STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315390	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cranford Park Care	600 Lincoln Park East Cranford, NJ 07016

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review, the facility failed to ensure the kitchen ceiling was clean above ready-to-eat foods and staff performed adequate hand hygiene when serving meals. The failures had the potential to increase the prevalence and spread of foodborne illness and infection for all 67 of 69 facility residents who received food prepared in the kitchen. Findings include: Review of the Diet Assigned listing, dated 08/20/25, revealed two residents out of the total 69 facility residents received nutrition by tube and did not eat food prepared in the kitchen. 1. During initial observations of the kitchen on 08/18/25 at 9:40 AM, the ceiling above the tray line area was covered with [NAME] of gray/brown dust, some which hung down in strings that were moving in the airflow. During tray line observation in the kitchen on 08/20/25 beginning at 11:34 AM, the ceiling above the tray line area was covered with [NAME] of dust, some which hung down in strings that were moving in the airflow. The dust was above the clean plates, open trays being prepared, serving line, and a cart containing uncovered cheese. At this time, the Dietary Manager (DM) confirmed the ceiling was dusty, and the dust had potential to contaminate the food. He stated this was a task that needed to be done frequently because it was an old building. The DM stated the dust would be removed today. During tray line observation on 08/21/25 beginning at 11:29 AM, the ceiling above the tray line area was still covered with [NAME] of dust, some of which hung down in strings that were moving in the airflow. At this time, the DM confirmed the dust had not yet been cleaned off the ceiling and still had potential of contaminating the food. 2. During tray line observation in the kitchen on 08/20/25 beginning at 11:34 AM, Dietary [NAME] (DC) 1 was observed wearing one pair of gloves throughout the entire service. He periodically touched surfaces off of the tray line, such as the plate warming cart, the oven knobs and handles, and handles of pans on the stove. While wearing the same gloves, DC1 used his hands to pick up bread to place on each resident's plate. DC1 was observed to touch foods like noodles or green beans on the plate to move them and to pick up a grilled cheese sandwich with the same gloves. During tray line observation on 08/21/25 beginning at 11:29 AM, DC1 was again observed while wearing one pair of gloves to wipe the cutting board with a rag, touch pan handles on the stove and touch his pants. Using the same gloves, DC1 picked up bread with his hands to put on each resident's plate. DC1 moved served food on the plate by touching it. At 11:52 AM, DC1's beard net fell below his chin. DC1 adjusted the beard net with his gloved hands and went on to continue serving. The DM reminded DC1 to wash his hands and apply new gloves after touching his beard net. DC1 washed his hands and donned clean gloves, then adjusted the beard net over his face, then continued to serve meals using the same gloves. At this time, DC1 confirmed in interview that he did not change his gloves after touching potentially contaminated surfaces before touching ready-to-eat foods. DC1 stated he had been trained to change his gloves anytime something potentially contaminated was touched for hygiene. The DM confirmed DC1 was touching ready-to-eat foods with his gloved hands and stated he should be using a new pair of gloves to touch food after touching potentially contaminated surfaces. Review of the policy titled, Bare Hand Contact with Food and Use of Plastic Gloves, dated 2017, revealed, Gloved hands are considered a food contact surface that can get (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged orsoiled, or when interruptions occur in the operation . Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed. NJAC 8:39-17.2(g)NJAC 8:39-19.7(d)

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure garbage was covered in area near the entrance to building A next to the stairs down to the kitchen entrance. This failure had potential to cause avoidable pest infestation that could affect all 69 facility residents. Findings include: During observation outside the stairs to the kitchen entrance on 08/18/25 at 9:40 AM, there were three open bins containing garbage bags and a pervasive trash/bowel movement/rotten food odor. None of the three bins had lids. During observation outside the stairs to the kitchen entrance on 08/20/25 at 11:28 AM, there were three open bins containing trash bags and a pervasive trash/bowel movement/rotten food odor. None of the three bins had lids. At this time, the Dietary Manager (DM) stated one bin was for kitchen trash and the others were for housekeeping waste. The DM confirmed none of the bins were covered. The DM stated the bin for kitchen trash was taken out to the dumpster after each meal or whenever it was full. During observation outside the stairs to the kitchen entrance on 08/21/25 at 11:29 AM, there were three open bins containing garbage bags and a pervasive trash/bowel movement/rotten food odor. None of the three bins had lids. The garbage in the kitchen bin was piled high above the top of the bin. There was a pair of used gloves on the ground next to the bin. During an interview on 08/21/25 at 12:37 PM, the Maintenance Director (MD), who also served as the director of housekeeping, stated the housekeeping trash bin was emptied into the dumpster each day at 7:00 AM, 11:00 AM, 3:00 PM, and 5:00 PM. The MD stated the two other housekeeping bins contained soiled linens to be sent out for laundering and were picked up by the company twice a week. The MD confirmed none of the bins were covered, stating the linen bins were provided by the laundry company and did not have lids. The MD stated the kitchen trash bin had a lid and it should be used to cover the trash. The MD stated all trash should be kept under cover to prevent potential infestation. A policy addressing waste disposal was requested from the Administrator on 08/21/25 at 3:33 PM; however, the Administrator stated the facility did not have a policy. NJAC 8:39-19.7

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and policy review, the facility failed to ensure menus were followed for the five residents (Resident (R) 41, R47, R48, R2, and R79) who received a pureed diet out of a facility census of 69. The failure had the potential to contribute to weight loss, malnutrition, or lack of satisfaction with meals for these residents. Findings include: Review of the Diet Assigned listing, dated 08/20/25 and provided on paper, revealed five residents (R41, R47, R48, R2, and R79) out of the total 69 facility residents received pureed foods. Review of the undated Week 1, Cycle Day 4 menu, provided on paper, revealed the 08/20/25 lunch menu for a pureed diet called for 8 ounces (oz) of pureed goulash (split into 4 oz pureed egg noodles and 4 oz pureed goulash), 4 oz of pureed green beans, and one slice of pureed garlic bread. During observation of lunch tray line in the kitchen on 08/20/25 beginning at 11:34 AM, Dietary [NAME] (DC) 1 served a pureed plate with 3-oz portions of pureed goulash, pasta, bread, and green beans. At this time, interview with DC1 confirmed he used 3-oz portions for the pureed foods, and he was unaware the menu called for 4-oz portions. DC1 stated he would look at the menu or each tray card for the correct portion size to serve. Concurrent interview with the Dietary Manager (DM) revealed DC1 did not serve the correct portion size, and the serving size for pureed diets would be corrected to be 4 oz for each food item. Review of the undated Week 1, Cycle Day 5 menu, provided on paper, revealed the 08/21/25 lunch menu for a pureed diet called for 8 oz of rigatoni with Italian sausage, 1 slice garlic toast, and 4 oz of broccoli. Review of the undated Rigatoni with Italian Sausage recipe, provided on paper, revealed it called for Italian sausage, penne pasta, tomato sauce, tomato juice, and mozzarella and parmesan cheeses to be combined and served together. During observation of the lunch tray line in the kitchen on 08/21/25 beginning at 11:29 AM, DC1 served a pureed plate with a pureed rigatoni and sausage without any tomato sauce that appeared green in color. DC1 topped the pureed mixture with a white cheese sauce. Additionally, DC1 did not serve any pureed bread with the meal. Interview at this time with DC1 revealed he used the white cheese sauce for residents who could not have tomatoes but confirmed the resident receiving the plate could have tomatoes and he did not know why he served cheese sauce with the rigatoni and sausage rather than the tomato sauce called for in the menu. DC1 stated he did not include bread in the pureed rigatoni and sausage mixture. DC1 stated, I normally don't do it [pureed bread]. In a concurrent interview, the DM stated he was unsure why the pureed rigatoni with sausage entree was prepared without sauce and served with white cheese sauce. He stated the recipe should have been followed and residents should have received the same entree as the regular menu. The DM agreed the mixture appeared green but did not know why. Review of the policy titled, Menu Planning, dated 2017, revealed, Regular and therapeutic menus will be written to provide a variety of foods served on different days of the week, adjusted for seasonal changes, and in adequate amounts at each meal to satisfy recommended daily allowances . Regular and therapeutic menus will be written by the facility's food and nutrition professional in accordance with the facility's approved diet manual, or purchased from an approved vendor. The registered dietitian nutritionist (RDN) or designee will approve all menus. NJAC 8:39-17.2

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and policy review, the facility failed to follow standard infection control practices for three of the 18 sample residents (Resident (R) 25, R71, and R3). The facility failed to ensure proper personal protective equipment was available for use, proper PPE disposal was available, that staff donned and doffed PPE appropriately, and that hand hygiene was conducted during wound care. These failures increased the risk of the spread of infections and COVID-19 among staff and residents. Findings include: 1. Review of R25's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed R25 was admitted to the facility on [DATE] with diagnoses including Covid 19 positive status. Review of R25's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/31/25, located under the MDS tab indicated R25 was set up assist for oral hygiene, toileting, dressing, and personal hygiene; supervision for showering/bathing. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R25 was cognitively intact. Review of R25's EMR under the Orders tab indicated an order dated 08/15/25, droplet precautions every day and night shift for 10 days. Review of R25's EMR under the Progress Notes tab revealed a progress note dated 08/14/25, PCR [polymerase chain reaction - a test that detects genetic material from an abnormal cell sample] performed in the hospital during her visit . the result positive for COVID-19. Patient placed in droplet precaution x 10 day in A unit. Review of R25's EMR under the Progress Notes tab indicated a progress note dated 08/20/25 . Resident in a private room, on droplet isolation, precautions maintained . Review of a sign that was posted at eye level on the left side of R25's door to her room indicated, STOP Droplet Precautions Everyone Must: Clean their hands, including before entering and when leaving room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. During an interview attempt with R25 on 08/18/25 at 1:40 PM, the surveyor could not locate any face shields or goggles to put on (don) prior to entering R25's room. Surveyor asked Licensed Practical Nurse (LPN) 1 for a face shield. LPN1 checked a secured closet, requiring an entry code, but could not locate a face shield and stated he would have to go to the basement to get a face shield. LPN1 returned with face shields and re-stocked the drawers outside of R25's room. At 1:55 PM, Surveyor removed personal protective equipment (PPE), prior to exiting R25's room, but there was not a receptable to discard PPE. Surveyor questioned LPN1 about a receptable and he stated he would obtain a receptable (a red bin) and place in R25's room. LPN1 explained that when a resident tested positive for COVID-19 it was a joint effort between nursing and maintenance to put the PPE supplies in place. During an observation on 08/20/25 at 8:45 AM, Certified Nursing Assistant (CNA) 2 was observed entering R25's room carrying bathing products and wearing a mask only. CNA2 was observed to exit R25's room at 9:03 AM carrying a plastic laundry bag and wearing a mask. CNA2 was observed sanitizing her hands after placing laundry in the laundry chute. During an interview on 08/20/25 at 1:50 PM, the Infection Preventionist (IP) confirmed R25 had tested positive for COVID-19 and was on droplet precautions. The IP stated mask, face shield, gown, and gloves were required when entering R25's room. When asked how a resident's room was prepared for droplet precautions, the IP stated she would put up signage (droplet precautions) on the outside of the resident's room, place stocked drawers (gloves, gowns, face shield, masks) on the outside of the resident's room, and garbage receptacles (red bins) in the resident's room. The IP stated when a new diagnosis of COVID-19 was determined and she was on site she placed the necessary PPE items outside of the resident's room and when she was not available, nurses on the floor were responsible to put the precaution signage up, stocked PPE drawers in place and red bins inside of resident's room. The IP stated she expected all staff to follow the droplet precaution guidelines when entering R25's room. The IP said she had provided education to facility staff about transmission-based precautions. During an interview on 08/20/25 at 2:05 PM, CNA2 stated when entering the room of a resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	positive for COVID-19 she would don a mask, gown, gloves, and a face shield and would remove all PPE and place in the red bin, prior to exiting the resident's room. CNA2 said she would wash her hands after removing her gloves. CNA2 confirmed she did not follow this process when entering R25's room that morning. CNA2 stated she had received training/education regarding donning PPE and when to utilize PPE since she began working at the facility five months ago. Review of the facility's policy titled, Infection Prevention and Control Manual Transmission-Based Precautions reviewed 01/08/25 indicated, Transmission-Based Precautions Transmission-based precautions (a.k.a. Isolation Precautions) refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections . There are three categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions . The Centers for Medicare & Medicaid Services (CMS) have outlined three categories of Transmission-Based Precautions: . Droplet - The use of droplet precautions applies when respiratory droplets contain pathogens which may be spread to another susceptible individual. Respiratory pathogens can enter the body via the nasal mucosa, conjunctivae and less frequently the mouth . Respiratory droplets are generated when an infected person coughs, sneezes, talks . Facemasks should be use upon entry into a resident's room . with respiratory droplet precautions. Based upon pathogen or clinical syndrome . gloves and gown as well as goggles (or a face shield in place of goggles) should be worn . COVID-19 Precautions: . Personal Protective Equipment includes: Gloves, Gown, Eye Protections that covers the front and sides, NIOSH-approved N95 or higher respirator . It is essential both to communicate transmission-based precautions to all healthcare personnel . Pertinent signage(i.e., isolation precaution in place, PPE instructions) . PPE must be available near the entrance to the resident room in order for PPE to be donned prior to entry. Review of the facility's policy titled, Personal Protective Equipment (PPE) dated 01/08/25 indicated, Procedure . 2. The facility will ensure that appropriate PPE is readily accessible and that employees use it . a. This includes a system for stocking and restocking . 4. Personal protective equipment will be discarded for resident's on transmission-based precautions or removed before leaving the work area and placed in a . container . disposal. 2. Review of R71's Profile tab of the EMR revealed she was admitted to the facility on [DATE] and had diagnoses including dementia, aphasia, depression, anxiety, and chronic pain. Review of R71's quarterly MDS with an ARD of 07/31/25, located under the MDS tab of the EMR, revealed she was unable to complete the BIMS and had short- and long-term memory problems and severely impaired cognition. The MDS indicated R71 did not have any current pressure ulcers in error (Cross-reference F641: MDS Accuracy). Review of R71's Care Plan, dated 05/23/25 and located under the Care Plan tab of the EMR, revealed, The resident has a stage 3 pressure ulcer on the sacrum r/t [related] to impaired mobility, incontinent. The approaches included, Enhanced barrier protection for infection prevention. Review of R71's EMR under the Orders tab revealed a physician's order, dated 12/09/24, for Enhanced Barrier Protection for infection prevention. Review of R71's August 2025 Treatment Administration Record (TAR), located under the Orders tab of the EMR, revealed a physician's order, dated 08/01/25, for treatment to the sacral wound every Monday, Wednesday, and Friday. The TAR indicated the treatment was completed as ordered throughout the month. During an observation on 08/20/25 at 10:56 AM in R71's room, CNA3 was at R71's bedside providing a bed bath. She was wearing gloves but not wearing a gown. There was a sign on R71's door that read, Enhanced Barrier Precautions and directed staff to don a gown in addition to gloves for high contact activities. There was a bin of gowns and gloves outside the room door. During an interview on 08/20/25 at 11:07 AM, CNA3 stated she had provided incontinence care and bed bath for R71 and did not wear a gown while providing the care. CNA3 stated R71 did not have any active infections, so no PPE was needed other than gloves. During an interview on 08/21/25 at 2:35 PM, the IP stated staff should be using gowns in addition to gloves when providing incontinence care and bed baths to R71, as she had an open chronic wound. The IP stated staff would be reeducated to implement enhanced barrier precautions (EBPs) with residents who had wounds or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indwelling medical devices, regardless of infection status. 3. During R3's wound care observation on 08/21/25 at 9:20 AM a sign posted outside R3's room indicated Enhanced Barrier Precautions were in place. Personal protective equipment was available in a storage drawer outside R3's doorway. LPN1 did not don a personal protective gown prior to providing wound care and the Staffing Coordinator (SC) did not don a personal protective gown and gloves prior to assisting with R3's positioning during the wound care treatment. During R3's wound care observation on 08/21/25 at 9:20 AM, LPN1 removed the dirty dressing from the right upper back pressure ulcer and doffed (removed) the dirty gloves. LPN1 did not sanitize or wash hands prior to donning clean gloves. LPN1 cleaned the wound with betadine, doffed dirty gloves and reapplied clean gloves without sanitizing or hand washing. LPN1 then applied a foam dressing to the right upper back pressure ulcer. During an interview on 08/21/25 at 9:35 AM, LPN1 stated that he should have put on a personal protective gown. LPN1 stated that he had been trained to implement EBP. LPN1 stated that he had not been trained to use hand sanitizer or wash hands between each glove change. During an interview on 08/21/25 at 9:50 AM, the SC stated that she forgot to put on a gown prior to assisting with R3's positioning during the treatment and she knew she was supposed to. During an interview on 08/21/25 at 1:55 PM, the IP stated that she had already begun training on handwashing, glove changes, EBP, and transmission-based precautions. The IP stated that she would follow up with random audits to ensure the training is adhered to. Review of the policy titled, Infection Prevention and Control Manual: Transmission-Based Precautions, dated 01/08/25, revealed, Enhanced Barrier Precautions: expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multidrug-resistant organisms] to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Review of the facility policy titled Enhanced Barrier Precautions Policy reviewed on 01/08/25 provided by the facility indicated Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with [infection or colonization with an MDRO]. The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High contact resident care activities include dressing, bathing/showering/ transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care. Review of the facility policy titled Glove Technique (Non-Sterile) reviewed on 01/08/25 indicated that It is the policy of this facility to don (put on) clean non-sterile gloves in accordance with Standard and Transmission-based Precautions, (i.e., when anticipating touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin or when a resident in Transmission-Based Precautions). Gloves cannot be worn for the care of more than one resident. Perform hand hygiene after the removal of gloves. NJAC 8:39-19.4

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review and policy review, the facility failed to allow one of one resident (Resident (R) 33) reviewed for care planning in a sample of 18 residents the right to participate in the development and implementation of her person-centered plan of care. This failure increased the risk that the resident would not have any direct input into her plan of care.Findings include: Review of R33's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R33 was admitted to the facility on [DATE] with the diagnoses of dementia, depression, and type II diabetes. Review of R33's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/25, located under the RAI [Resident Assessment Instrument] tab indicated R33 needed set up assist for eating; supervision for oral hygiene; partial/moderate assist for bed mobility and toileting; showering/bathing, dressing and personal hygiene were substantial /maximum assist. The MDS showed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R33 was cognitively intact. Review of R33's EMR under the Progress Notes tab indicated there was no documentation regarding R33 being invited by the Social Service Director (SSD) or any staff member to attend her care plan meetings. Review of R33's EMR under the Care Plan tab indicated there were care plan meetings held for R33 on 10/15/24 (admission), 01/14/25 (quarterly) and 04/16/25 (quarterly). Upon review of the documentation associated with each care plan meeting there was no documentation regarding R33 being invited to or attending the care plan meeting. During an interview on 08/19/25 at 9:20 AM, R33 and her family member (F33) both denied ever being invited or taking part in a care plan meeting since R33's admission to the facility. During an interview on 08/21/25 at 8:45 AM, the SSD stated R33 had been invited to her care plan meetings. SSD stated that once the care plan meeting was scheduled but prior to a resident's care plan meeting she hand delivered an invitation form to all residents or called the responsible party if the resident was confused. The SSD explained she did not document this process in the resident's medical record or retain a copy of the invitation. The SSD confirmed the resident invite was not documented in the care plan meeting notes. Review of the facility's policy titled, Interdisciplinary Care Plan revised 03/21/25 indicated, The interdisciplinary team includes: The physician, nursing, the resident and or concerned party . social services.Procedure: . 11. Each meeting will allow ample time to address the needs of the resident. Suggested time allotted for the review is 15 minutes . 15. Resident and family will be invited to their prospective meeting and allotted time for input . II. The Care Plan: . 4. Responsible Discipline Column . b. If resident or family attend IDCP (Interdisciplinary Care Plan) conference and agree with the care goals, add their initials in responsible discipline column. Review of the facility's policy titled, Resident Rights revised 03/07/25 indicated, Policy It is the policy of the facility that employees and staff will treat all residents with kindness, dignity and respect the rights of each residents as outlined in the federal nursing home reform law. Procedure . 4. Each resident is educated about their rights upon admission, information about . rights to participate in ones own care. NJAC 8:39-4.1(a)3NJAC 8:39-11.2(e)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to provide the residents and/or their representatives with written information of the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for two of 18 sample residents (Resident (R) 11 and R17) reviewed for Advanced Directives. This failure created the potential for the residents' wishes not to be followed if the residents were unable to speak for themselves. Findings include: 1. Review of R11's undated admission Record located in the electronic medical record (EMR) under the Profile tab revealed R11 was admitted to the facility on [DATE]. Review of R11's EMR revealed no documentation that R11 had an Advance Directive or that the facility provided written information to the resident, or the resident representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 2. Review of R17's undated admission Record located in the electronic medical record (EMR) under the Profile tab revealed R17 was admitted to the facility on [DATE]. Review of R17's EMR revealed no documentation that R17 had an Advance Directive or that the facility provided written information to the resident, or the resident representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 08/20/25 at 10:30 AM, the Social Services Director (SSD) stated, I ask the resident or the resident representative if they have an Advance Directive, and I talk to the resident and the resident representative on admission about an Advance Directive, but we use the POLST [Physician Order for Life Sustaining Treatment] form. When asked if information was provided on how to formulate an Advance Directive she stated, No, I only give them the POLST form in order to make their choices and then make a note in their chart in the progress notes. During an interview on 08/20/25 at 3:30 PM, the administrator stated, We use the POLST form, but during admission the SSD does discuss Advance Directives with the residents and resident representatives. We will do whatever we need to correct this. NJAC 8:39-4.1(a)2,4NJAC 8:39-9.6

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	315390	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure written notice to the resident or representative of the transfer to the hospital included a statement of the appeal rights, information on how to file an appeal, and appeals contact information for two of two residents (Resident (R) 73 and R2) reviewed for hospitalization in a sample of 18 residents. This failure created the potential for a lack of understanding of appeal rights should the resident not be permitted to return or disagree with the reason for transfer, potentially causing confusion or distress upon transfer. Findings include: 1. Review of R73's Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with a diagnosis of discitis (infection of the spine). He was discharged from the facility on 05/20/25. Review of R73's Discharge - Return Anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/20/25, located under the MDS tab of the EMR, revealed he was transferred to a hospital.Review of R73's Acute Transfer Form, dated 05/20/25, located under the Miscellaneous tab of the EMR, revealed it included a reason for transfer, transfer location, and Ombudsman contact information. There was no statement of the resident's appeal rights, information on how to file an appeal, or contact information for the appeal agency. During an interview on 08/21/25 at 8:55 AM, the Social Services Director (SSD) stated she was responsible for completing the transfer form and providing to the resident or representative. The SSD stated she was not aware appeal rights and information were required to be included in the notice for transfers to the hospital. During an interview on 08/21/25 at 10:08 AM, the Administrator stated he did not believe appeal rights and information were necessary to include in the hospital transfer form, as residents were not sent to the hospital against their will. He stated he understood it was a regulatory requirement to include the appeals information. 2. Review of R2's Face Sheet located under the Profile tab of the EMR revealed R2 was admitted to the facility on [DATE] with diagnoses including malnutrition, heart disease, type II diabetes, and cardiac pacemaker. Review of R2's five-day MDS with an ARD of 07/10/25, located under the EMR MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating R2 was severely cognitively impaired Review of the facility provided form for R2 titled, New Jersey Universal Transfer Form indicated R2 was transferred to the hospital on [DATE] due to a hemoglobin (a protein in red blood cells that carries oxygen and carbon dioxide) of 6.8 gm/dL (grams per deciliter) (normal level for a male is between 13.5 - 18 grams). Review of the facility provided untitled and undated form regarding the notice of transfer and bed hold policy, indicated on 05/26/25 a transfer notice was completed for R2. This form provided only the NJ Long-Term Care Ombudsman contact information in the event R2 or his family disagree with the transfer. There was no statement of the resident's appeal rights, information on how to file an appeal, or contact information for the appeal agency included on the form. Review of R2's EMR under the Progress Notes tab indicated a progress notes dated 05/26/25, 2 pm . Hemoglobin 6.8 NP [Nurse Practitioner] aware of labs and order to send out to . hospital. NP called out to residents' son and hospital to make aware of transfer . During an interview on 08/21/25 at 8:45 AM, the SSD stated she was not aware that the notice of a resident's transfer needed to include information about a resident's right to appeal the transfer/discharge and the agency a resident can contact regarding the appeals process. During an interview on 08/21/25 at 10:02 AM, the Administrator stated he was not aware that the notice of a resident's transfer needed to include information about a resident's right to appeal the transfer/discharge and the agency a resident can contact regarding the appeals process. Review of the Transportation - Acute Emergency policy, dated 03/22/25, revealed, A 'Transfer Form' will be completed and sent with the resident upon discharge from the facility. The policy failed to address the required contents of the form. NJAC 8:39-4.1(a)31,32

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the presence of a stage III pressure ulcer for one of three residents (Resident (R) 71) reviewed for pressure ulcers out of a sample of 18. This failure created potential for an incomplete or ineffective plan of care related to pressure ulcer treatment and healing measures. Findings include: Review of R71's Diagnosis tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] and had diagnoses including dementia, aphasia, depression, anxiety, and chronic pain. Review of R71's quarterly MDS with an Assessment Reference Date (ARD) of 07/31/25, located under the MDS tab of the EMR, revealed she did not have any current pressure ulcers. Review of R71's Care Plan, dated 05/23/25 and located under the Care Plan tab of the EMR, revealed, The resident has a stage 3 pressure ulcer on the sacrum r/t [related] to impaired mobility, incontinent. The approaches included, Apply Heel Booties to B/L [both] feet q [every] shift . Enhanced barrier protection for infection prevention. Review of R71's Report of Consultation, dated 06/20/25 and provided by the facility on paper, revealed the resident's healed sacral wound had re-opened at a stage III and outlined a treatment order and offloading instructions. Review of subsequent wound care consultation reports, dated 07/18/25 and 08/01/25, revealed the continued presence of a stage III sacral pressure ulcer and continued treatment orders. Review of R71's Treatment Administration Record (TAR), dated July 2025 and located under the Orders tab of the EMR, revealed a physician's order, dated 06/23/25, for wound treatment: Sacral Wound: Cleanse with saline. Apply Collagen powder Mon, Wed, Fri and cover with dressing. Zinc oxide to periwound. Protective Dressing. Reposition side to side. Monitor for changes one time a day every Mon, Wed, Fri. The TAR indicated these treatments were provided as ordered. This order was changed on 07/30/25 to, Sacral Wound: Cleanse with saline. Apply prisma/collagen and cover with foam border gauze every Mon, Wed, Fri. Zinc oxide to periwound. Protective Dressing. Reposition side to side. Monitor for changes every night shift every Mon, Wed, Fri. The TAR indicated this treatment was completed on 07/30/25. During an interview on 08/21/25 at 1:30 PM, the MDS Coordinator (MDSC) stated she missed coding R71's sacral pressure ulcer, as there was no documentation in the EMR to indicate the pressure ulcer had re-opened after healing on 06/11/25. The MDSC stated the paperwork showed R71 had a pressure ulcer during the lookback period for the MDS and should have been coded. The MDSC stated she would make this correction immediately. Review of the Resident Assessment MDS Policy, dated 03/20/25, revealed, It is the policy of the facility to ensure that each resident who is admitted receives the care needed to meet his or her individual needs. An assessment shall be completed by a registered nurse, initially upon admission or readmission. And, in conjunction with the interdisciplinary team in accordance with regulatory mandates, a comprehensive assessment utilizing the Minimum Data Set (MDS) shall be completed according to the required time frames. NJAC 8:39-33.2(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure one of three residents (Resident (R) 71) reviewed for pressure ulcers out of a sample of 18 received physician-ordered pressure ulcer prevention measures. This failure created potential for development of avoidable pressure ulcers and associated risks for pain, infection, and slow healing.Findings include: Review of R71's Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] and had diagnoses including dementia, aphasia, depression, anxiety, and chronic pain. Review of R71's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/31/25, located under the MDS tab of the EMR, revealed she was unable to complete the Brief Interview for Mental Status (BIMS) and had short- and long-term memory problems and severely impaired cognition. R71 was dependent on staff for all activities of daily living and bed mobility. R71 was at risk for pressure ulcer development and used a pressure-reducing device for her bed. The MDS indicated R71 did not have any current pressure ulcers in error (Cross-reference F641: MDS Accuracy). Review of R71's Care Plan, dated 05/23/25 and located under the Care Plan tab of the EMR, revealed, The resident has a stage 3 pressure ulcer on the sacrum r/t [related] to impaired mobility, incontinent. The approaches included, Apply Heel Booties to B/L [both] feet q [every] shift . Enhanced barrier protection for infection prevention. Review of R71's EMR under the Orders tab revealed a physician's order, dated 07/28/24, for Bilateral Booties to feet q [every] shift dated 08/15/24, to Apply Cushion Pad between left foot toes and offload with heel boots one time a day for wound care. Review of R71's Nursing - Braden Scale for Predicting Pressure Ulcer Risk Evaluation, dated 07/29/25 and located under the Notes tab of the EMR, revealed R71 was at high risk for pressure ulcer development. During an observation on 08/19/25 at 9:19 AM, R71 was lying in bed in her room. R71 had a pressure-reducing mattress on the bed and had wedges in place for positioning. Her legs were bent at a 90-degree angle and laying to the side. No boots were visible under the covers. During an interview and concurrent observation in R71's room on 08/20/25 at 8:06 AM, R71 was lying in bed with thick socks on. Licensed Practical Nurse (LPN) 1 stated R71 did not have any pressure ulcers on her feet. LPN1 uncovered R71's feet and confirmed she did not have boots on. LPN1 removed R71's socks and confirmed there was no cushion pad on her left toes. During interviews and concurrent observations in R71's room on 08/20/25 10:32 AM, 11:07 AM, and 12:54 PM, R71 was lying in bed with thick socks on. Certified Nursing Assistant (CNA) 3 confirmed R71 was not wearing boots while lying in bed. R71's socks were not removed at these times. During an interview and concurrent observation in R71's room on 08/20/25 at 3:16 PM, R71 was lying in bed with thick socks on. CNA1 confirmed R71 was not wearing boots. CNA1 stated R71 did not have boots and did not use them. R71's socks were not removed at this time. During an interview and concurrent observation in R71's room on 08/21/25 at 10:26 AM, R71 was lying in bed with socks on. LPN1 confirmed she did not have heel boots on, but stated her thicker socks worn on 08/20/25 were considered booties. LPN1 removed R71's socks and confirmed there was no cushion/pad on her left toes. During a subsequent interview on 08/21/25 at 10:36 AM, LPN1 stated he had not been applying the heel boots or cushion pad to her left toes as she no longer had any skin issues on her foot. LPN1 stated he did not have a good answer why the orders were initialed as completed each shift on the TAR. LPN1 stated the orders should be discontinued as they were no longer needed. During an interview on 08/21/25 at 2:16 PM, the Director of Nursing (DON) stated booties and heel boots were large foam boots used to offload pressure from the heels, and both terms meant the same thing. The DON stated the thick socks worn by R71 were not considered booties or heel boots. The DON stated the use of heel boots and a cushion pad for the left toes were current orders and still should be implemented daily in order to prevent recurrence of pressure ulcers on the feet, especially since R71 was at high risk for pressure ulcer development due her limited mobility. Review of the Wounds: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pressure Ulcers & [and] Ulcers of Different Types Protocol for: Prevention, Assessment & Monitoring, Intervention, Documentation, and Evaluation, dated 03/21/25, revealed, Interventions for prevention of residents who are classified as either high, moderate, or low risk for developing a pressure ulcer are individualized to that resident's need and are listed on the resident's plan of care. It is important to note, in the development of the plan of care, the resident's choice is valued in consideration of interventions. The interventions are monitored by direct care staff and are evaluated individually daily. NJAC 8:39-27.1(e)