STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315397	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preferred Care at Wall	2350 Hospital Road Allenwood, NJ 08720

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 40744 Based on observation, interview, and record review it was determined the facility failed ensure a Preadmission Screening and Resident Review (PASARR) was completed accurately for a newly admitted resident. This deficient practice was identified for 1 of 2 residents reviewed for PASARR (Resident #9), and was evidenced by the following: On 2/19/25 at 11:10 AM, during the initial tour of the facility, Resident #9 was observed in the day room. A review of the Admission Record face sheet (an admission summary) indicated Resident #9 had medical diagnoses which included but were not limited to; diabetes (high blood sugar), respiratory conditions due to smoke inhalation, bipolar disorder, schizophrenia, and heart failure. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 12/19/24, revealed the resident had a Brief Interview of Mental Status score of 11 out of 15, meaning the resident had moderate cognitive impairment. A review of Section J Active Diagnoses revealed that the resident had diagnoses including bipolar disorder and schizophrenia. A review of the resident's individualized comprehensive care plan included a focus area dated 12/14/24, for multiple medications related to diagnoses of major depressive disorder, schizophrenia, and bipolar disorder. The ICCP included an additional focus area dated 12/14/24, that the resident utilized psychotropic medications related to schizophrenia and bipolar disorder. On 2/21/25 at 9:15 AM, the facility provided the surveyor with the resident's PASARR Level I. A review of the PASARR screening, section two titled Mental Illness Screen was marked No for the resident having a diagnosis or evidence of a major mental illness or evidence of a major mental illness. On 2/25/25 at 10:30 AM, during an interview with the Director of Nursing (DON), the DON told the surveyor that the Social Worker who was responsible for the PASARR was Very good, I don't know what happened, she missed it. I think she was out of work at the time. A review of a facility's Resident Assessment-Coordination with PASARR policy dated revised 7/2024, included the Social Services Director shall be responsible for keeping track of each resident's PASARR evaluation report . NJAC 8:39-27.1 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833 Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to revise an individual comprehensive care plan (ICCP) with the resident's personal preference for incontinence care and the need for incontinence briefs. This deficient practice was identified in 1 of 9 residents observed for incontinence care (Resident #35), and was evidenced by the following: On 2/19/25 at 9:55 AM, during initial tour of the facility, the surveyor accompanied by the Certified Nursing Aide (CNA), observed incontinence care for Resident #35. The surveyor observed that the resident had an adult incontinence brief on with a pull-up incontinence brief on top. At that time, the CNA informed the surveyor that it was the resident's preference to wear two incontinence briefs. The surveyor asked the resident if they had a preference to be double briefed, and the resident stated yes, due to the feeling of better support. On 2/21/25 at 11:22 AM, the surveyor reviewed Resident #35's electronic medical record (EMR) and the following was indicated: A review of the Admission Record face sheet (an admission summary) indicated that the resident was admitted to the facility with diagnosis which included but was not limited to; major depressive disorder, type two diabetes, and chronic kidney disease. A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool assessment dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated fully intact cognition. The MDS further revealed that the resident was dependent on staff for toileting hygiene and was always incontinent of bowel and bladder. A review of the ICCP included a focus area dated 1/24/25, and revised 2/7/25, for a risk for skin breakdown and/or have actual skin impairment related to bladder incontinence, bowel incontinence, and impaired mobility. The ICCP included an update dated 2/19/25, the same day as surveyor inquiry, that the resident preferred and requested to wear an adult brief with a pull-up over it. On 2/21/25 at 11:57 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) in the presence of the Nursing Educator (NE). The LPN/UM stated that the CNA's responsibilities when it came to incontinence care was to ensure the residents were checked every two hours and to treat the residents with respect. The LPN/UM stated that residents should not, under normal circumstances, be double briefed as it could cause skin irritation, which could lead to skin breakdown and infection, as well as take away from the resident's dignity. The LPN/UM further stated that residents had the right to prefer to wear double briefs, but nursing staff were responsible to educate and update the care plan to include the resident's preference, and the CNAs were expected to communicate with the nurses to ensure it was completed. The LPN/UM acknowledged that Resident #35's care plan was not updated to indicate the resident's preference for double incontinence briefs until after the surveyor's observation and inquiry. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/25 at 12:23 PM, the surveyor interviewed the Director of Nursing (DON), who stated that residents had the right to their preference in care, including to be double briefed, but nursing was responsible to educate the resident and family, and to update the resident's care plan timely the moment the resident's preference was known or within 24 hours. On 2/21/25 at 12:55 PM, the surveyor observed Resident #35 in their room watching television. The resident informed the surveyor that they had been at the facility for approximately a month and that they informed the nurse that passes the medication that they preferred to be double briefed when they were first admitted to the facility. On 2/24/25 at 12:29 PM, the surveyor interviewed the DON, who confirmed that Resident #35 was cognitively intact and able to make their needs and preferences known. On 2/25/25 at 9:30 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team, acknowledged that Resident #35's care plan should have been updated prior to surveyor inquiry and observation, and that the resident's preference should have been communicated by the nursing staff. A review of the facility's Comprehensive Care Plans policy with a last revised date of 7/2024, included the care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed . NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44833 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that proper incontinence care was provided to dependent residents. This deficient practice was identified for 1 of 9 residents observed for incontinence care (Resident #43), and was evidenced by the following: On 2/19/25 at 9:55 AM, during initial tour of the facility, the surveyor accompanied by the Certified Nursing Aide (CNA), observed incontinence care for Resident #43. The surveyor observed that the resident had an adult incontinence brief on with a pull-up incontinence brief on top. The surveyor asked the resident if they had a preference to be double briefed, and the resident shrugged their shoulders indicating they did not know. On 2/19/25 at 10:09 AM, the surveyor interviewed the CNA, who stated that residents should not be double briefed and that residents who required incontinence care should have been checked every two hours at a minimum to ensure they were dry. On 2/21/25 at 11:27 AM, the surveyor reviewed Resident #43's electronic medical record (EMR) and the following was indicated: A review of the Admission Record face sheet (an admission summary) indicated that the resident was admitted to the facility with diagnosis which included but was not limited to; dementia, chronic kidney disease, and need for assistance with personal care. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 1/29/25, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident had severe cognitive impairment. The MDS further revealed that the resident was dependent on staff for toileting hygiene and was frequently incontinent of bowel and bladder. A review of the individualized comprehensive care plan (ICCP) included a focus area with an initiation date of 1/28/25, and a revision date of 1/29/25, that the resident was at risk for activities of daily living (ADL) self-care deficit related to physical limitations. On 2/21/25 at 11:57 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) in the presence of the Nursing Educator (NE). The LPN/UM stated that CNA's responsibilities when it came to incontinence care was to ensure the residents were checked every two hours and to treat the residents with respect. The LPN/UM stated that residents should not, under normal circumstances, be double briefed because it could cause skin irritation, which could lead to skin breakdown and infection, as well as take away from the resident's dignity. On 2/21/25 at 12:23 PM, the surveyor interviewed the Director of Nursing (DON), who confirmed that residents should not be double briefed as it could take away from their dignity and could cause skin breakdown. The DON confirmed that Resident #43 was unable to verbalize preferences and should not have been double briefed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 9:30 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team, acknowledged that residents should not have been double briefed. After multiple requests from the surveyor, the facility was unable to provide a policy that included the proper general incontinence care procedure. NJAC 8:39-27.1(a); 27.2(h)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33106 Based on observation, interview, and the review of pertinent facility documentation, it was determined that the facility failed to a.) provide supportive rational for starting a new antianxiety medication and b.) document targeted behaviors for a resident on psychoactive medication. This deficient practice was identified for 1 of 3 residents reviewed for psychoactive medication use (Resident #88), and was evidenced by the following: A review of the Admission Record face sheet (admission summary) indicated that Resident #88 was admitted to the facility with the diagnoses which included but was not limited to; dementia and unspecified psychosis not due to a substance or known psychological condition. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 12/26/24, reflected that Resident #88 had severe cognitive impairment and did not exhibit any behaviors. The MDS also indicated that the resident required partial assistance from another person to complete activities of daily living (ADLs). On 2/19/25 at 11:06 AM, during initial tour, the surveyor observed Resident #88 sitting up in the wheelchair in the dining room, pleasantly confused and coloring. The resident was unable to be interviewed due to impaired cognitive. The surveyor reviewed the resident's electronic medical record (EMR) which revealed the following: A review of the Physician Order Summary Report (POSR) dated 2/7/25, reflected that Resident #88 was ordered the antianxiety medication lorazepam (Ativan) 0.5 milligram (mg) tablet; administer 1 tablet by mouth every 12 hours as needed for anxiety for 14 days. A review of the nursing Progress Note (PN) dated 2/7/25, indicated that the nurse discussed with the Advanced Nurse Practitioner (ANP) the resident's behaviors of frequent and repeatedly yelling out at night and that staff were having difficulty redirecting the resident's behavior. The note reflected that the APN discussed with the resident's Responsible Party (RP) and ordered the antianxiety medication Ativan 0.5 mg as needed (prn) for 14 days. A review of the the Progress Notes from 2/1/25 until 2/7/25, prior to the order for the Ativan, there was no supporting documentation on the evening or night shifts that the resident was exhibiting behaviors such as yelling, and that staff were having difficulty redirecting the resident's behavior. A review of the February 2025 Medication Administration Record (MAR) revealed that the resident received Ativan on 2/10/25, 2/19/25, and 2/20/25. A review of the corresponding PN dated 2/10/25, 2/19/25, and 2/20/25, included no clinical behavior documentation to support the administration of the antianxiety medication on those dates. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #88's individualized comprehensive care plan (ICCP) indicated that the staff focused on the use of psychotropic medication for the targeted behaviors such as yelling to the point of exhaustion. Interventions included: medications were to be administered as ordered and to monitor and document for side effects and effectiveness of medications; monitor/record occurrences for target behavior symptoms such as screaming, violence, aggression toward staff and others and document as per the facility policy. A review of the Psychotropic Monthly Review dated January 2025, reflected that the resident had zero episodes of targeted behaviors such as yelling to the point of exhaustion and hallucinations. A review of the Psychiatric Consult (PC) dated 2/7/25, reflected that the resident was seen for a psychiatric follow-up and medication management. The Psychiatrist documented that the resident was re-examined and that staff had reported that the resident had periods of behavior dyscontrol and was more redirectable during the daytime hours. The documentation indicated that the resident had no hallucinations, delusions, or other symptoms of psychotic process that were reported. The Psychiatrist also documented that the resident had no manic symptoms that were reported and no side effects to medications. The surveyor reviewed Resident #88's progress notes which did not reflect that the resident's targeted behaviors of yelling were being documented or that the staff had attempted non-pharmacological approaches to manage the behaviors prior to obtaining a physician's order for the use of an antianxiety medication. On 2/20/25 at 12:15 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated that when any resident in the facility who was started on new psychotropic medication, the nurse assigned to the resident was required to document what behaviors the resident was exhibiting. The LPN stated that behaviors were documented by exception; that before a psychotropic medication was ordered, there should be documentation in the resident's medical records that the resident was exhibiting behaviors, what the behaviors were, and non-pharmacological interventions that were attempted prior to administration of psychotropic medications. The LPN stated that after the resident was started on a psychotropic medication, the nurses were to document for 14 days after initiating the new psychotropic drug. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 12:19 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated that when a resident was on a psychotropic medication, that documentation included monthly psychotropic notes. The LPN/UM stated that the Psychiatrist was updated every Friday when they came in to see the residents. The LPN/UM explained that she had documented on 2/7/25 at 4:09 PM, that Resident #88 was having increased yelling and staff had difficulty redirecting the resident during the night hours. The surveyor asked the LPN/UM who reported those behaviors because a review of the clinical documentation did not reflect that the resident was exhibiting any behaviors at night prior to the Ativan being ordered. The LPN/UM stated that it was reported to her by the resident's roommate and not by the clinical staff. The surveyor asked the LPN/UM if the resident was assessed for pain or any other reasons that they may have been yelling, and the LPN/UM stated that she did not document that and could not recall. The LPN/UM confirmed it would have been important to document if any non-pharmacological interventions were attempted prior to starting the resident on Ativan. The LPN/UM reviewed the resident's nursing progress notes and the 24-hour report and could not find any documentation from the clinical staff that the resident was exhibiting yelling at night repeatedly and was difficult to redirect. The LPN/UM stated that behavior monitoring was done by exception, and that documentation would only occur if the resident was exhibiting behaviors. The LPN/UM stated that after starting any new medication, the resident was monitored for 14 days. The LPN/UM reviewed the resident's medical record and could not find any documentation indicating that the use of the antianxiety medication Ativan was being monitored for effectiveness after use. The surveyor reviewed the facility 24-hour report from 2/1/25 until 2/7/25, and there was no documentation that Resident #88 was exhibiting the behaviors such as yelling or screaming or that the resident was difficult to redirect. On 2/21/25 at 8:49 AM, the surveyor interviewed the primary care Certified Nursing Aide (CNA), who stated that the resident was confused but was able to recognize him. The CNA stated that the resident would resist care at times, but was easy to redirect. The CNA stated that the resident exhibited more behaviors at night such as resisting care or screaming, but he did not know how often it had occurred. The CNA continued to explain that when Resident #88 resisted care, he just talked the resident through it, and then the resident would then allow care to be performed. The CNA also added that the resident had behaviors such as screaming, but did not exhibit it all the time. On 2/25/25 at 9:32 AM, the surveyor interviewed the Director of Nursing (DON), who stated that she had reviewed the resident's medical record and agreed that there was no documentation that the resident was exhibiting behaviors such as screaming at night prior to obtaining an order for the antianxiety medication Ativan. The DON also confirmed that there was no documentation of any non-pharmacological interventions initiated prior to administration of the medication. A review of the facility's Use of Psychotropic Drugs policy dated 1/2025, included that a resident who had not used psychotropic drugs were not to be given these drugs or prn psychotropic medications unless the medication was necessary to treat a specific condition diagnosed and documented in the clinical record . NJAC 8:39-29.3(a); 33.2 (a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45208 Based on observation, interview, and record review, it was determined that the facility failed to a.) maintain kitchen equipment in a clean and sanitary manner and b.) maintain pantry equipment in a clean and sanitary manner on 3 of 3 units. The evidence was as follows: On 2/19/25 at 9:31 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and observed the following: 1. The stand mixer was covered with a clear plastic bag which indicated that it was clean. The FSD removed the bag and the connecting bearing that holds the mixer attachment had hard dried white sediment on it. The FSD was able to wipe it off with a gloved hand. The FSD acknowledge it was not properly cleaned. 2. The can opener blade was worn, discolored, and had a rolled pointed edge. The FSD acknowledged it look like it had not been changed in a while and that it needed to be to prevent injury, metal splintering and cross contamination of food particles. 3. The microwave interior ceiling was covered with dried stuck on debris in a range of different colors. The FSD acknowledged and stated, it was not cleaned according to policy. On 2/19/2025 at 9:45 AM, the surveyor interviewed the FSD, who stated the mixer, microwave, and can opener blade did not meet her's or the facility policy's expectations. The FSD acknowledged that the equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination. On 2/21/25 at 9:28 AM, in the presence of the Director of Housekeeping (DH), the surveyor observed the following: 1. The B-unit pantry had debris on the counter, in one cabinet drawer, and on two lower cabinets. The gaskets on the refrigerator door had particle buildup of white and brown debris in the gasket folds. 2. The C-unit pantry had a water dispenser that required maintenance that was indicated by the flashing wrench on the electronic screen. Two cabinet drawers had white and black sediment and debris on the interior portion. The refrigerator gaskets had debris inside of the folds. 3. The D-unit pantry had stains and debris in several cabinet drawers and on the counter. The gasket on the refrigerator door had debris in the folds, a tare in the gasket on the top of the door corner and the gasket at the base of the refrigerator door was covered with black discoloring, torn, and falling off the refrigerator. On 2/19/25 at 9:50 AM, the surveyor interviewed the HD, who acknowledged that the pantry equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/25/25 at 09:30 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), who both acknowledged the surveyor's concerns. No additional information was provided. A review of the facility's General Kitchen Sanitation Policy, dated 8/2024, included clean and sanitize all food preparation areas after use .keep food contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated debris . A review of the facility's Nursing and housekeeping and dietary Policy, dated 1/2025, revealed ensure all pantry areas in the facility are maintained in a clean and sanitary condition, in compliance with NJDOH and CMS infection control regulations, to prevent contamination and ensure resident safety .countertops, sinks and high touch surfaces to wiped and disinfected daily .refrigerators must be fully cleaned and sanitized . cabinets and storage shelves must be emptied, wiped and reorganized .any maintenance issues must be reported immediately to the maintenance department . NJAC 8:39-17.2(g)

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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 - Few	Provide and implement an infection prevention and control program. 33106 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure Enhanced Barrier Precautions (EBP) were maintained while providing direct resident care in accordance with infection control standards of practice and facility policy. The deficient practice was identified for 1 of 9 residents observed for incontinence care (Resident #105), and was evidenced by the following: A review of Resident #105's Admission Record face sheet (admission summary) indicated that the resident was admitted to the facility with dementia and rheumatoid arthritis (RA). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 12/12/24, indicated that the resident had severe cognitive impairment and required maximum assistance with all aspects of activities of daily living (ADLs). On 2/19/24 at 9:55 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) accompanied the surveyor to conduct incontinent rounds for Resident #105. Prior to entering the resident's room, the surveyor observed signage posted on the door that indicated that a resident in that room was on Enhanced Barrier Precautions (EBP). There was also a personal protective equipment (PPE) caddy hanging on the door which contained gloves, isolation gowns, and masks. The resident was observed lying in bed and was unable to be interviewed due to cognitive impairment. The surveyor observed that Resident #105 was lying on an air mattress and was wearing green foam booties to bilateral lower extremities. The LPN put on gloves and proceeded to turn the resident to check the resident's incontinence briefs and stated that the resident was clean and dry. The LPN/UM was only wearing gloves at that time. The LPN/UM performed hand hygiene after resident care. The surveyor asked the LPN/UM if the resident was on EBP precautions, and LPN/UM responded that Resident #105 was on EBP due to a wound. The LPN/UM acknowledged that she did not apply an isolation/protective gown prior to performing direct care for the resident. The LPN/UM stated that the gown was important to apply to protect the resident from any microorganisms that she may have had on her clothing that could be transferred to the resident and cause an infection. On 2/21/25 at 8:54 AM, the surveyor interviewed the primary care Certified Nursing Aide (CNA), who stated that Resident #105 was cognitively impaired and required total care with all aspect of ADLs. The CNA stated that the staff were required to apply (don) PPE prior to providing direct resident care. The CNA stated that Resident #105 was on EBP precautions because the resident had a wound on their right buttocks. On 2/21/25 at 11:16 AM, the surveyor interviewed the Infection Preventionist (IP), who stated that the LPN/UM should have worn an isolation gown when performing direct care with Resident # 105. The IP stated that the importance of wearing PPE while caring for a resident with open access to the body was to protect the resident from any bacteria that could be transferred from the caregivers' clothes to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Preferred Care at Wall		STREET ADDRESS, CITY, STATE, ZIP CODE 2350 Hospital Road Allenwood, NJ 08720	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #105's individualized comprehensive care plan (ICCP) dated 7/15/24, reflected that the resident was on EBP related to having a wound. The interventions included that staff wore a gown and gloves when providing high contact activity such as dressing, bathing, transferring when high contact is anticipated, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or wound care. A review of the Physician's Order Summary Report dated 12/13/24, included a physician's order (PO) to maintain EBP due to the residents wound every shift. A review of the Medication Administration Record (MAR) dated 12/13/24, reflected an PO to maintain EBP due to wound every shift. On 2/25/25 at 9:40 AM, the Director of Nursing (DON) confirmed that all nurses should don the proper PPE that was specified by the signage on the resident's door prior to providing direct resident care for a resident that was on EBP. A review of the facility's Enhanced Barrier Precautions dated 3/21/24, included EPB was utilized for the prevention of transmission of targeted multi-resistant organism to keep residents safe. The policy indicated that EBP is initiated for residents meeting the criteria such as wounds and indwelling medical devices. Implementation of EBP specified that gowns and gloves be available for use during high contact activities . NJAC 8:39-19.4 (a); 27.1(a)