| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315378 | A. Building<br>B. Wing | 07/24/2025 |

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

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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 9 of 11 residents reviewed, Resident #2, #4, #7, #8, #10, #11, #39, #59, and #67 reviewed for physician progress notes.This deficient practice was evidenced by the following:1. On 7/16/24 at 10:57 AM, the surveyor reviewed Resident #8's hybrid medical records (combination of electronic and paper chart).Review of Resident #8's admission Record (AR) reflected that Resident #8 was admitted to the facility with medical diagnoses that included but were not limited severe protein-calorie malnutrition, chronic obstructive pulmonary disease, hypothyroidism and hypertension.<br><br>Review of the Medical Progress Notes (PN) written by Physician #1(MD#1), from 4/23/25 to 6/20/25 were held in DRAFT by MD#1 documenting a letter (Z) to keep the place. No other information was evidenced in the Medical PN.<br><br>2. On 7/16/24 at 11:00 AM, the surveyor reviewed Resident #2's hybrid medical records. Review of Resident #2's AR reflected that Resident #2 was admitted to the facility with medical diagnoses that included but were not limited Parkinson's disease, asthma, type 2 diabetes mellitus, and wedge compression fracture of T11-T12 vertebra.<br><br>Review of the Medical PN written by MD#1, from 3/18/25 to 7/11/25 were held in DRAFT by MD#1 documenting a letter (Z) to keep the place. No other information was evidenced in the Medical PN.<br><br>3. On 7/16/24 at 11:04 AM, the surveyor reviewed Resident #4's hybrid medical records. Review of Resident #4's AR reflected that Resident #4 was admitted to the facility with medical diagnoses that included but were not limited sepsis, pneumonia, chronic obstructive pulmonary disease and acute and chronic respiratory failure with hypoxia.<br><br>Review of the Medical PN written by MD#4, from 1/21/25 to 6/20/25 were held in DRAFT by MD#1 documenting a letter (Z) to keep the place. No other information was evidenced in the Medical PN.<br><br>4. On 7/16/24 at 11:06 AM, the surveyor reviewed Resident #11's hybrid medical records. Review of Resident #11's AR reflected that Resident #11 was admitted to the facility with medical diagnoses that included but were not limited metabolic encephalopathy, sepsis, cystitis and hydronephrosis.<br><br>Review of the Medical PN written by MD#1, from 1/31/25 to 7/11/25 were held in DRAFT by MD#1 documenting a letter (Z) to keep the place. No other information was evidenced in the Medical PN.<br><br>5. On 7/16/24 at 11:10 AM, the surveyor reviewed Resident #59's hybrid medical records. Review of<br>(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 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #59's AR reflected that Resident #59 was admitted to the facility with medical diagnoses that included but were not limited end stage renal disease, chronic congestive heart failure, myocardial infarction, and type 2 diabetes mellitus.<br><br>Review of the Medical PN written by MD#1, from 1/21/25 to 7/11/25 were held in DRAFT by MD#1 documenting a letter (Z) to keep the place. No other information was evidenced in the Medical PN.<br><br>On 7/21/2025 12:40 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review concerns found during the survey. The DON stated MD#1 who also serves as the Medical Director, should be writing complete and signing the progress notes at the time of visit, leaving the notes in draft for months is unacceptable.<br><br>On 7/21/25 at 12:56 PM, the DON provided the surveyor with a facility policy titled, By-laws, rules and regulations for medical staff of the Homestead Rehabilitation and Healthcare Center, LLC with a revised date of 5/6/2016. Under the procedures section of the chart it states, 9. The Medical Director shall be responsible for all medical policies of the Facility. He/she shall see that proper medical records are maintained.G. A Progress Note is written and signed by the Attending Physician at the time of each visit, and he/she signs all orders.<br><br>On 7/22/25 at 11:19 AM, the surveyor conducted a phone interview with MD#1. MD#1 stated they are the current Medical Director for the building and have been so for the past 8 to 9 years. MD#1 further stated he is in the building at least two times per week to see the residents. MD#1 agreed that progress notes should be completed and signed at the time of service but acknowledged he does not complete and sign his progress notes at the time of service. MD#1 agreed this was not in the best interest of the residents and is not best practice.<br><br>7/24/25 at 1:15 PM, the surveyor met with the LNHA and DON for the exit conference. The DON stated that MD#1 subacute residents have been switch to another physician and MD#1 would not be getting any new residents until he was in compliance with his progress notes. No further pertinent information provided.6. On 7/16/24 at 10:20AM, the surveyor reviewed Resident #7's hybrid medical records (combination of electronic and paper chart).<br><br>Review of Resident #7's admission Record (AR) reflected that Resident #8 was admitted to the facility with medical diagnoses that included but were not limited schizophrenia, major depressive disorder, hyperlipidemia, and chronic kidney disease.<br><br>Review of the Medical Progress Notes (PN) written by Physician #1(MD#1), from 3/04/25 to 7/21/25 were held in DRAFT by MD#1 documenting a letter (Z) to keep the place. No other information was evidenced in the Medical PN.<br><br>7. On 7/16/24 at 10;47 AM, the surveyor reviewed Resident #39's hybrid medical records.<br><br>Review of Resident #39's AR reflected that Resident #39 was admitted to the facility with medical diagnoses that included but were not limited to schizophrenia, hypertension, schizoaffective disorder, bipolar type, and generalized anxiety disorder.<br><br>Review of the Medical PN written by MD#1, from 4/23/25 to 7/21/25 were held in DRAFT by MD#1 documenting a letter (Z) to keep the place. No other information was evidenced in the Medical PN.<br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 8. On 7/16/24 at 11:11 AM, the surveyor reviewed Resident #4's hybrid medical records.<br><br>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 chronic obstructive pulmonary disease, gastro-esophageal reflux disease, and acute and vitamin deficiency.<br><br>Review of the Medical PN written by MD#1, from 3/04/25 to 07/21/25 were held in DRAFT by MD#1 documenting a letter (Z) to keep the place. No other information was evidenced in the Medical PN.<br><br>9. The surveyor reviewed the closed medical record for Resident #67.<br><br>A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia, heart failure, need for assistance with personal care, and major depressive disorder.<br><br>A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 2/11/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated a severely impaired cognition. A further review revealed that the resident needed partial assistance from another person to complete activities of daily living (ADLs).<br><br>A review of the Progress Noes revealed the following Medical Notes entered by the Medical Director (MD) in draft status that only included a z as the note for 2/18/25 at 7:00 PM, 2/28/25 at 10:42 PM, 3/4/25 at 8:37 PM, and 3/7/25 at 8:47 PM.<br><br>On 7/22/25 at 10:06 AM, the surveyor reviewed with the DON Resident #67's Progress Notes, and she acknowledged the physician Progress Notes were in draft status with z as the note. The DON acknowledged that physician's notes were to be documented at the time of the visit.<br><br>On 7/22/25 at 11:20 AM, the surveyor conducted a telephone interview with the MD, who stated that he was at the facility twice a week. When asked how often a resident needed to be seen, the MD stated once a month. When asked when he documented the notes of the visits, the MD stated that he took his personal notes home and put them in the resident's electronic medical record later on and whenever have a chance. The surveyor asked when the MD was required to document the visit into the resident's medical record, the MD stated at the time of visit or in a reasonable amount of days. At this time, the surveyor stated that they observed notes that were still not written from February of 2025, and the MD confirmed and stated that he was catching up and should be finished documenting by the end of the month.<br><br>NJAC 8:39-23.2(b)(d) |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on interview, review of Nurse Staffing Report sheets, and other pertinent facility documents, it was determined that the facility failed to ensure a Registered Nurse worked seven days a week for at least 8 consecutive hours a day for 5 of 14 days reviewed. This deficient practice was evidenced by the following:On 7/16/25 at 10:29 AM, during the entrance conference, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 6/29/25 through 7/5/25; 7/6/25 through 7/12/25 and 3/2/25 through 3/8/25.The surveyor reviewed the Nursing Staffing Reports, which revealed there was no Registered Nurse (RN) to work eight consecutive hours on the following dates: 1. No RN on 7/4/25; the last RN was scheduled on 7/3/25 2. No RN on 7/5/25; the last RN was scheduled on 7/3/25 3. No RN on 7/6/25; the last RN was scheduled on 7/3/25 4. No RN on 7/9/25; the last RN was scheduled on 7/8/25 5. No RN on 7/10/25; the last RN was scheduled on 7/8/25 A review of the corresponding nursing staff sheets verified the following: During the 7-3 shift on 7/3/25, there was an RN scheduled, and the next RN scheduled to work on 7/4/25. During the 7-3 shift on 7/3/25, there was an RN scheduled, and the next RN scheduled to work on 7/5/25. During the 7-3 shift on 7/3/25, there was an RN scheduled, and the next RN scheduled to work on 7/6/25. During the 3-11 shift on 7/8/25, there was an RN scheduled, and the next RN scheduled to work on 7/9/25. During the 3-11 shift on 7/8/25, there was an RN scheduled, and the next RN scheduled to work on 7/10/25. On 7/21/25 at 12:20 PM, the surveyor interviewed the Director of Nursing (DON), who stated that she was aware that the facility required an RN to be present in the facility daily. She further stated the facility would need an RN for critical care and assessments. On 7/21/25 at 12:30 PM, the surveyor interviewed the scheduling coordinator (SC), who stated that she was aware of the need for an RN in the facility for 8 hours in a 24-hour period and further stated that the facility had more Licensed Practical Nurses (LPN) in the facility than RN's and does the best she could to staff the facility. On 7/24/25 at 11:30 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, acknowledged the facility had days where there were no RNs scheduled for eight consecutive hours. No further pertinent information or policies were provided by the facility for review. NJAC 8:39-25.2(h) |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observe each nurse aide's job performance and give regular training.<br><br>Based on interview, record review, and review of facility documents, it was determined that the facility failed to evaluate the performance of all Certified Nursing Assistants (CNA) on an annual basis. This deficient practice was identified for 5 of 5 CNA's whose personnel records were reviewed and was evidenced by the following: On 7/24/25 at 10:17 AM, the surveyor reviewed the personnel files for 5 CNAs:1. CNA#1, with a date of hire of 8/17/22, no recent employee evaluation was completed.2. CNA#2, with a hire date of 8/23/23, no recent employee evaluation was completed.3. CNA#3, with a hire date of 7/2/24, no recent employee evaluation was completed.4. CNA#4, with a hire date of 10/1/24, no recent employee evaluation was completed.5. CNA#5, with a hire date of 7/22/23, no recent employee evaluation completedOn 7/24/25 at 10:17 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the facility does not have competencies for the CNAs. The DON stated that she had a stack of folders on her desk but was unable to provide the five employee evaluations or competencies. On 7/24/25 at 11:30 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the DON, who stated that no policy could be provided, and no further pertinent information was provided. NJAC 8:39-43.17 (b) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>Based on interview, and review of pertinent facility documents, it was determined that the facility failed to serve and document residents received a nourishing snack in the evening (HS) when there was more than 14 hours between dinner and breakfast mealtimes. This deficient practice was identified for 3 of 3 residents (Resident #15, #38, and #42) during the 7/21/25 resident council group meeting and evidenced by the following:On 07/21/2025 at 10:33 AM, the surveyor conducted the resident council meeting with three residents (Residents #15, #38 and #42) who were alert and oriented and selected by the facility to attend the group meeting. The residents stated that they received dinner between 5:00 PM-5:30 PM, and breakfast was delivered between 8:00 AM-8:30 AM. All three residents stated that they were not offered nor received snacks in the evening. On 7/21/25 at 12:40 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns. The LNHA stated that evening snacks were delivered to the units and that he would investigate what the process was.On 7/22/25 at 9:51 AM, in the presence of the survey team, the LNHA stated that he was unable to find the accountability book for the 8 PM snacks. The DON confirmed that the recreation staff passed out the 8 PM snacks but that she was also unable to locate the book which would confirm that the residents either received or refused the evening snacks.On 07/22/2025 at 10:27 AM, during an interview with the surveyor, the Food Service Director (FSD) stated that the dietary staff sends up extra snacks to the units which include sandwiches, cookies, beverages and yogurt. Once on the units, the activities staff and the CNAs were responsible for delivering the snacks to the residents. The FSD further stated, if there were more than a 14-hour gap between meals, snacks needed to be offered to all residents. On 7/24/25 at 8:30 AM, during an interview with the surveyor, the Director of Recreation confirmed that the activity staff only distributed the morning 10:00 AM, and afternoon 2-3:00 PM snacks. She further stated her staff was not responsible for passing out the evening snacks.On 7/24/25 at 8:45 AM, during an interview with the surveyor, the DON stated that she had not been aware that the activity staff were not passing out the 8:00 PM snacks, until it was discussed at the resident council meeting. The DON met with the Director of Recreation who confirmed that activity staff were not responsible for passing out evening snacks. A review of the evening (HS) snack policy and procedure dated 12/14/23 reflected: It is the policy of this facility to ensure that residents are offered snacks three times day. The facility will ensure that snacks are offered to all residents as a strategic intervention for meeting nutrition care goals. The food service director will ensure a supply of snacks are available on each unit.On 7/24/ 2025 at 10:00 AM, during an interview with the surveyor, the LNHA stated that he had not been aware, before the surveyor's inquiry, that there was no documentation or accountability regarding whether snacks were offered, accepted, or refused, and that such accountability was necessary. On 7/24/25 at 1:15 PM, no further information was provided by the facility.NJAC 8:39-17.2 (f))(1) (i) (ii) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>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 7/16/2025 at 10:01 AM, the surveyor in the presence of the chef toured the kitchen and observed the following:1. In the 3-door standing refrigerator, the surveyor observed 10, 2oz cups of sliced pickles dated 7/7/25 -7/12/25 and 12, 2oz cups of grated cheese with a use by date of 7/15/25. The chef was unable to state why those items had not been disposed of by the use-by date. 2. In the 6-door standing refrigerator, the surveyor observed a round container of grape jelly covered with plastic wrap, labeled opened on 7/11/25. The chef was unable to explain why the label did not have a use-by date but stated that the jelly should have been discarded three days after opening. The surveyor also observed an open package of sliced American cheese without a label. The chef was unable to state when the American cheese was opened and why the use-by label had not been placed.3. In the dry storage area, the surveyor observed a 5lb bag of B'gan brand biscuit mix, the bag was observed distended, all other bags of biscuit mix observed not distended. Multiple ceiling tiles were observed to be discolored. At that time, the chef discarded the biscuit mix and further stated that maintenance would be informed of the discolored ceiling tiles.4. In the Walk-in freezer, the surveyor observed that the circulating fans had a dust-like debris, and a rapid cooling ice container was observed with dust-like debris on the handle. The chef stated that maintenance was responsible for cleaning the fans, and the cooling container would be cleaned immediately.On 7/17/2025 at 9:35 AM, the surveyor interviewed the Food Service Director (FSD), who stated that all items in the kitchen needed to be labeled with a received, opened, and use-by date, and all items should be disposed of by the use-by date. The FSD further stated that the fans and the rapid cooling container in the freezer should always be clean and in good repair.On 7/17/25 at 1:45 PM, the FSD provided the surveyor with multiple facility policies, all of which were last reviewed on 12/14/23. The Labeling and Dating policy states under the procedure section, # 2. Do not write over the expiration date. Receive date and expiration date must be visible.5. All prepared foods are dated the date they were made and counting as day one. Must have a use by date. All foods prepared in the kitchen must be dated with a use by date and discarded in three days. The Freezer policy states under the procedure section, 4. For walk-in freezers, mop floors, wash walls, and ceiling as needed.On 7/21/2025 at 12:40 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review concerns identified during the survey. The DON stated that their kitchen concerns are ongoing, and the FSD conducts multiple in-services for the staff.On 7/24/25 at 1:15 PM, the surveyor met with the LNHA and DON for an exit conference; no further pertinent information was provided.NJAC 8:39-17.2(g) |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>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 evidenced by the following:On 7/16/2025 at 10:01 AM, the surveyor, in the presence of the chef, toured the kitchen and garbage area and observed the following:There was garbage debris that included food wrappers, food containers, cups, gloves, paper products, and medication cups around the dumpster and surrounding areas. The chef said that the maintenance and dietary departments should have cleaned the area.On 7/17/2025 at 9:35 AM, the surveyor interviewed the Food Service Director (FSD), who stated that the garbage areas are a shared area; the kitchen, maintenance, and housekeeping departments are all in charge of cleaning that area. On 7/21/25 at 12:36 PM, the FSD provided the surveyor with a facility policy titled Dumpster Sanitation Policy with a revised date of 4/1/25. Under the procedure section of the policy, it states, 2. Dietary, Housekeeping, and Maintenance Departments will monitor when taking out garbage, that the areas are clean of debris and other items.On 7/21/2025 at 12:40 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review concerns found during the survey. The DON stated that the garbage area concerns will immediately be addressed.On 7/24/25 at 1:15 PM, the surveyor met with the LNHA and DON for the exit conference; no further pertinent information was provided.NJAC 8:39-19.7 |

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| F 0841<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.<br><br>Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure the medical director: a.) implemented the facility's policies and procedures for resident care including physician visits documented at the time of visit and b.) ensure facility policies and procedures were reviewed and updated as needed. This deficient practice has the potential to affect all residents, and was evidenced by the following:Refer F 711A review of the undated facility provided Director Roles and Responsibilities for the Medical Director's job description included:Physician Leadership: Help the facility ensure that patients have appropriate physician coverage and ensure the provision of physician and health care practitioner services.Provide guidance for physician performance expectations; Help the facility ensure that a system is in place for monitoring the performance of health care practitioners.Patient care-Clinical Leadership: Participate in administrative decision-making and the development of policies and procedures; Help develop, approve, and implement specific clinical practices for the facility to incorporate into its care-related policies and procedures, including areas required by laws and regulations.Help review policies and procedures regarding the adequate protection of patient's rights, advance care planning, and other ethical issues.On 7/22/25 at 11:20 AM, the surveyor conducted a telephone interview with the Medical Director (MD), who stated that he has been the medical director at the facility for 8-9 years. The MD stated his job responsibilities included: to take care of resident care, oversee all resident, and fill in for another physician as needed. The MD stated that he was at the facility twice a week and participated in the facility's Quality Assurance and Improvement Program (QAPI). When asked how often a resident needed to be seen, the MD stated once a month. When asked when he documented the notes of the visits, the MD stated that he took his personal notes home and put them in the resident's electronic medical record later on and whenever have a chance. The surveyor asked when the MD was required to document the visit into the resident's medical record, the MD stated at the time of visit or in a reasonable number of days. At this time, the surveyor stated that they observed notes that were still not written from February of 2025, and the MD confirmed and stated that he was catching up and should be finished documenting by the end of the month. The surveyor asked how many residents the MD saw, and he stated about 40 residents. (Facility census upon entrance was 58.) The surveyor asked if documenting months later was allowed, and the MD stated that he did not know.The surveyor then asked if he reviewed Statements of Deficiencies for the facility's surveys to see what they were cited for, and the MD confirmed no. The surveyor asked if he recalled having a conversation during the previous standard survey about not documenting at the time of the physician's visit, and the MD confirmed he did. The surveyor asked if he reviewed the facility's policies and procedures, and the MD stated if there were changes. The MD confirmed he had not reviewed all the facility's policies.On 7/22/25 at 12:00 PM, the surveyor reviewed the facility's Census Detail Report, which revealed that the Medical Director saw 38 residents, and the other two physicians saw 20 residents combined.On 7/24/25 at 11:40 AM, the surveyor interviewed the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), who stated that the facility had a binder of nursing policies and procedures that had not been updated since 2020. The LNHA stated certain policies like infection control and antibiotic stewardship were updated annually. The DON stated that the facility had a care plan policy, but it was not updated since 2014. The MD stated that policies should be reviewed at least annually and updated as needed.NJAC 8:39-23.1(a) |

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| | 315378 | A. Building<br>B. Wing | 07/24/2025 |

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| Homestead Rehabilitation & Health Care Center | 129 Morris Turnpike<br>Newton, NJ 07860 |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure that their Quality Assurance and Performance Improvement (QAPI) Program was being implemented to ensure sustainability with previously cited deficiencies. The facility was cited during last standard survey on 3/12/24, and was evidenced by the following:Refer to F686, F711, F755, F880 During the entrance conference on 7/16/24 at 10:29 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) a copy of the facility's QAPI program plan and the 2024 and 2025 quarterly sign-in sheets and QAPI notebook.On 07/21/2025 at 12:40 PM, the survey team met with the LNHA and DON to discuss their concerns, which included treatment and services to prevent pressure ulcers, physician visits, pharmacy services, and infection control.A review of the Centers for Medicare & Medicaid Services (CMS) 2567 statement of deficiencies from the facility's last standard survey included the facility was cited for the following concerns: treatment and services to prevent pressure ulcers, physician visits, pharmacy services, food storage and sanitation, and infection control.On July 24, 2025, at 10:46 AM, the surveyor interviewed the LNHA and DON to discuss the facility's QAPI program, which both staff members were involved in. When asked where the facility obtained their concerns for their QAPI program, the LNHA stated the facility utilized information from the residents, minutes from the resident council meeting, employees, and visitors' comments. The survey team informed the facility that there were repeated concerns from the last standard survey, which included treatment and services to prevent pressure ulcers, physician visits, pharmacy services, and concerns regarding infection control. The LNHA acknowledged that even though he and the DON started at the facility in January 2025, they both were present for the April 2025 quarterly QAPI meeting. At that time, the LHNA stated he was aware of the facility's previous deficiencies and that the facility had educated its staff and completed reports.A review of the facility provided Director of Nursing job descriptions included . The Director of Nursing is responsible for being an active member of the QAPI committee, coordinating and/or developing ongoing QAPI activities for nursing service to monitor nursing compliance with standards and regulatory requirements through rounds, interviews, and record reviews. Compiles a summary of findings for the Quality Assurance committee. Participates in the preparation of the Plan of Correction response to an inspection survey and implements any follow-up QAPI required for any nursing allegations.NJAC 8:39-33.1(a)(e); 33.2 (a)(b)(c)(d) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>Based on interview, and review of facility documentation, it was determined that the facility failed to ensure that Certified Nurse Assistant (CNA) received at least 12 hours of mandatory in-service training for 5 of 5 CNA's education reviewed, (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5).This deficient practice was evidenced by the following: On 7/24/25 at 10:17 AM, the surveyor requested the personnel education files for 5 CNA's1. CNA#1, with a date of hire of 8/17/22 no record of education was provided.2. CNA#2, with a hire date of 8/23/23 no record of education was provided.3. CNA#3, with a hire date of 7/2/24 no record of education was provided.4. CNA#4, with a hire date of 10/1/24 no record of education was provided.5. CNA#5, with a hire date of 7/22/23 no record of education was provided.On 7/21/25 at 12:20 PM, the survey requested CNA education from the Director of Nursing (DON).On 7/24/25 at 10:17 AM, the surveyor interviewed the DON, who stated that she could not provide any staff education including the CNA's 12-hour mandatory education. She stated that the program used for staff education was changed to a different system and was not able to retrieve the education of the staff, and copies were not saved in the employee files. At this time, the surveyor requested the policy for mandatory staff education.On 7/24/25 at 11:30 AM during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA) and DON stated the facility could not provide policies and provided no further pertinent information.N.J.A.C. 8:39-43.17(b) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation and interview, it was determined that the facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner on 1 of 3 Nursing Units (Unit 3). The deficient practice was evidenced by the following:On 7/21/25 at 11:25 AM, during a tour of the 3rd floor nursing unit, the surveyor observed cracked floor tiles and chipped paint throughout the unit on the low and high sides. The surveyor also observed soiled and cracked ceiling tiles on the low side near the elevator.On 7/22/25 at 10:40 AM, during an interview with the surveyor, the Director of Maintenance acknowledged that the floor, paint, and ceiling tiles were all in disrepair.On 7/22/25 at 1:15 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) stated that he was aware of the cracked flooring, chipped paint, and soiled ceiling tiles on the 3rd floor Nursing Unit. The LNHA stated that the last contractor was in the middle of repairs and then left abruptly. The LNHA stated that the facility needed a new roof, and as a result, the tiles needed to be replaced every time it rained. The LNHA acknowledged that the residents should be provided a clean homelike environment.NJAC 8:39-4.1(a)11. 31.4 (a) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>NJ Complaint#: NJ0018771Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an allegation of staff-to-resident abuse between Certified Nursing Assistant (CNA #1) and Resident #29 that occurred on 2/2/25 and a Licensed Practical Nurse (LPN#1) that appeared intoxicated when reporting to work on 7/2/25. This deficient practice was identified for 1 of 2 reported complaints reviewed.On 6/26/25 the NJDOH received an anonymous complaint from an employee of Homestead Rehabilitation and Health care Center. The employee claimed there was an issue with quality of care specifically citing, an allegation of staff to resident abuse from a CNA (name detached) which had resulted in injury as well as a nurse being intoxicated when reporting to work.On 7/17/25 at 10:04 AM, the surveyor reviewed the employee files for CNA#1 and LPN#1. A review of CNA#1's employee file revealed a Facility Reported Incident dated 5/23/25 at 3:00 PM revealed a staff member reported to the Licensed Nursing Home Administrator (LNHA) that they felt CNA#1 was inappropriately touching a resident, the staff member further stated that they did not witness anything but wanted to report it. CNA#1 was suspended pending the investigation. The investigation included statements from staff and residents who all worked with or received care from CNA#1. None of the statements accused CNA#1 of abuse. CNA#1 returned to work on 5/27/25. Further review of CNA#1's employee file revealed an employee disciplinary action sheet, marked as Final Warning dated 2/4/25. An employee statement provided by CNA#2 dated 2/2/25 at 1:00 PM, revealed CNA#1 was upset about not being able to take their break because they had to provide feeding assistance to Resident #29. Upon entering Resident #29's room, CNA#1 slammed their door. CNA#2 further stated upon seeing the resident's door slam, they entered the room and saw CNA#1 was visibly upset. CNA#1 was observed cutting the residents food and pushed the food towards Resident #29 in an aggressive manner. CNA#2 told CNA#1 to go on break, and they would provide feeding assistance to the resident. CNA#1 left the room without incident. A review of CNA#1 statement on 2/2/25 at 1:07 PM, revealed they were feeding Resident #29, when CNA#2 barged into the room and stated they would take over assisting Resident #29 and accused CNA#1 of abuse. No further information paperwork regarding the issue was provided.A review of LPN#1 employee file revealed an employee disciplinary action form marked as; Final Warning dated 7/3/25. The specifics of the incident portion of the form revealed, Name redacted (LPN#1) showed up to scheduled 11-7 shift on 7/2 smelling of alcohol as well as appearing intoxicated. The employee statement portion of the form revealed, employee admitted to taking some shots prior to coming to work and admitted to knowing it was wrong. The corrective action to be taken portion of the form indicated: 1. Name redacted (LPN#1) is on family medical leave act (FMLA). 2. With clearance will return in a supervised setting on 7am-3pm shift. 3. Reported to Board of Nursing (BON) and Department of Health (DOH). On 7/17/25 at 10:43 AM, the surveyor interviewed the DON, who stated a Facility Reported Incident (FRI) for CNA#1 was completed on 5/23/25. The DON further stated that CNA #1 was suspended pending the investigation, was cleared of any allegation, and returned to work. The DON stated there had not been an FRI reported for the 2/2/25 allegation of abuse and was unable to provide reasoning why an FRI was not reported. The DON stated with regarding to LPN#1, on 7/2/25 the DON observed LPN#1 clock into work, appeared intoxicated and was sent home immediately. DON also stated they had reported LPN#1 to nursing boards and DOH.A review of a facility policy title, Abuse Prohibition, with an updated date of 4/4/25. Under the process section of the policy revealed, 7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following. 7.1 Report allegation involving abuse (physical, verbal, sexual, mental) not later than 2 hours after allegation is made. 7.2 Report allegation to appropriate state and local authority(s) involving neglect, exploitation or mistreatment, suspected<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | criminal activity, and misappropriation of patient property not later than two hours after allegation is made.7.4 Notify local law enforcement, licensing boards and registries and other agencies as required.On 7/17/25 at 1:00 PM, the DON provided the surveyor with an FRI dated 7/17/15 at 12:45 PM. DON stated that they called in the FRI to the NJDOH after surveyor inquiry. The DON was unable to provide evidence of LPN#1 actions being called into the DOH. The DON further stated that LPN#1 alleged violations should be reported to the DOH in a timely manner and abuse allegations should have been reported within 2 hours, On 7/21/2025 at 12:40 PM, the surveyor met with the LHNA and DON and the LNHA stated they believed the allegation of abuse by CNA#1 was more of a personal issue between CNA#1 and CNA#2 and felt an FRI was not needed at that time. The LNHA stated any abuse allegation should always be reported. The further information was provided for LPN#2. On 07/24/2025 at 1:15 PM, the surveyor met with the LNHA and DON and no further pertinent information provided. NJAC 8:39-9.4(f) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Complaint #: NJ184361 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure care plan interventions were implemented for a resident's skin integrity. This deficient practice was identified for 1 of 2 residents reviewed for abuse (Resident #67), and was evidenced by the following:The surveyor reviewed the closed medical record for Resident #67. A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia, heart failure, need for assistance with personal care, and major depressive disorder. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 2/11/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated a severely impaired cognition. A further review revealed that the resident needed partial assistance from another person to complete activities of daily living (ADLs).A review of the individualized comprehensive care plan (ICCP) included a focus area dated effective 2/7/25, for at risk for skin breakdown related to impaired circulation, decreased mobility, and poor intake. Interventions included: to keep skin clean and dry; inspect skin daily and monitor for any reddened areas or skin breakdown; notify physician as needed for skin breakdown; turn and reposition every two hours while in bed or chair; and monitor for changes in circulation. A review of the Facility Reportable Event (FRE) dated 3/10/25, included that Resident #67's Representative (RR) informed the Social Worker (SW) that they had numerous complaints about the resident's skin when they left the facility including skin irritations. On 7/22/25 at 1:00 PM, the surveyor reviewed the resident's ICCP with the Director of Nursing (DON), and asked how the facility ensured the resident's intervention for inspection of skin daily was completed. The DON stated that she would have to get back to the surveyor. On 7/24/25 at 10:12 AM, the surveyor interviewed the DON, who stated that the resident's inspect skin daily was an automated intervention in the facility's electronic medical record system, and the resident should not have had that intervention. The surveyor asked then if everyone should have that intervention then, the DON stated that the nurse misread it when she implemented the intervention in the ICCP. The DON stated it should have just been a visual look when the aide was providing care. and The DON stated that care plans were done by the MDS Coordinator and updated by her as needed. The DON confirmed that staff were expected to implement all interventions in the resident's ICCP. On 7/24/25 at 10:49 AM, the surveyor interviewed the MDS Coordinator, who confirmed that she took part in the ICCP process. The MDS Coordinator stated that care plans were done annually and updated as needed. The MDS Coordinator stated that interventions were selected from a library in the facility's electronic medical record system, and that she could add additional interventions as needed. When asked about Resident #67's ICCP intervention for inspecting skin daily, the MDS Coordinator stated that she thought it meant for the Certified Nursing Aide (CNA) to inspect during care. The MDS Coordinator stated that she found out that she could link the intervention to the CNA instructions to do. The MDS Coordinator acknowledged that staff are expected to implement all ICCP interventions and if they were unaware of what an intervention meant, staff should have asked for clarification. A review of the facility provided Interdisciplinary Care Plans policy dated revised 3/17/14, included 2. Interventions: a. all interventions must be clear, concise and measurable. b. Interventions must address how each problem will be resolved . NJAC 27.1(a) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on interview and review of pertinent facility documents, the facility failed to ensure a resident who required assistance for bathing received a shower upon admission to the facility and on their scheduled shower day. This deficient practice was identified for 1 of 3 residents reviewed for activities of daily living (Resident #67), and was evidenced by the following:The surveyor reviewed the closed medical record for Resident #67. A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia, heart failure, need for assistance with personal care, and major depressive disorder. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 2/11/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated a severely impaired cognition. A further review revealed that the resident needed partial assistance from another person to complete activities of daily living (ADLs). A review of the individualized comprehensive care plan (ICCP) included a focus area dated effective 2/7/25, for requiring increased assistance with ADL function due to debility due to recent hospitalization, impaired mobility, cognitive deficit with poor safety awareness, and medication changes. Interventions included to assistance provided with care as needed, administer medication as ordered, and encourage participation in self-care as able. A review of the Facility Reportable Event (FRE) dated 3/10/25, included that Resident #67's Representative (RR) informed the Social Worker (SW) that they had numerous complaints about the resident smelled and was not showered. A review of the Certified Nursing Aide (CNA) Documentation Detail for bathing, provided by the Director of Nursing (DON), revealed that while the resident was in the facility, they refused a shower on 2/13/25 at 7:26 PM, received a shower on 2/17/25 at 10:38 AM, did not received a shower on 2/20/25, and received a shower on 2/27/25 and 3/6/25. On 7/22/25 at 12:35 AM, the surveyor interviewed CNA #1 and CNA #2, who both stated that they knew what care a resident received on their assignment from the ADL tracker that the resident's shower day was highlighted and the schedule was also on the wall. They both stated on shower days, a box for bathing would appear that you put a code in that it was completed or not completed. The CNAs stated that if the resident was not showered, the CNA coded that an 8 and they were required to document why the resident was not showered. The CNAs stated the nurse was informed, and the nurse might document as well. On 7/22/25 at 12:51 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the CNAs documented the resident's showers in the ADL Tracker system, and the nurses documented the resident's refusal of a shower in the progress notes. The surveyor reviewed the resident's medical record with the DON, who confirmed that there was no documentation on 2/20/25, as to why the resident was not showered, and there should have been. The surveyor requested the physician's order (PO) for when the resident's shower days were scheduled, and any additional information regarding when the resident was showered. On 7/24/25 at 10:12 AM, the DON informed the surveyor that there was no PO for bathing, that it was documented on the resident's ADL schedule. The DON provided a bathing schedule that indicated Resident #67 was to be bathed every Thursday during the 3:00 PM to 11:00 PM shift. When asked when a resident should be showered upon admission, the DON stated with 72 hours of their admission. The DON stated that the resident should be showered at least twice a week and confirmed the resident was only scheduled for once a week on Thursdays. The DON stated that the resident did receive a shower the night before their discharge from the facility. The DON also confirmed there was no documentation as to why the resident did not receive a shower on 2/20/25. On 7/24/25 at 11:40 AM, the surveyor interviewed the DON and Licensed Nursing Home Administrator (LNHA), who both confirmed the facility had a nursing binder of policies that had not been updated since 2020. The DON stated that the facility did not have an ADL or showering policy, but a resident should receive a shower within 72 hours of admission and at least once a week. The DON stated that in the sub-acute unit, residents are offered a shower daily, and the CNA documented in the ADL<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | tracker if they received one. The DON confirmed there was no documentation that the resident received a shower within 72 hours of admission. NJAC 8:39-27.1(a); 27.2(h-i) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to maintain infection control standards and procedures during wound care treatment for 1 of 2 Residents (Resident #2) reviewed for care and services for pressure ulcers.This 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 7/21/25 at 11:30 AM, the surveyor observed Resident #2 in bed. The surveyor obtained the resident's permission to observe the treatment to his/her sacral wound. The surveyor observed signage on the door, which indicated the resident was on Enhanced Barrier Precautions (an infection control strategy implemented in long term care facilities that uses gloves and gowns during high-contact resident care to reduce the spread of multidrug- resistant organisms.) The surveyor reviewed the medical record for Resident #2.A review of the admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to: Parkinson's Disease, Diabetes Mellitus, and a Stage 3 Pressure Ulcer of the sacral region (full thickness skin loss into subcutaneous tissue and fat).A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 6/22/25, reflected that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 2 of 15, indicating a severe cognitive impairment. Section M documented that the resident had one stage 3 pressure ulcer.A review of the 7/21/25 Weekly Wound Assessment Report included documentation regarding the stage 3 sacral pressure ulcer, which was currently improving.A review of the Physician's Order (PO) dated 6/25/25 included: clean sacrum with saline, pack with Iodoform, also pack tunnel, protective dressing daily and prn (as needed.) On 7/21/25 at 11:35 AM, the surveyor observed the Licensed Practical Nurse/Wound Nurse (LPN/WN) perform the treatment to Resident #2's stage 3 pressure ulcer and observed the following: The Certified Nursing Assistant (CNA), who assisted the LPN with positioning of Resident #2, donned (put on) a disposable gown, mask, and gloves, entered Resident #2's room, and disinfected the over-bed table. The LPN/WN gathered the supplies, which included three (10 cc) Normal Saline syringes (NSS), a container of packing strips, a foam dressing, 4x4 gauze pads, a bag of cotton tip wooden applicators, scissors, and a marker. The LPN/WN donned a mask, disposable gown, and gloves and entered Resident #2's room. The LPN/WN placed a clean barrier on the overbed table and then placed all of the supplies on it. The LPN/WN reviewed the supplies at the resident's bedside and realized he had brought in packing strips that did not contain the Iodoform as per the physician's order. The LPN/WN doffed (took off) his disposable gown, mask, and gloves, sanitized his hands with Alcohol Based Hand Rub (ABHR), and left the room.The LPN/WN returned to Resident #2's room with the Iodoform packing strips (used to prevent bacterial infection and promote healing). The LPN/WN donned a gown and gloves and placed a plastic bag on Resident #2's bed, which he stated would be used to collect the soiled dressing and used supplies. The LPN/WN removed the soiled dressing, which he described as having a moderate amount of serosanguinous drainage (a mix of serous fluid and blood), and discarded it into the bag on the resident's bed. The LPN/WN removed his gloves and discarded them into the bag on the bed. The LPN/WN applied ABHS, donned a new pair of<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | gloves, cleaned the wound with the NSS syringe, measured the sacral wound, and, with the same gloves (now contaminated) opened the Iodoform packing strips. The LPN/WN used the wooden end of the Q-Tip to pack the wound. The LPN measured the packing strip as he removed it from the container, touching it with his gloved hand (now contaminated). After packing the wound, the LPN/WN cut the strip from the container. The LPN then taped the end of the packing strip to the resident's already compromised skin. The LPN used the same contaminated gloves to put the lid back on the Iodoform packing strips. The LPN applied the foam dressing, put the date, time, and initials on a piece of tape, and applied the tape to the dressing. The LPN cleansed the scissors and pen with alcohol pads. The LPN discarded the used supplies in the bag on the resident's bed. The CNA who assisted with the resident's positioning removed her mask, gown, and gloves and performed hand hygiene. The LPN/WN and surveyor observed that the CNA washed her hands under the stream of water for 8 seconds without first lathering and applying friction to her hands outside of the running water.The LPN removed the trash bag from the resident's bed, doffed his gown, mask, and gloves, and washed his hands. The LPN/WN brought the containers of Plain and Iodoform packing strips out of the resident's room (now contaminated) and put them back into the treatment cart. The LPN did not disinfect the overbed table after the treatment was completed. The surveyor observed that throughout the treatment, the LPN did not assess the resident for pain.On 7/21/25 at 12:25 PM, the surveyor discussed the breaks in technique with the LPN/WN. The LPN/WN confirmed that he had not assessed the resident for pain or checked with the medication nurse to see if the resident received pain medication prior to the wound treatment. The LPN acknowledged that he should not have placed the trash bag on the resident's bed, should not have touched the packing strip with his soiled gloves, and should not have placed the containers of packing strips back into the treatment cart for infection control prevention. The LPN/WN further confirmed that he should have disinfected the overbed table after the treatment was completed. The LPNWN stated that he observed the unacceptable hand washing performed by the CNA. On 7/21/25 at 12:30 PM, during an interview with the surveyor, the CNA acknowledged she should have washed her hands for 20 seconds outside the stream of water. The CNA stated that she usually lathered outside of the water but didn't this time because she was nervous. On 7/21/25 at 12:40 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations and concerns.A review of the facility's policy Wounds: Pressure Ulcers & Ulcers of different types of Protocol for: Prevention, Assessment & Monitoring, Intervention, Documentation, and Evaluation updated 2/23/2016 reflected.In the event that a resident is admitted with a pressure sore or a resident develops a pressure sore, the resident will receive the necessary care and services to promote healing and prevent additional ulcers. A review of the facility's Hand Washing policy revised 3/9/2021 reflected.Hand hygiene techniques.Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously outside the stream of water for 30 seconds, covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use a towel to turn off the faucet. On 7/24/25 at 1:15 PM, no further information was provided by the facility.NJAC 8:39-19.4(a); 27.1 (a) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview, and record review, it was determined that the facility failed to (a) ensure that a medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing and (b) ensure a system was in place for the accurate acquiring, receiving, and dispensing of medications in accordance to professional standards of practice. This deficient practice was identified for 2 (two) of 4 (four) residents (Resident #33 and Resident #42) observed during the medication observation pass and had the potential to affect all residents. The deficient practice was evidenced by the following:<br><br>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.<br><br>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.<br><br>1). On 07/21/25 at 8:37 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN#1) in the room of Resident #42. The surveyor observed LPN#1 checking the resident's identification bracelet and informed Resident #42 that she would be administering the resident's medications.<br><br>On 07/21/25 at 8:40 AM, the surveyor observed LPN #1 preparing to administer nine (9) medications to Resident #42 which included the following: Calcium Carbonate 600 mg tablets (supplement), Eliquis 5 mg (blood thinner), Lexapro 5mg (anti-depressant) tablet, Gabapentin 100 mg tablet (nerve pain), multivitamin tablet (supplement), Vitamin D3 1000-unit tablet (supplement), Vitamin B-12 500 mg (supplement), Torsemide 20 mg (water pill) and Potassium Cl 10 MEQ. The surveyor observed LPN#1 prepared Resident #42's Potassium. The electronic medication administration record (EMAR) revealed that the resident had an order for one Potassium 10 MEQ tablet to be administered. The surveyor observed the Potassium 10 MEQ medication packaging a pharmacy label to administered two tablets which was equivalent to 20 MEQ. At that time, LPN#1 stated that the resident had an order for one tablet and that she was going to call the pharmacy and have them change the label. LPN#1 acknowledge that the pharmacy medication packaging was confusing and had the potential to cause a medication error.<br><br>A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; hypokalemia (low potassium), vitamin deficiency, and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, and significant impairment of daily functions).<br><br>A review of the admission Minimum Data Set, an assessment tool used to facilitate the management<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of care, dated 4/25/25, 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.<br><br>A review of the July 2025 Physician's Orders (PO) revealed a Physician's Order dated 6/26/25, for Potassium chloride ER 10 mEq tablet, extended-release tablet, give 1 tablet by mouth one time a daily with food for hypokalemia.<br><br>A review of the April 2025 electronic medication administration record (EMAR) revealed an order dated 06/26/25, for Potassium Chloride ER 10 mEq tablet, extended release, give 1 tablet by mouth once daily with food for hypokalemia (plotted time at 8:30 AM).<br><br>On 07/22/25 at 10:20 AM, the surveyor in the presence of LPN#3 inspected the third-floor high side medication card. In the presence of the surveyor, LPN#3 pulled out Resident #42's Potassium medication card (medication packaging) which still included the instructions to administer 2 tablets of Potassium for a dose of 20 MEQ. LPN#3 reviewed the EMAR and stated that the resident had an order for one tablet of 10 mEq of Potassium. LPN#3 stated that the instructions on the medication card was confusing and had the potential to cause a medication error. She stated that she will remove this medication card from active medication and will call the pharmacy for a new medication card with proper instructions.<br><br>2). On 07/21/25 at 9:19 AM, during the medication administration observation, the surveyor observed the LPN #2 in the room of Resident #33. The surveyor observed LPN#3 checking the resident's identification bracelet and informed Resident #33 that she would be administering the resident's medications.<br><br>On 07/21/25 at 9:20 AM, the surveyor observed LPN #3 preparing to administer nine (9) medications to Resident #33 which included the following: Abilify 5 mg tablets (anti-depressant), Zyrtec 10 mg tablet (allergies), Dilantin 30 mg extended-release capsules (seizures), two Dilantin 50 mg chewable tablets (seizures), Ferrous sulfate 325 mg (supplement), Primidone 250 mg tablets (seizures), Folic Acid 1 mg (supplement), Namenda 10 mg (dementia), and B-complex tablet (supplement). The surveyor observed LPN#3 administer Resident #33's medications.<br><br>A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to epilepsy (a neurological condition characterized by recurrent, unprovoked seizures), Alzheimer's disease (a progressive disease that destroys memory and other important functions) and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, and significant impairment of daily functions).<br><br>A review of the quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated 5/08/25, reflected that the resident's cognitive skills for daily decision-making score was 10 out of 15, which indicated that the resident had moderate cognitive impairment.<br><br>A review of the July 2025 Physician's Orders (PO) revealed two Physician's Orders dated 02/19/25, for Dilantin 30 mg capsule, give 1 capsule by mouth every 12 hours for seizure disorder every 8 AM and every 8 PM and for Phenytoin (Dilantin) 50 mg chewable tablet, chew 2 tablets (100mg) by oral route 3 times per day for seizure disorder every 8:00 AM, 4:00 PM, and 8:00 PM.<br><br>A review of the July 2025 EMAR revealed two physician's orders dated 02/19/25, for Dilantin 30 mg<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | capsules, give 1 capsule every 12 hours for seizure disorder (plotted time 8:00AM and 8:00 PM) and an order for Phenytoin 50 mg chewable tablets, chew two tablets (100 mg) by oral route three times daily for seizure disorder (plotted time 8:00 AM, 4:00 PM, and 8:00 PM).<br><br>On 7/21/25 at 11:14 AM, the surveyor interviewed LPN#2 regarding two orders (Dilantin 30 mg and Dilantin 50 mg) administered late (outside from the allotted time frame). LPN#2 reviewed the orders and acknowledge that both Dilantin orders should have been administered no later than 9 AM. LPN#2 also stated that it was important that a medication being taken more than once a day should be administered at the appropriate time. LPN#2 further acknowledge that Dilantin 30 mg was ordered to be administered every 12 hours and Dilantin 50 mg had an order to administered three times daily.<br><br>On 07/21/25 at 12:30 PM, the surveyor discussed the above concerns with the facility administration team that consisted of both the Director of Nursing (DON) and the Licensed Nursing Home Administrator.<br><br>There was no additional information provided.<br><br>A review of the facility's policy for Medication Administration that was undated and was provided by the DON revealed no information that address the concerns presented by the surveyor.<br><br>3. On 7/22/25 at 9:51 AM, the survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), and the DON stated that the facility had a policy that allowed staff to borrow medication from a resident to administer to another resident. The DON continued that the facility would borrow the medication from a resident, and they completed a form that the medication was borrowed from the resident, and the form was sent to the Provider Pharmacy, and the medication was replaced. The surveyor asked if the facility was allowed to borrow medication from another resident, and the DON stated it was the facility's policy that we can borrow and the fill out the form. The surveyor then requested a copy of all borrowed medication since last standard survey, and the DON denied borrowing any medication from residents.<br><br>A review of the facility's Medication Administration: Borrowing Policy updated 2/23/16, indicated that nursing staff may, on a temporary basis, borrow prescribed medication until the next delivery. Medication may be borrowed from the supply of another resident only for the following reasons: resident ran out of medication; new order received after daily pharmacy delivery, needed medication before the pharmacy delivery; or the emergency pharmacy was closed .<br><br>On 7/22/25 at 11:07 AM, the surveyor attempted to conduct a telephone interview with the Consultant Pharmacist (CP) who did not answer, and the surveyor was unable to leave a message.<br><br>On 7/22/25 at 11:20 AM, the surveyor conducted a telephone interview with the Medical Director (MD), who stated that you were not allowed to borrow medication from one resident for another resident because it was that resident's property. The surveyor asked if the facility had a policy to borrow medication from another resident was it okay, and the MD stated no, that the facility had an emergency back-up box of medication to use. The surveyor informed the MD that the facility did not have narcotics in their emergency back-up supply and asked if it was okay to borrow a narcotic. The MD stated no. The MD also acknowledged that he was unaware the facility had a borrowing policy for medications and acknowledged that he had not reviewed all the facility's policies.<br><br>On 7/22/25 at 11:56 AM, the surveyor conducted a telephone interview with the Provider Pharmacist (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (PP), who stated that the facility received deliveries twice a day, and if there was a medication needed stat (immediately), the pharmacy would call in the prescription to a local pharmacy for the facility to pick up. The surveyor asked f it was acceptable for the facility to borrow medication from one resident to give to another resident, and the PP stated no, that as far as the pharmacy was concerned, a pharmacist was not dispensing the medication. The PP stated that it was the pharmacist's scope of practice to dispense medications to ensure the correct dosage, drug interactions, and allergies, and the facility would be acted out of their scope of practice since the pharmacy would no longer be dispensing the medication.<br><br>NJAC 8:39-11.2 (b), 29.2 (d) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:<br><br>Number of residents cited:<br><br>The surveyor reviewed the closed medical record for Resident #67.A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: unspecified dementia, heart failure, need for assistance with personal care, and major depressive disorder.A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated a severely impaired cognition. A further review revealed that the resident needed partial assistance from another person to complete activities of daily living (ADLs).A review of the individualized comprehensive care plan (ICCP) included a focus area dated effective [DATE], for requiring increased assistance with ADL function due to debility due to recent hospitalization, impaired mobility, cognitive deficit with poor safety awareness, and medication changes. Interventions included to assistance provided with care as needed, administer medication as ordered, and encourage participation in self-care as able.On [DATE] at 10:15 AM, the surveyor requested from the Licensed Nursing Home Administrator a copy of the complete Facility Reportable Event (FRE) including all witness statements dated [DATE], for Resident #67.On [DATE] at 10:23 AM, the LNHA provided the surveyor with Resident #67's FRE.A review of the FRE dated [DATE], included that Resident #67's Representative (RR) informed the Social Worker (SW) that they had numerous complaints about the resident smelled and was not showered. I review of the Grievance/Concern Form included in the FRE indicated that the Recommended Corrective Action(s): were reviewed documentation [.] showers were given twice a week and confirmed compliance with Certified Nursing Aide (CNA). The FRE did not include any witness statements from staff including CNAs.A review of the Certified Nursing Aide (CNA) Documentation Detail for bathing, provided by the Director of Nursing (DON), revealed that while the resident was in the facility, they refused a shower on [DATE] at 7:26 PM, received a shower on [DATE] at 10:38 AM, did not received a shower on [DATE], and received a shower on [DATE] and [DATE]. This documentation did not corroborate the Grievance/Concern Form that indicated the resident received showers twice a week.On [DATE] at 12:40 PM, the survey team met with the LNHA and DON, and the surveyor requested any statements obtained for Resident #67's FRE dated [DATE].On [DATE] at 9:51 AM, the surveyor team met with the LNHA and DON to discuss concerns addressed the day before. The surveyor asked for the statements requested for the FRE from [DATE], and none were provided.On [DATE] at 12:51 PM, the surveyor interviewed the DON, who stated that during an investigation for an injury of unknown origin or abuse, statements were gathered by staff who were assigned to the resident for the past 72 hours. The DON stated for grievances; statements were also obtained. The DON stated that she completed the grievance for Resident #67, which included collecting statements from the CNAs who took care of the resident. The DON stated that she had those statements, and the surveyor requested a copy of the statements.On [DATE] at 10:12 AM, the surveyor interviewed the DON, who stated that a resident received a shower within 72 hours of admission, and then at least twice a week. The DON stated that the resident was only scheduled to receive showers on Thursdays, which was not twice a week. The DON stated that the resident received a shower the night before they were discharged from the facility. The surveyor inquired about the statements from the investigation, and the DON stated she would provide them.On [DATE] at 10:23 AM, the LNHA provided the survey team with Resident #67's FRE from [DATE]. It included a typed page with Interviews conducted by the DON which included one<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | nurse and two CNAs' statements. There were also two additional handwritten statements from staff.On [DATE] at 11:34 AM, the surveyor asked the LNHA if the facility had a medical records policy, and he stated he was unaware if the facility did because the policies were not updated annually or kept in one place. The surveyor asked where the statements for the resident's FRE was located, and the LNHA stated there were 17 binders to look through. The LNHA acknowledged that all medical records should be maintained accurately and accessible.On [DATE] at 11:51 AM, the surveyor interviewed the DON, who stated that the resident should have received a shower within 72 hours of admission to the facility, and then at least once a week after. The DON stated that residents on the sub-acute unit were also offered showers daily, and showers were documented in the ADL Tracker. The DON stated there were no policies for showering or ADLs for residents. A review of the facility provided Medical Records Policy and Procedure dated revised [DATE], included that medical records are to be maintained on all residents admitted to [facility name redacted] in accordance with professional standards of practice. Medical records of discharged or deceased persons are maintained in the medical records area as designated in locked file cabinets to prevent loss, destruction or unauthorized use.Health Records are maintained on each individual admitted to the nursing facility, initiated on the day of admission. The health record contains sufficient information to identify the resident clearly, to justify diagnoses and treatment and to document the results accurately. These records are filed in the nursing unit.NJAC 8:39-35.2(d) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) develop and maintain an infection prevention and control program (IPCP) that included all of the required elements, the facility failed to review the IPCP policy on an annual basis b.) failed to follow infection control procedures with 2 of 3 residents on Oxygen (O2) Therapy. This deficient practice was identified for 2 of 3 residents (Resident #4 and #8) reviewed for O2 therapy.This deficient practice was evidenced by the following:<br><br>1.The Surveyor reviewed the facility's IPCP policy which reflected that the policy did not include A system of surveillance which is designed to identify possible infections before they spread to other residents in the facility; who possible infections should be reported to; and failed to document the requirements for the isolation of a resident.<br><br>A review of the facility's IPCP policy reflected that it was last reviewed January 2024.<br><br>On 7/24/25 at 10:15 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that the IPCP policy was required to include a system of surveillance, elements for when and to whom an infection was to be reported to and should include that a resident received the least restrictive isolation procedure possible. The DON confirmed that the IPIC Policy did not include these required elements. The DON further acknowledged the IPCP policy's last review date was January 2024 and should have been reviewed annually, no later than January 2025.<br><br>2. On 7/16/25 at 10:57 AM, the surveyor observed and interviewed Resident #8 awake in bed, with oxygen (O2) via nasal cannula (NC) (medical device to provide supplemental oxygen therapy to people who have lower O2 levels) at 2.0 liters/minute (LPM), O2 running. The surveyor further observed the O2 tubing laying directly on the floor of the resident's room.<br><br>The surveyor reviewed the admission Record (AR; or face sheet; an admission summary) which revealed that the resident had been admitted to the facility with diagnosis that included severe protein-calorie malnutrition, chronic obstructive pulmonary disease, hypothyroidism and hypertension.<br><br>A review of the Quarterly Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 6/29/25, revealed that the resident had a score of 2 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated that the resident has severe cognitive impairment. The MDS also reflected that the resident received continuous O2 therapy.<br><br>On 7/17/25 11:09 AM, in the presence of the Licensed Practical Nurse (LPN#1), the surveyor observed Resident #8's O2 tubing on the floor of the resident's room. LPN#1 stated they Resident #8's O2 tubing should be secured in a bag and/or off the floor. LPN#1 immediately changed and disposed of the soiled O2 tubing and secured the new tubing in a bag off the floor.<br><br>3. On 7/16/25 at 11:04 AM, the surveyor observed Resident #4 in bed, lethargic during interview, observed O2 set 1.5 L/min. resident currently on hospice O2 tubing noted on the floor. The surveyor further observed the O2 tubing laying directly on the floor of the resident's room.<br><br>Review of Resident #4's AR reflected that Resident #4 was admitted to the facility with medical diagnoses that included but were not limited sepsis, pneumonia, chronic obstructive pulmonary<br>(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<br>B. Wing | 07/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Homestead Rehabilitation & Health Care Center | 129 Morris Turnpike<br>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.

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | disease and acute and chronic respiratory failure with hypoxia.<br><br>A review of the Significant Change MDS with an ARD of 5/4/25, revealed that the resident had a score of 9 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated that the resident has moderate cognitive impairment. The MDS also reflected that the resident received continuous O2 therapy.<br><br>On 7/17/25 11:13 AM, in the presence of the Licensed Practical Nurse (LPN#1) the surveyor observed Resident #4 O2 tubing on the floor of the resident's room. LPN#1 stated Resident #4's O2 tubing should be secured in a bag and/or off the floor. LPN#1 immediately changed and disposed of the soiled O2 tubing and secured the new tubing in a bag off the floor.<br><br>On 7/21/25 12:40 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review concerns found during the survey. The DON stated all O2 resident will be checked to assure the O2 tubing is secured to prevent infection control concerns.<br><br>On 7/21/25 at 12:56 PM, the DON provided the surveyor with a facility policy titled, Infection Control Policy with a revised date of 5/20/21. The surveyor reviewed the policy which revealed, the purpose is to, To control spread of infection. Under the procedure portion of the policy revealed, Resident care equipment, handle soiled patient care equipment in a manner to prevent, skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other resident and environments.<br><br>On 7/22/25 at 9:00 AM, the surveyor interviewed the Infection Preventionist (IP), who stated O2 tubing should be secured in a bag, dated, changed weekly, and stored off the floor to prevent contamination.<br><br>On 7/24/25 at 1:15 PM, the surveyor met with the LNHA and DON for the exit conference. No further pertinent information provided.<br><br>NJAC 8:39- 27.1 (a) |

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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.

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|---|---|
| F 0924<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Put firmly secured handrails on each side of hallways.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure handrails were secure and intact on 1 of 2 resident units (observed on 3rd floor nursing unit). This deficient practice was evidenced by the following:On 07/21/25 at 9:12 AM, the surveyor was observing medication administration pass on the 3rd floor low-side and observed two handrails that were missing the return part (end part of the handrail) which was located next to room [ROOM NUMBER] and room [ROOM NUMBER]. The missing return part of the handrail exposed a screw and metal components that attached the handrail to the wall.On 07/22/25 at 10:30 AM, the surveyor interviewed a Licensed Practical Nurse (LPN#1) on the 3rd floor low side, who in the presence of the surveyor observed the handrail missing the return part. At that time, LPN#1 stated that the handrail that was missing the return part was a potential hazard to the resident's because it exposed the residents to a sharp object (screw and metal component that was affixing the handrail to the wall).On 07/22/25 at 10:35 AM, the surveyor interviewed a Certified Nursing Assistant (CNA) who was providing care to residents on the 3rd floor low side. In the presence of the surveyor the CNA observed the handrails that were missing the return part and stated that not having a fully attached handrail was a potential hazard to residents.On 07/22/25 at 12:30 PM, the surveyor interviewed the Maintenance Director (MD), who acknowledge that two handrails (one next to room [ROOM NUMBER] and another next to room [ROOM NUMBER]) were missing the return portion of the handrail. The MD told the surveyor that a contractor was working on the handrails and quit working and never put the return portion back on the handrail. The MD acknowledge that the handrails that were missing the return part was a potential hazard to the residents who are using these handrails.On 07/22/25 at 1:15 PM, the above concern was presented to the facility administration team that consisted of the License Nursing Home Administrator (LNHA) and the Director of Nursing. The facility had no additional documentation to provide the surveyors. The surveyor was provided the facility's Maintenance Service policy from the LNHA which revealed the following: 10. The facility will equip corridors with firmly secured handrails on each side. NJAC 8:39-31.2(e) |