STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315383	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheshire Home	9 Ridgedale Ave Florham Park, NJ 07932

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to provide a homelike environment for residents in 1 of 12 resident rooms observed and was evidenced by the following.On 1/5/26 at 6:50 PM, the surveyor knocked on door for room [ROOM NUMBER] and received permission from Resident #7 to enter the room. The resident pointed out the ceiling in the center of room and stated, this does not look nice. Resident #7 stated being upset that the ceiling gridwork and ventilation cover were soiled and in need of cleaning and maybe replacement. The surveyor observed a reddish brown colored crusted substance on the ceiling gridwork slats and black colored stains on HVAC (heating, ventilation and air conditioning) diffuser on the ceiling in the center of the resident's room. The surveyor observed that the door frames in the bathroom in room [ROOM NUMBER] were covered in a reddish-brown colored crusted substance as well. A review of Resident #7's admission record reflected that the resident was admitted to the facility with diagnoses including but not limited to paraplegia (paralysis of lower half of the body) and a tracheostomy (an artificial opening in the front of the throat for breathing). A review of the Quarterly Minimum Data Set, an assessment tool dated 10/8/25 reflected the resident had Brief Interview for Mental Status score of 15 of 15, which indicated no deficits in cognition. On 1/7/26 at 11:25AM, the surveyor interviewed the Maintenance Director (MD) regarding the policy and procedure for repairs to resident rooms and the environment. The MD reported the facility used a paper reporting system that all staff complete and they place the repot in a box outside maintenance office. The MD described that during his maintenance rounds I regularly round the building and rooms to assess for issues yet, the MD did not have a formal log or documentation of those rounds. The MD accompanied the surveyor to room [ROOM NUMBER]. The surveyor asked about the stained HVAC diffuser and reddish-brown substance on ceiling gridwork and reddish-brown substance on bathroom door jams and their impact on the resident's environment. The MD agreed that these conditions detracted from the facility's homelike environment and should be repaired. The MD confirmed he had no open maintenance work orders or reports on those conditions. The MD confirmed that the issues should have been repaired. On 1/7/26 at 12:32 PM, the surveyor reviewed the above concerns with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant LNHA. The LNHA confirmed that these conditions detracted from the facility's home like environment and should not occur and that the issues would be corrected. NJAC 39-4.1(a)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to follow their abuse policy to ensure criminal background checks were completed prior to hire for 2 out of 47 newly hired staff (Staff #45 and #47).This deficient practice was evidenced by the following: The surveyors reviewed 47 new employee files for criminal background and reference checks which revealed the following: A review of Staff #45's file, a driver with a date of hire (DOH) of 11/25/24, showed a background screening report (BSR) dated 12/9/24 and there were no references found in their file. The BSR was completed after Staff #45's DOH. A review of Staff #47's file, a Licensed Practical Nurse with a DOH of 3/25/25, showed a BSR dated 3/26/25. The BSR was completed after Staff #47's DOH. On 1/8/26 at 12:57 PM, the surveyor interviewed the Human Resources Director (HRD) about criminal background checks. The HRD stated BSR were completed prior to a new employees' DOH. The surveyor informed the HRD of the above concerns for Staff #45 and Staff #47. On 1/8/26 at 1:21 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing, and the Assistant LNHA of the above concerns found for the new employee files reviewed. There was no additional information provided by the facility. A review of the facility's Abuse Prohibition Policy and Procedures, with a last revised date of October 2017, under Procedure for Screening revealed, . As part of the Pre-Hire Procedure, each new hire will . c. Undergo a criminal background check and business reference checks. N.J.A.C. 8:39-9.3 (a), (b)

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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 0656 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive, person-centered care plan (CP) for a resident on antidepressant medication. This deficient practice was identified in 1 (one) of the 13 residents (Resident#5) reviewed for CP.This deficient practice was evidenced by the following: On 1/6/26 at 11:30 AM, the surveyor observed Resident #5 out of bed to the motorized wheelchair and able to answer questions appropriately. On 1/6/26 at 11:50 AM, the surveyor reviewed the electronic Health Record (eHR)/ hybrid medical record (paper and electronic) of Resident #5, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #5 was admitted with diagnoses that included but were not limited to paraplegia (paralysis that affects the lower part of the body). A review of the admission Minimum Data Set (an assessment tool used to facilitate the management of care) on 10/28/25 indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status score of 15 out of 15, which indicated that the resident had intact cognition. A review of the Order Summary Report revealed an order of Sertraline HCl (hydrochloride) 25 mg (milligram) by mouth daily for depression (feeling of sadness) with an order date of 12/17/25. A review of Resident #5's comprehensive Care Plan (CP) report revealed no CP for the use of antidepressant medication. On 1/6/26 at 11:57 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the above concern. The LPN stated that antidepressant medications should be included in the CP. On 1/7/26 at 12:32 PM, the team of surveyors discussed the above concern with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON). The DON stated that the facility usually does a CP for antidepressants. A review of the facility policy with the revision date of August 2021 titled, Medical Records Resident Care Planning under Essential Components of a Care Plan: A compliant LTC care plan typically includes Interventions: The specific services, treatments, and items provided by the facility to reach goals. NJAC 8:39-11.2(d)

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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. Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure that physician ordered weekly skin assessments were conducted at scheduled intervals for 2 of 4 residents (Residents #3 and #33), reviewed for pressure ulcer prevention and was evidenced by the following: 1.A review of Resident #3's admission record reflected Resident #3 was admitted to the facility with diagnoses including but not limited to quadriplegia (paralysis of all four extremities), stage III pressure ulcer in area of right buttock and chronic osteomyelitis (an infection of the bone). A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated 10/29/25, reflected the resident had a Brief Interview Mental Status (BIMS) score of 15 of 15 which indicated that there were no deficits in cognition. The MDS assessment reflected that the resident had a limited range of motion, an inability to turn and reposition, and was at high risk for skin breakdown or pressure ulcer development. A review of the physician's orders (PO) for Resident # 3 reflected a PO, dated 4/4/24 with direction to Complete weekly skin check tool in assessments every night shift every Friday for skin integrity. A review of the resident's Electronic Medical Record (EMR) assessment section, reflected that the PO for skin check assessments was not documented for the dates of 11/29/25, 12/12/25, 12/19/25, and 12/26/25. On 1/7/26 at 10:20 AM, the surveyor interviewed the facility's Wound Nurse (WN). The WN confirmed that there was a PO for Resident #3 to complete weekly skin tool in assessments every night shift every Friday night. The WN reviewed Resident #3's EMR and confirmed that there was no weekly skin assessment was completed for the dates noted above. A review of the facility's policy titled Skin Assessments reflected that weekly skin check including documentation should be in the medical record, and that the weekly skin check tool will be performed for every resident, every week on their scheduled shower day. 2. On 1/5/2026 at 7:14 PM, the surveyor observed Resident #33 sitting in a motorized wheelchair in their room. Resident #33 was alert and verbally responsive. The resident had no concerns with their care. On 1/7/2026 at 11:15 AM, the surveyor reviewed the EMR of Resident #33. The admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, quadriplegia and traumatic brain injury. A quarterly MDS assessment, a tool used to facilitate the management of care, dated 10/1/2025, indicated the facility assessed the resident's cognition using a BIMS score. Resident #33 scored a 15 out of 15, which indicated the resident was cognitively intact. Under Section M (Skin Conditions), Resident #33 was coded as being a risk of developing pressure ulcers/injuries. A physician's order dated 12/15/25 indicated to Complete Weekly Skin Check Tool in Assessments every night shift, every Thursday for Skin Integrity. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 12/26/25 indicated to cleanse the right ankle with normal saline solution, pat dry, and cover with border foam every night shift every Tuesday, Thursday, and Sunday for protection. The resident had a care plan with a focus area on Activities Daily Living (ADL) self-care performance deficit with an initiation date of 12/26/17. An intervention of the care plan dated 12/26/17 documented Resident #33 required skin inspection weekly and as needed. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. The resident had a care plan with a focus area on risk for the potential development of pressure ulcer which had an initiated date of 1/29/19. An intervention of the care plan dated 12/27/17 indicated weekly skin check, as per facility protocol. A review of the December 2025 and January 2026 Treatment Administration Record (TAR) revealed the weekly skin check entry order was signed as administered by the nurses. A review of the Assessment section of the EMR for weekly skin check assessments revealed after 12/18/25 there was no documented weekly skin assessments for Resident #33. A review of the progress notes revealed there was no documentation by nurses of a weekly skin check assessment being completed. On 1/7/2026 at 11:20 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #33 about weekly skin checks. The LPN stated the nurses signed off the weekly skin check entry on the TAR to indicate a weekly skin check assessment was documented in the EMR and the resident's skin was assessed. The LPN further explained if the entry in the TAR was signed as administered it would be expected under the assessments section of the EMR for there to be a weekly skin check assessment documented. On 1/7/2026 at 11:30 AM, the surveyor interviewed the Director of Nursing (DON) about skin assessments. The DON stated weekly skin checks were signed off in the TAR and the corresponding weekly skin check assessment was documented in the Assessment section of the EMR. The DON further explained that was the only documented assessment that would indicate a weekly skin check was completed. The surveyor informed the DON of the concern that there was no documentation of weekly skin checks being completed for Resident #33 after 12/18/25. The DON stated she would review to provide any additional information. On 1/7/2026 at 12:32 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the DON, the Assistant LNHA, and an administrative staff of the concern that there were no weekly skin checks documented for Resident #33 since 12/18/25. The DON stated the resident's weekly skin check order coincided with the resident's shower day. Resident #33's shower day was changed in December which may have contributed to the missed weekly skin check assessments. On 1/8/2026 at 10:26 AM, the LNHA, the DON, the Assistant LNHA, and an administrative staff met with the survey team. The DON stated upon review they identified the residents completed their own showers and believed there may be a lack of communication between staff and the resident. The surveyor reviewed the facility's policy titled, Wound Management Program Staging, with a revised date of September 2024. Under Documentation and Care Planning revealed: . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Required comprehensive description of pressure ulcer weekly, at a minimum. The policy did not further address routine weekly skin assessments on a resident. NJAC 8:39-27.1 (a)(e)