interviewed the Registered Nurse (RN#1) who stated that the sheet should be signed by every incoming and outgoing nurse on each shift. The surveyor reviewed the Narcotics Accountability Policy with a documented facility review date of 5/16/23 which states, It is the policy of the facility to ensure that all narcotics are counted daily by two nurses and enter in the log. Under the Procedure 1. Section, All Narcotics given must be documented in the narcotic accountability sheet. At the end of the shift, narcotics must be counted with two nurses. Outgoing and incoming nurses must count every end of the shift and sign the narcotic count form. On 3/5/24 at 10:00 AM, the surveyor discussed the discrepancy related to the shift sign in and out narcotic sheet with the Licensed Nursing Home Administrator and the Director of Nursing. No further information was provided. NJAC 8:39-29.4(g)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 31656 Based on observation, interview, and record review it was determined that the facility failed to maintain a medication error rate below 5%. The surveyor observed 2 nurses administer 26 doses of medication to 3 residents and there were 3 errors which resulted in a medication error rate of 11.54 %. The deficient practice was evidenced by the following: On 3/8/24 at 8:06 AM, the State Surveyor observed the start of medication pass with the Licensed Practical Nurse (LPN#1) on the 3rd floor. 1. On 3/8/24 at 8:14 AM, LPN#1 administered Multi-Vitamin with Minerals to Resident #19. The surveyor noted that the computer screen reviewed by LPN#1 documented Multivitamin 50 Plus on the electronic medical administration record (eMAR). After Resident #19 medication administration was completed the surveyor interviewed LPN#1. LPN#1 stated that Multi-Vitamin with Minerals was the same as Multivitamin 50 Plus. Review of the March 2024 Physician's Order (PO) revealed an order for Multivitamin 50 Plus tablet that began on 2/9/24. On 3/8/24 at 12:00 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who explained that the formula for Multivitamin 50 Plus is different than that of Multi-Vitamin with Minerals. 2. On 3/8/24 at 8:14 AM, LPN#1 administered Potassium Chloride Extended Release (ER) 10 meq (milliequivalent) to Resident #19. The surveyor noted that the computer screen reviewed by LPN#1 documented Potassium Chloride Extended Release 10 meq once daily with food on the (eMAR). LPN#1 did not offer any food to Resident #19 at the time of medication administration. After Resident #19 medication administration was completed the surveyor interviewed LPN#1. LPN#1 stated that she only offers food when the resident requests it. LPN#1 informed the surveyor that breakfast is served at about 9:00 AM. Review of the March 2024 Physician's Order (PO) revealed an order for Potassium Chloride ER 10 meq 1 tablet once daily with food that began on 3/6/24. On 3/8/24 at 1:00 PM, the surveyor interviewed the Provider Pharmacist (RPh) who explained that Potassium Chloride would be administered with food to avoid any possible stomach discomfort. 3. On 3/8/24 at 8:24 AM, LPN#1 administered Decadron 6 milligrams (mg) to Resident #18. The surveyor noted that the computer screen reviewed by LPN#1 documented Decadron 6 mg once daily on the eMAR. The surveyor observed that there was a cautionary sticker on the medication packaging that read, Take with Food or Milk. LPN#1 did not offer any food to Resident #19 at the time of medication administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After Resident #18 medication administration was completed the surveyor interviewed LPN#1. LPN#1 stated that she only offers food when the resident requests it. LPN#1 informed the surveyor that breakfast is served at about 9:00 AM. Review of the March 2024 Physician's Order (PO) revealed an order for Decadron 6 mg once daily for 10 days that began on 2/28/24. On 3/8/24 at 1:00 PM, the surveyor interviewed the RPh who explained that Decadron 6mg would be administered with food or milk due to the harsh effect on the stomach. The RPh added that the manufacturer recommends taking Decadron (Dexamethasone) with food or mild to minimize gastrointestinal irritation. On 3/8/24 at 12:00 PM, the errors noted during medication passage were discussed with the LNHA and Director of Nursing (DON). The LNHA and DON could not explain why these errors resulted and did not provide any further information. NJAC 8:39-29.2 (d)

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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. 31656 Based on observation, interview, and record review it was determined that the facility failed to properly store and refrigerate medication at the required temperature. This deficient practice was observed for 1 of 2 facility units inspected during the initial facility unit inspection. The deficient practice was evidenced by the following: On 3/4/24 at 1:00 PM, the State Surveyor accompanied by the RN#1 inspected the 2nd floor locked medication refrigerator located in the locked medication room. The thermometer located inside the refrigerator was found to be 32 degrees Fahrenheit (F) upon inspection. The State Surveyor inspected the medication that was in the refrigerator at the time: 1. 17x10 milliliter (ml) Insulin Pens 2. 1x3.7 (ml) Calcitonin Salmon Nasal Spray 3. 3x2.5 ml Latanoprost Ophthalmic Solution 0.005% 4. 1x1ml Tuberculin Purified Protein Derivative Diluted Aplisol 5. 1x30 ml opened Lorazepam Intensil Oral Concentrate 2mg/ml 6. 1x30 ml sealed Lorazepam Intensil Oral Concentrate 2mg/ml Upon inspection all the medications seemed to be in good condition The State Surveyor interviewed RN#1 who explained that the refrigerator temperature is inspected daily by the 11PM-7AM shift nurse. The State Surveyor then reviewed the Daily Freezer/Refrigerator Temperature Log which was documented as checked on 3/4/24 at 12:00 AM with a recorded temperature of 40 degrees F. The documented instructions on the log stated, Refrigerators should be between 36 degrees F and 41 degrees F. Review of the Medication Storage Police revised by the facility on 5/22/23 documents, Medications will be stored in a manner that maintains the integrity of the product, ensures safety of the customers, in accordance with state Department of Health guidelines and are accessible only to licensed nursing and pharmacy personnel. Review of the Procedure section H details, Medications requiring refrigeration will be stored in a refrigerator that is maintained between 2-8 degrees Celsius (36-46 degrees F). (continued on next page)

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Homestead Rehabilitation & Health Care Center	129 Morris Turnpike Newton, NJ 07860

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/24 at 1:30 PM, the surveyor discussed the discrepancy related to the 2nd floor refrigerator temperature with the Licensed Nursing Home Administrator and the Director of Nursing. No further information was provided. NJAC 8:39- 29.4(b)2

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on observation, interview, and review of facility documentation, it was determined that the facility failed to prepare vegetables in the proper consistency for 2 of 4 residents (Resident #5 and #36) reviewed on a modified diet. This deficient practice was evidenced by the following: On 3/5/24 at 11:30 AM, the surveyor observed the lunch tray line. The Certified Dietary Manager (CDM) requested a mechanical soft diet tray (mechanical soft diet is a type of diet that involves foods that are physically soft, making them easier to eat without the need for extensive chewing), which contained three whole fish sticks, regular mixed vegetables (carrots, broccoli, and cauliflower) and mashed potatoes. The Surveyor interviewed the CDM in reference to the fish sticks and vegetables served whole for a mechanical soft diet. The CDM explained, they do serve mechanical soft residents whole fish stick and regular mixed vegetables because they are considered fork mash-able or fork tender. The CDM identified that the CNA or resident will be able to mash the food with a fork at tableside. The Surveyor asked if mechanical soft diet consistency is considered chopped (bite size pieces) or minced (ground consistency)? The CDM verified, mechanical soft is considered minced consistency. 1. On 3/5/24 at 12:05 PM, the surveyor observed Resident #5 in their room with CNA #3 at bedside, on the second floor. CNA #3 stated the resident is on 1:1 feeding assistance. The surveyor observed Resident #5 holding the whole fish stick and taking small bites as well as whole vegetables on the resident's tray. On 3/5/24 at 12:07 PM, the surveyor interviewed CNA #3 who verified that Resident #5 was on mechanical soft diet. CNA #3 explained that the fish sticks are soft, and the fish is minced within the fish stick breading. The surveyor observed CNA #3 cutting the mixed vegetables with a knife. The surveyor reviewed the International Dysphagia Diet Standardization Initiative (IDDSI), which is a framework for classifying food textures and drink consistencies for people with swallowing difficulties. Documentation on the IDDSI Diet Levels & Information explains that Fork Mashable Diet is a type of dysphagia diet that is soft, tender, and moist throughout. The IDDSI Diet describes that a mashable diet can be eaten with a fork, spoon, or chopsticks. It also states that the food can be mashed or broken down with pressure from a fork, spoon, or chopsticks. Chewing is required before swallowing. A knife is not required to cut food but may be used to help load fork/spoon. The surveyor reviewed Resident #5 Admission Face Sheet indicated the resident had diagnosis which included but not limited to: Down syndrome, gastro-esophageal reflux disease with esophagitis, and protein-calorie malnutrition. A review of the quarterly Minimum Data Set, dated dated dated [DATE] reflected a BIMS score of 3 out of 15 which indicated severe cognitive impairment. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Physician Orders (PO) 2/21/23, reflected a physician's order dated 7/9/23, for No Added Salt (NAS) diet, Mechanical soft texture, Thin Liquids consistency. A review of the resident's individualized care plan reflected a focused area dated 11/24/21 and last reviewed 6/8/24, that the resident has potential alteration in nutritional status due to dx. Interventions included but were not limited to: provide diet as ordered NAS/Mechanical soft diet and monitor intake and tolerance. A review of the SLP treatment and encounter notes with a completed date 7/23/23. Precautions: Decreased cognition Contraindications: No contraindications present. 92526: Resident (Rt) treatment for skilled ST for tolerance of least restricted diet. Rt able to ingest mechanical soft adequately despite prolonged [NAME] pattern mastication. Significant prolonged mastication noted with treatment trials of regular solids. No overt signs and symptoms of aspiration with all po. Response to treatment: Response to session interventions actively participates with skilled interventions, compliant with skilled interventions and compliant with trained techniques. Oral intake: Current foods/solids: Mechanical soft + Bite-sized foods SB6 2. On 3/5/24 at 11:50 AM, the surveyor inspected the second floor dining room and observed Resident #36 seated in a wheelchair at a table. Resident #36 was observed receiving their lunch tray from CNA #1. Resident #36's lunch tray ticket read, Mechanical soft diet and was observed with intact fish sticks, intact mixed vegetables, and mashed potatoes. The surveyor observed CNA #1 cut the fish sticks and mixed vegetables with a fork and knife. On 3/5/24 at 11:55 AM, the surveyor interviewed CNA #1 in reference to Resident #36's diet consistency. CNA #1 explained that the resident is on mechanical soft diet consistency which is considered foods that are fork mashable. CNA #1 indicated that since the resident's food had to be cut with a knife, it would probably not be considered to be mashable. The surveyor reviewed Resident #36 Admission Face Sheet (Face Sheet is a one page an admission summary) indicated the resident had diagnosis which included but not limited to: epilepsy, mental disorder, dysphagia, and senile degeneration of brain. A review of the quarterly Minimum Data Set, an assessment tool, dated 12/8/23 reflected a Brief Interview of Mental Status (BIMS) score of 99 indicating the resident could not be interviewed. A review of the Physician Orders (PO) 7/24/23, reflected a physician's order dated 3/9/23, for No Added Salt (NAS) diet, Mechanical soft texture, Thin Liquids consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's individualized care plan reflected a focused area dated 9/1/19, that the resident may be at risk for alteration in nutritional status related to impaired cognition and dysphagia. Interventions included but were not limited to: provide NAS/Mechanical soft diet and monitor intake and tolerance. No recent speech evaluations available. DT stated they are a new therapy company in the facility and has only been in the facility for a week. On 3/5/24 at 11:55 AM, the surveyor interviewed the Director of Therapy (DT) on the second floor dining as the Speech Language Pathologist was not in the building. The surveyor had the DT check an identified Mechanical Soft Food containing tray prior to it being served to a resident. The DT acknowledged that the food did not look mechanical soft, but stated if the food is fork mash-able it is considered mechanical soft. The DT revealed that he was not sure if the food needs to be cut with a knife, it be considered mechanical soft. The DT explained that he would consult with the Speech Language Pathologist (SLP) as it was their expertise. On 3/6/24 at 11:05 AM, the surveyor interviewed the SLP. The SLP explained that residents can be served whole foods that must be fork mash-able for a mechanical soft diet. The SLP established that foods need to be fork mashable to be considered mechanical soft and should not need to be cut with a knife. The SLP established that any foods that need to be cut with a knife, need to be cut in very small pieces to be considered mechanical soft which should be done in the kitchen. On 3/6/24 at 1:30 PM the CDM provided the surveyor with diet information titled, Mechanical Soft Diet, no reviewed date was noted. The CDM stated that the information can be found in their diet manual. The provided diet information stated, the mechanical soft diet is designed to minimize the amount of chewing necessary to ingest food and increase the ease of swallowing. The diet is used for individuals with chewing and swallowing problems due to irritation of the mouth, lack of teeth, surgery, therapy, or dysphagia. Grinding foods with a commercial food processor can modify the texture of the foods. Menu planning guidelines follow the regular diet with the following changes: meats are ground to the consistency of ground meat, serve soft and diced fruits and vegetables. The diet information also included a reference guide with all food groups broken into two categories: food recommended and foods to limit. Under the vegetables food group for foods recommended it states, soft and diced vegetables and foods to limit included: broccoli and cauliflower. Under the fish food group for foods recommended, it states, ground breaded fish and foods to limit whole fish. On 3/11/24 at 1:30 PM, the survey team met with Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review concerns. The LNHA stated all residents on mechanical soft diets, the food should have been prepared in the kitchen and not cut at table side to ensure all foods are prepared to the correct size. No further information was provided. N.J.A.C. 8:39 - 17.4(a)

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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 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. 44605 Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store, label, and discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 3/4/24 at 09:25 AM, the surveyor in the presence of the Certified Dietary Manager (CDM) observed the following during the kitchen tour: 1. During the kitchen inspection, the surveyor observed on the inside of the 3 door refrigerator, individual 2 ounce (oz) condiment cups with parmesan cheese without open or use by labels. The surveyor also observed a gallon of whole milk as well as a gallon of fat-free milk and a 1/2 gallon of 2% milk container, all opened without open or use by dates. The CDM explained that the facility goes by the expiration dates printed on the large containers of parmesan cheese and the use by dates on the milk containers to evaluate their freshness. The CMD agreed that all products when opened should have an open and use by date clearly documented by the kitchen staff. 2. During the kitchen inspection, the surveyor observed, inside of the standing dual ovens, black-colored baked on debris on both ovens. The CDM stated the ovens are cleaned weekly but could not state why the debris was present at this time of observation or when the ovens were cleaned last. 3. During the kitchen inspection, the surveyor observed in a preparation area, 14 open spice containers, with written dates on bottles. The CDM could not differentiate if the written dates were received, open or use by dates. Above the spice containers, the surveyor observed multiple wiring, and plastic tubing all with grey colored dust like debris. The CDM stated the maintenance department is responsible for cleaning that area but could not determine when the area was cleaned last. 4. During the kitchen inspection, the surveyor observed all windows along the wall that appeared to be soiled with yellow color debris. The window screens were observed with dust-like debris. The CDM stated the maintenance department also is responsible for cleaning that area but could not determine when the area was cleaned last. 5. During the kitchen inspection, the surveyor observed on the shelf under the chef preparatory table, a 2 liter container with a yellow colored liquid without an open or use by label (no date), an opened 1 gallon bottle of soy sauce, 1 gallon bottle of gravy aid, and 1 gallon Worcestershire sauce all dated. The CDM could not explain whether the dates documented were open, use by or delivered dates. The CDM stated the yellow colored liquid was cooking oil that was poured from a larger container; no labeling observed on either container (larger container and 2 liter container). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. During the kitchen inspection, the surveyor observed in the dry storage room, multiple canned goods without delivered/received dates. The surveyor further observed an open bag of tricolor and spiral pasta, no open or discard dates observed. On the top shelf the surveyor observed a circulating fan with a brownish colored caked on debris. The CMD stated that all delivered items should have a received date, the opened bags of pasta should be labeled with an open and use by date. The CMD informed the surveyor that the maintenance department was responsible for the cleaning of the fan but could not determine when the area was cleaned last. 7. During the kitchen inspection, the surveyor observed Dietary Aide #1 (DA#1) with a hat and hairnet on, but sides of his hair sticking out. The CDM agreed that DA#1 should fully cover his hair. 8. During the kitchen inspection, the surveyor observed a small bowl of cooked scrambled eggs with a label dated: 2/3/24 inside a 3 door standing refrigerator. The CDM stated she thought the date should have read 3/2/24, not 2/3/24. On the bottom shelf of the refrigerator, the surveyor observed one opened container of liquid eggs without an open/use by date. 9. During the kitchen inspection, the surveyor inspected the walk-in refrigerator and observed the fans, light fixtures, and parts of the ceiling with dust-like debris. In the walk-in freezer, the surveyor observed ice on ceiling, floor, and fans. The CDM explained that the maintenance department was responsible for maintaining the area but could not determine when the area was cleaned last. On 3/5/24 at 10:15 AM, the CDM provided the surveyor with multiple facility policies including Labeling and Dating, Dietary Department Dress Code, and Cleaning Instructions: Refrigerators. All policies were reviewed in December 2023. The Labeling at Dating policy states under procedures, 1. All food received in the building, dry, dairy, refrigerated or frozen, must have a received date. 2. Received date and expiration date must be visible. 5. All foods prepared in the kitchen must be dated with a use by date and discarded in three days. 8. Opened bulk - mayo, syrup, mustard, ketchup follow manufacturers expiration date. Once opened, must be dated with open date, and refrigerated. On 3/11/24 at 1:30 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review concerns. The LNHA and DON had no comments regarding the kitchen. NJAC 8:39-17.2(g)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices to decrease the possibility of spreading infection during medication administration and failed to ensure that the sharps container (SC) that were filled with contaminated sharps/needles were disposed properly, for 3 of 3 units reviewed for infection control practices. This deficient practice was evidence by the following: 1. On 3/7/23 at 10:06 AM, the surveyor observed Licensed Practical Nurse # 2(LPN#2) perform a wound treatment to Resident #1. LPN #2 went to wash her hands at the sink in the resident's room after entering the resident's room. LPN #2 turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands for 16 seconds outside the running water prior to rinsing, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. On 3/7/24 at 10:11 AM, LPN #2 after cleansing the resident's wound site, removed her gloves and went to wash her hands at the sink. LPN #2 turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands for 10 seconds outside the running water prior to rinsing, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. On 3/7/24 at 10:16 AM, LPN #2 removed her gloves, sanitized her hands with alcohol based hand rub (ABHR) and went to the treatment cart to get another dressing for the wound treatment. LPN #2 retrieved the treatment cart key, opened the cart, obtained the dressing, and returned to the resident's room. LPN #2 went in room, closed the door for privacy, and applied gloves to apply treatment and clean dressings to wound. LPN #2 did not sanitize her hands prior to applying gloves. On 3/7/24 at 10:20 AM LPN#2 applied dressings to wound, removed her gloves and went to wash her hands at the sink. LPN #2 turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands for 8 seconds outside the running water prior to rinsing, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. On 3/7/24 at 10:25 AM, the surveyor interviewed LPN #2 after the wound treatment observation about hand hygiene. The surveyor informed LPN#2 of the hand hygiene concerns observed during the wound treatment. LPN #2 stated hand hygiene should be at least for 20 seconds lathering outside the stream of running water. LPN #2 did not realize she did not sanitize her hands upon re-entering the room during wound treatment. LPN # 2 acknowledged hand hygiene should have been performed when re-entering room, and prior to procedure. On 3/7/24 at 12:00 PM, the Director of Nursing (DON) provided the facility's hand hygiene policy. The DON stated hand hygiene should be performed at least 20 seconds, lathering hands outside the stream of running water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled Hand Washing with a revised date of 5/13/2023, under Policy it read: .In order to prevent transmission of infectious diseases, all personnel working in the facility are required to wash their hands before and after resident contact, before and after performing any procedure . Under Process, Hand hygiene techniques it read: 1 .Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds, covering all surfaces of the hands and fingers . On 3/11/24 at 3:17 PM, the surveyor met with the DON, Licensed Nursing Home Administrator (LNHA) and LPN #2 about the above concerns. There was no additional information provided by the facility. 31656 2. On 3/8/24 at 8:06 AM, the State Surveyor observed the start of medication pass with the Licensed Practical Nurse (LPN#1) on the 3rd floor. a. LPN#1 proceeded to wash her hands appropriately but used the paper towel (lying by the sink against the backsplash area) used to previously dry her hands to wipe the water that had splattered around the sink. LPN#1 then took a new paper towel from the unprotected pile of paper towels and continued drying her hands, wiped around the sink, and proceeded to dry her hands again with the same contaminated paper towel. b. LPN#1 proceeded to pick up a pitcher filled with water that LPN#1 explained was from the previous shift. LPN#1 spilled out the water from the pitcher and without cleaning the pitcher filled the pitcher with new water from the water dispenser and placed it on the medication cart, without rewashing her hands. c. LPN#1 removed an open saline solution, that was not dated found on top of a cart. LPN#1 explained that she would have to discard this open bottle of saline as she did not know when it was opened or what it was used for. LPN#1 handled this contaminated bottle of saline solution and proceeded to handle medication, administer medication without washing or sanitizing her hands. On 3/8/24 at 12:00 PM, the State Surveyor discussed the breeches in infection control during the medication passage with the LNHA and DON. The DON explained that the pitchers should be cleaned daily prior to refilling with water and that LPN#1 should have known to wash her hands after touching the contaminated saline solution prior to beginning medication passage. There was no further information provided. 39399 3. On 3/11/24 at 12:41 PM, the surveyor toured the soiled utility room in the 3rd and 4th floor nursing unit with the facility's Director of Housekeeping (DOH). On the 3rd floor Soiled Utility Room ([NAME]) the surveyor observed several SC piled up in a bio-hazard bag that were not sealed and overflowing. The SC bins were observed to be filled with contaminated needles. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/24 at 12:45 PM, in the 4th floor soiled utility room, the surveyor observed several SC stored in a bio-hazard bag that were unsealed and overflowing. The SC bins were observed to be filled with contaminated needles. The surveyor interviewed the DON who stated that it was the Maintenance Department's responsibility to dispose the SC bins. The surveyor interviewed the maintenance staff member who stated that he was not aware that it was part of his responsibility to dispose of filled SC since he started working for the facility in August 2023 and was the only employee of the maintenance department. The maintenance staff member added that he was not informed by any staff to empty the SC bins inside the soiled utility room. A review of the facility's policy and procedure titled, Waste Management under III. Discard contaminated sharps immediately or as soon as feasible in sharps containers. 6. Disposal of full sharps containers the responsibility of Environmental Services personnel. On 3/11/24 at 3:30 PM, the survey team discussed the above concern with the facility's LNHA and DON. No further information was provided. N.J.A.C. 8:39-19.4

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 39399 Based on facility staff interviews and review of other pertinent facility documentation, it was determined that the facility failed to ensure that the designated Infection Preventionist (IP) had completed specialized training in infection prevention and control and was qualified by certification and experience for 1 of 1 staff member reviewed in accordance with Center for Medicare and Medicaid Services (CMS) and New Jersey State guidelines. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following: ii. Required Core Practices for Infection Prevention and Control: Facilities are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; or b. A Physician who has completed an infectious disease fell owship; or c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of Infection Control experience. iv. Facilities with 100 or more beds or on-site hemodialysis services must: 1. Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021. During an interview, in the presence of the facility's Interim Director of Nursing (DON) on 3/11/2024 at 10:31 AM, the surveyor interviewed the Licensed Practical Nurse #2 (LPN#2), who served the role as the facility's IP. LPN #2 stated that her status to date was a per-diem employee. LPN #2 also stated that she was still in-training and have not yet completed the certification. LPN #2 explained that her work hours every week can be 40 hours or less. LPN #2 added that at times she would work on the unit to administer medications in a clinical role and does wound rounds with the wound team. At 3/11/34 3:30 PM, the Licensed Nursing Home Administrator and DON clarified that LPN #2 did not complete any type of infection control training or certification to date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315378	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Rehabilitation & Health Care Center	129 Morris Turnpike Newton, NJ 07860

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The survey team met with the LNHA, DON and LPN #2 at 3/11/2024 at 3:30 PM and discussed that LPN #2 did not meet the qualifications to be the IP. LPN #2 did not have the required 5 years of experience as an IP, and it was not her only designated job title. NJAC 8:39-20.2