| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>Based on the interview and review of facility documentation, it was determined that the facility failed to ensure that facility wide assessment included the resources required to establish policies and procedures for the management of staffing contingency plans in order to meet the requirements and needs of all residents in the facility. This failure had the potential to affect all 107 residents who currently live in the facility.This deficient practice was evidenced by the following:During the entrance conference on 3/3/26 at 10:08 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a copy of the Facility Assessment (FA). The LNHA stated that the facility's census (the number of residents currently under the care of a specific facility) was 107.A review of the facility's Facility Assessment with resident population profile dates from 8/11/24 to 8/10/25, did not include information about the facility's contingency plan for staffing and grid to follow for staffing.A review of the Nurse Staffing Report (NSR) for the week from 8/31/25 to 9/13/25, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts.A review of the NSR for the week from 12/14/25 to 12/27/25, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts.Further review of the NSR for 2 weeks of staffing prior to survey from 2/15/26 to 2/28/26, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts.On 3/9/26 at 9:36 AM, the surveyor interviewed the LNHA during the Quality Assurance Performance and Improvement (QAPI) Meeting and FA was discussed. The LNHA informed the surveyor that the FA was reviewed annually and as needed. The surveyor asked the LNHA if he was aware of the updated guidance with regard to FA, and he responded, I do not remember honestly. The surveyor then notified the LNHA of the above concern that the FA that was done in 2025 did not include information about the contingency planning for staffing and grid for staffing. The LNHA stated he was unaware of the new guidance. The surveyor asked the LNHA should the new updated and revised requirement in the regulation for FA be in their 8/10/25 FA, and he stated absolutely.On that same date and time, the LNHA acknowledged that the FA should had include the NJ (New Jersey) Mandated law for staffing and the contingency plan. The surveyor asked the LNHA what guidance the facility followed for staffing, and the LNHA stated that as far as staffing, for the CNA we follow 5 CNA (Certified Nursing Aid) in day shift, 10 CNAs for 3-11 shift, and I think 12 in 11-7 shift by census.Furthermore, the surveyor asked the LNHA if the facility was able to meet the required minimum staffing requirement by NJ Mandated law, and he responded, I wouldn't say 100% of all the times, because they had a big challenges with the snow storm.A review of the undated facility's Facility Assessment Policy that was provided by the LNHA, revealed under policy, this facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. The purpose of this policy is to establish responsibilities and procedures for the facility assessment process Policy Explanation and Compliance Guidelines: .3. The facility will use the facility assessment to: .3. Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for<br>(continued on next page) |



| 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 |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | resident care 10. The facility assessment will be reviewed and updated as necessary and at least annually, whenever there is, or the facility plans for, any change that would require a substantial modification to consider specific staffing needs for each shift (e.g., day, evening, night, weekend shifts) and for each resident unit in the facility based on changes to resident population. Any changes to the assessment will be documented, along with a revision history.On 3/9/26 at 1:52 PM, the survey team met with the LNHA and Director of Nursing for an exit conference, there was no additional information provided by the LNHA. NJAC 8:39-5.1(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide a safe, clean, and comfortable homelike setting. This deficient practice was identified for 2 of 3 units (2nd and 3rd floors), 2 of 3 Residents rooms (room [ROOM NUMBER] and room [ROOM NUMBER]), and common areas (3rd floor family room, 2nd and 3rd floors dining rooms, 2nd and 3rd floors Bather, 2nd and 3rd floors hallways, and 2nd floor soiled utility room) and was evidenced by the following:The deficient practice was evidenced by the following:<br><br>1.On 3/3/26 at 10:18 AM, Surveyor #1 (S#1) observed the 3rd floor Certified Nursing Assistant (CNA) charting area on the low side, the desk with peeling wood on the lower drawer. S #1 interviewed the Licensed Practical Nurse (LPN) who confirmed that the wood was peeling and that residents will use the phone on the desk to make phone calls. The LPN stated that she did not know how long the drawers have been like that and work orders were sent via e-mail.<br><br>On 3/3/26 at 10:49 AM, S #1 observed room [ROOM NUMBER] (R315), a family room, three residents watching television, and the rug was observed with multiple areas, stained with dark, brown spots. S #1 interviewed Housekeeper #1 (HK #1) who stated that she did not clean the rugs, and the [NAME] was responsible for the floors.<br><br>On 3/3/26 at 10:55 AM, S #1 observed in room [ROOM NUMBER] (R318), the bathroom entry with one broken floor tile. S #1 observed in the hallway, the CNA charting station desk on the high side with peeling wood on the drawers. The CNA confirmed that the residents use the phone on the desk and did not know how long it was been like that.<br><br>On 3/3/26 at 11:18 AM, S #1 observed room [ROOM NUMBER] (R344), a family room with five residents watching television, and the rug was observed with multiple areas, stained with dark brown spots, by the entry way.<br><br>On 3/3/26 at 11:25 AM, S #1 observed room [ROOM NUMBER] (R343), main dining room, five ceiling tiles with brownish stains.<br><br>On 3/4/26 at 10:34 AM, S #1 toured the 3rd floor with the Maintenance Staff (MS) and the Registered Nurse/Unit Manger (RN/UM). The MS stated regarding the stained rugs, that he would find out who was responsible for cleaning the rugs. He stated the floor tiles were the responsibility of maintenance including the ceiling tiles. He further stated that the brown stains on the ceiling tiles were from condensation and the peeled wood on the furniture should not be like that. He stated that they did rounds every day on all floors and that work orders were submitted by email. The MS and RN/UM confirmed the rugs, drawers from CNA charting stations, bathroom floor tiles, and ceiling tiles should be cleaned and repaired, since residents are using those areas, neither were not aware how long it was been like that.<br><br>On 3/6/26 at 12:30 PM, S #1 notified the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding environmental issues and asked who was responsible for cleaning the rugs. The LNHA stated that housekeeping, in which the [NAME] was under was responsible for cleaning the rugs. The LNHA further stated that if the rugs were soiled, it should be cleaned right away.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. On 3/3/26 at 11:15 AM, during the initial tour of the facility, Surveyor #2 (S #2) entered room [ROOM NUMBER] (R245; bather also known as the shower room of the residents) and observed upon entry, in the middle of the room a ceiling vent with accumulation of blackish substances. The next cubicle upon entry, to the right was the shower area and the air vent with accumulation of grayish substances. Cubicle #2 inside the room where equipment was being stored like the shower chair, the window sill with accumulation of grayish and blackish substances. The last cubicle was in the toilet area and observed with wall vent and ceiling vent with accumulation of grayish substances.<br><br>On 3/4/26 at 11:35 AM, S #2 asked the 2nd floor Licensed Practical Nurse/Unit Manager (LPN/UM) to accompany S #2 to tour the unit.<br><br>On 3/4/26 at 11:38 AM, S #2 and the LPN/UM both observed the hallway in front of room [ROOM NUMBER] (R250) and the Cluster 1 Unit Secretary's section with computer, which the LPN/UM informed S #2 that the Unit Secretary was at that time scheduling appointments. Resident #135 was in the area seated in a wheelchair. Both S #2 and the LPN/UM observed four ceiling lights dimmed, and the LPN/UM stated that it was probably the light bulbs had to be changed. The LPN/UM acknowledged that four ceiling lights were dimmed.<br><br>On 3/4/26 at 11:40 AM, S #2 and the LPN/UM went to room [ROOM NUMBER] (R247, soiled utility room) the light was dimmed and the LPN/UM stated that she would notify the Maintenance.<br><br>On 3/4/26 at 11:44 AM, S #2 and the LPN/UM went to R245, and both observed what had S #2 was observed on 3/3/26 at 11:15 AM, with air vents and window sill. The LPN/UM confirmed it was accumulation of dust, and she stated should have been cleaned.<br><br>Outside R245, the LPN/UM stated that it was the responsibility of both housekeeping and maintenance to clean and maintain the bather. S #2 also notified LPN/UM that they were observed yesterday and still the same.<br><br>3. On 3/4/26 at 9:16 AM, S #2 asked the RN/UM of the 3rd floor to accompany S #2 for the environmental tour. S #2 and the RN/UM went inside room [ROOM NUMBER] (R352), which was a residents' room, upon entry to the door, both observed blackish stains on the baseboard molding around the room which the RN/UM stated should have been cleaned. There were scattered blackish and grayish substances on the floor which the RN/UM stated could need some cleaning and buffing and she was unsure when was the last time it was cleaned. On the left side upon entry was the toilet room with wall vent, near the ceiling with grayish substances, and confirmed by the RN/UM as accumulation of dust. Next to the toilet room was bed A (room [ROOM NUMBER]A, left of the room) with bed foot area of the floor was blackish, whitish, brownish, and blackish stains, and accumulation of grayish substances which the RN/UM claimed were accumulation of dust, and need some buffing and not sure when was the last time it was buffed. The window sill with accumulation of grayish substances and confirmed by the RN/UM upon wiping it with her bare finger it was accumulation of dust.<br><br>On that same date and time, next to bed A was bed B (room [ROOM NUMBER] B (R352B), right of the room) with accumulation of grayish substances and confirmed by the RN/UM as dust, window sill with accumulation of dust confirmed by RN/UM, and the baseboard extended up to R352B the blackish stains.<br><br>On 3/4/26 at 9:22 AM, both S #2 and the RN/UM observed the hallway between room [ROOM<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | NUMBER] (R350) and the computer desk, four ceiling lights dimmed with scattered accumulation of blackish substances. Housekeeper #2 (HK #2) came, tried to wipe it with feather duster, and unable to, and HK #2 stated that she did not usually clean them it was the [NAME] who cleaned them. The RN/UM stated it was the Maintenance department who checked the light bulbs, and it was probably the light bulb that needed to be changed, and the RN/UM confirmed that the lights were dimmed.<br><br>On 3/4/26 at 9:32 AM, S #2 and RN/UM went to room [ROOM NUMBER] (R345; bather) and both observed the 1st cubicle to the right side with air vent with accumulation of grayish substances which the RN/UM confirmed dust.<br><br>On 3/6/26 at 12:21 PM, the survey team met with the LNHA and the DON, and S #2 notified them of the above findings and concerns with regard to 2nd and 3rd floor environmental tours.<br><br>A review of the undated facility's Safe and Homelike Environment Policy revealed under Policy .the facility will provide a safe, clean, comfortable and homelike environment .Under Definitions revealed, Environment refers to any environment in the facility that is frequented by residents including residents' rooms, bathrooms, hallways, dining areas .Under Policy Explanation and Compliance Guidelines #3 revealed, Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .<br><br>On 3/9/26 at 12:37 PM, the survey team met with the DON, and the LNHA stated that we did the QAPI (Quality Assurance Performance and Improvement) for environmental rounds after surveyor's inquiry. The LNHA further stated that we will be doing rounds in a monthly basis, and we would be checking housekeeping issues. He also stated that the light bulbs were due to be replaced and cleaned.<br><br>On 3/9/26 at 1:30 PM, the LNHA and DON provided no additional information.<br><br>NJAC 8:39-31.2(e); 31.4(a)(b)(e)(f) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on interview and review of pertinent facility documents, it was determined that the facility failed to verify the credentials and substantiated findings for staff in the Criminal Background Screening Report and reference checks prior to date of hire in accordance with the facility's abuse policy and procedure for the screening of newly hired employees. This deficient practice was identified for 9 of 79 newly hired employees (Staff #24, #33, #42, #43, #56, #64, #69, #71, and #78) as evidenced by the following: 1.On 3/5/26 at 1:20 PM, Surveyor #1 (S #1) reviewed total of 30 new employee files and revealed:<br><br>A review of Staff #24's file, a Recreation Aide, with a date of hire (DOH) of 7/9/25, revealed a criminal background screening report (CBSR) dated 7/22/25. The CBSR was completed after Staff #24's DOH.<br><br>A review of Staff #33's file, a Certified Nursing Aide, with a DOH (rehired) of 12/29/25, revealed a CBSR dated 3/9/26. The CBSR was completed after Staff #33's DOH.<br><br>A review of Staff #42's file, a Certified Nursing Aide, with a DOH of 11/17/25, revealed a CBSR dated 3/9/26. The CBSR was completed after Staff #42's DOH.<br><br>A review of Staff #43's file, a Registered Nurse, with a DOH of 11/11/24, revealed a CBSR dated 3/9/26. The CBSR was completed after Staff #43's DOH.<br><br>2. On 3/5/26 at 1:54 PM Surveyor #2 (S #2) reviewed a total of 14 of 79 new employee files and revealed:<br><br>A review of Staff #56's file, a Licensed Practical Nurse, with a DOH of 12/13/24, revealed a CBSR dated 3/9/26. The CBSR was completed after Staff #56's DOH.<br><br>A review of Staff #64's file, a Certified Nurse Aide, with a date of DOH of 12/17/25, showed a CBSR dated 1/29/26. The CBSR was completed after Staff #64's DOH.<br><br>3. On 3/5/26 at 1:10 PM, Surveyor #3 (S #3) reviewed a total of 27 of 79 newly hired employee files.<br><br>A review of Staff #69's file, an Environmental Service Staff, with a date of DOH of 5/19/25, revealed there were no references found in their file.<br><br>A review of Staff #71's file, a Social Worker, with a DOH of 7/14/25, revealed there were no references found in their file.<br><br>On 3/6/26 at 8:44 AM, S #3 interviewed the interim Human Resources (HR) staff who stated it was expected for all new employees to have a criminal background check and reference checks.<br><br>On 3/6/26 at 12:21 PM, Surveyor #4 (S #4) notified the Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON) of the above concerns found for the new employee files reviewed.<br><br>A review of the facility's New Hire Background Investigations Policy dated October 2022, revealed under Policy: Job reference checks, licensure verifications and criminal conviction record checks are conducted on all personnel making application for employment with this company .<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. On 3/9/26 at 9:23 AM, Surveyor #5 (S #5) reviewed the pre-employment screening for eight employee files from 79 new hires from last recertification 10/17/24 to current.<br><br>A review of Staff #78, Department-Human Resources, with a DOH of 4/8/25, revealed CBSR that was dated 3/4/26, completed late (over 10 months) after the DOH.<br><br>On 3/9/26 at 10:31 AM, S #5 interviewed the covering HR, who had been covering for the last one month. The covering HR stated that they complete the CBSR prior to DOH. The covering HR confirmed that Staff #78's CBSR was done after the DOH.<br><br>On 3/9/26 at 1:30 PM, the LNHA and DON provided no additional information.<br><br>A review of the facility's undated Abuse and Neglect Policy revealed under Policy, it is the policy .to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedure that prohibit and prevent abuse, neglect, exploitation Under Screening, A. Potential employees will be screened for a history of abuse, neglect, exploitation<br><br>NJAC 8:39-13.4(c)2i-vi |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Complaint NJ#2616278Based on interviews, record review, and review of facility provided documents, it was determined that the facility failed to provide information to the resident or the Resident Representative (RR) that explains the Bed Hold and Reserve Bed Payment policy. This deficient practice was identified for 3 of 3 residents, (Resident #11, #129, and #132), reviewed for discharge process.The deficient practice was evidenced by the following:<br><br>1. A review of closed medical records revealed that Resident #132 had an acute transfer on September 2025 due to diagnoses of hypernatremia (high sodium concentration in the blood) and sepsis (serious condition in which the body responds to an infection).<br><br>On 3/4/26 at 1:49 PM, Surveyor #1 (S#1) reviewed Resident #132's medical records (MR) which revealed an admission Record (AR; an admission summary) diagnoses that included but not limited to, cerebral infarction (stroke), Parkinson's disease (neurodegenerative disorder) with dyskinesia (movement disorder) without mention of fluctuations, unspecified dementia, unspecified severity, without behavioral disturbance, without psychotic, without mood and anxiety disturbances.<br><br>A review of the comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 9/5/25, revealed a Brief Interview of Mental Status (BIMS) score of 6 out of 15 indicating severe impaired cognition.<br><br>A review of the physician order dated 9/8/25, reflected, transfer to hospital for evaluation related to hypernatremia.<br><br>A review of the Progress Note, electronically signed by the License Practical Nurse (LPN), dated 9/8/25 at 9:51 PM, revealed, critical labs, Medical Doctor made aware and ordered patient to be sent to emergency room (ER), patient left unit via stretcher at 9:45 PM.<br><br>Further review of the MR revealed there was no bed hold notifications that was documented and sent to the resident and/or RR.<br><br>On 3/6/26 at 10:26 AM, S #1 interviewed the 2nd floor Licensed Practical Nurse/Unit Manager (LPN/UM) and the Registered Nurse (RN)/Supervisor/Assistant Director of Nursing (ADON) who was on duty on 9/8/25 at 3-11 PM shift. The RN/Supervisor/ADON stated residents who go to the hospital, their bed would be on hold, and the admission staff would be responsible for notifying the RR of the bed hold.<br><br>On 3/6/26 at 12:40 PM, S #1 notified the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding concerns with Bed Hold and Reserve Payment notifications.<br><br>2. On 3/3/26 at 12:36 PM, Surveyor #2 (S #2) reviewed Resident #11's hybrid (electronic and paper) MR.<br><br>A review of Resident #11's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; gastrostomy (a procedure to create an opening in the stomach to insert a feeding tube (G-tube) for long-term nutritional support), cerebral infarction (also known as ischemic stroke, is a medical emergency caused by blocked blood flow to the brain, leading to tissue (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | necrosis and oxygen deprivation) and type 2 diabetes mellitus (a chronic condition characterized by insulin resistance and relative insulin deficiency, leading to high blood sugar).<br><br>A review of Resident #11's most recent discharge return anticipated MDS (DRAMDS) reflected that the resident's cognitive skills for daily decision making was moderately impaired. Further review of the MDS indicated that the resident was transferred to a short term general hospital.<br><br>A review of Resident #11's hybrid MR included a letter to the RR dated 2/19/26, which included that the resident was transferred to the hospital for G-tube dislodgement. Further review of Resident #11's hybrid MR did not include any written notification of the bed hold policy or the facility's bed hold reserve payment.<br><br>3. On 3/5/26 at 9:36 AM, S #2 reviewed Resident #129's closed hybrid MR. The resident no longer resided at the facility.<br><br>A review of Resident #129's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; gastrostomy, type 2 diabetes mellitus and parkinsonism (an umbrella term for a group of neurological disorders causing movement issues).<br><br>A review of Resident #129's most recent DRAMDS reflected that the resident's cognitive skills for daily decision making was severely impaired. Further review of the MDS indicated that the resident was transferred to a short term general hospital.<br><br>A review of Resident #129's hybrid MR included a letter to the RR dated 12/26/25, which included that the resident was transferred to the hospital for shortness of breath. Further review of Resident #11's hybrid MR did not include any written notification of the bed hold policy or the facility's bed hold reserve payment.<br><br>On 3/5/26 at 10:39 AM, S #2 interviewed the Admissions Director (AD) who stated that she sent the notification of transfer to the family and to the ombudsman. The AD stated that to her knowledge, the facility did not send out bed hold notifications. S #2 requested information on who in the facility sent out the bed hold notification.<br><br>On 3/5/26 at 10:55 AM, the AD stated that the facility did not have an official letter that was sent out [regarding bed hold] when a resident was sent to the ER. The AD stated that there was a paragraph about bed holds in the admission agreement that they went over with the resident or RR when admitted .<br><br>On 3/6/26 at 12:47 PM, S #2 notified the LNHA and DON the concern that Resident #11 and Resident #129 did not have documented evidence that a written bed hold notification was sent.<br><br>On 3/9/26 at 12:43 PM, in the presence of the DON, the LNHA stated that they would issue bed hold notices accordingly and monitor it on a monthly basis.<br><br>The LNHA did not provide any additional information.<br><br>A review of the undated facility's Bed Hold Policy included the following: Policy Statement: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Policy Interpretation and Implementation: 1. Residents may return to (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and resume residence in the facility after hospitalization or therapeutic leave as outlined in this policy.3. If in agreement with the bed-hold, written information will be given to the resident representatives that explains: a. The duration of the bed-hold; b. The reserved bed payment; and c. The details of the transfer (per the Notice of Transfer).<br><br>NJAC 8:39-4.1(a)31; 5.1; 5.4(c) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint NJ #2616278Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents received care consistently with professional standards of practice, by failing to; a.) monitor, evaluate, report and document changes in the skin condition as soon as identified b.) develop a relevant care plan that includes measurable goals for management of pressure ulcer/pressure injuries (PU/PIs) with appropriate interventions c.) use clean technique for PU/PI dressing protocols, and d.) utilize a formal method of evaluating PU/PIs in accordance to facility's policies. This deficient practice was identified for 4 of 5 residents (Resident #17, #118, #131, #132) reviewed. This deficient practice was evidenced by the following:<br><br>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.<br><br>1. On 3/4/26 at 1:49 PM, Surveyor #1 (S#1) reviewed the closed records of Resident #132.<br><br>A review of the admission Record (AR; an admission summary) reflected that the resident was admitted to with diagnoses that included but not limited to; cerebral infarction, Parkinson's disease with dyskinesia without mention of fluctuations, unspecified fall subsequent encounter, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic, mood and anxiety disturbances, difficulty in walking not elsewhere classified, weakness<br><br>A review of the admission minimum data set (aMDS), with an assessment reference date (ARD) of 9/5/25, revealed a brief interview for mental status (BIMS) score of 6 out of 15 indicating severely impaired cognition. The aMDS indicated also that the resident was occasionally incontinent of urine, frequently incontinent of bowels, used a walker and wheelchair, toileting partial/moderate assistance, rolling left and right partial/moderate assistance, sit to stand partial/moderate, walking not attempted due to medical condition or safety concerns, no pressure ulcer coded but at risk, pressure reducing device for bed and chair, and a Formal Skin Instrument Assessment Tool used.<br><br>A review of the Care Plan (CP) revealed, potential impairment to skin integrity related to (r/t) impaired physical mobility and incontinence, date initiated 9/2/25; Patient exhibits decreased muscle strength, decreased neuromuscular skills, decreased bed mobility skills, decreased transfer skills, decreased ambulation skills, date Initiated: 8/30/25.<br><br>A review of the Physician Orders (PO) revealed: wound consult needed, open area to sacrum, ordered<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 9/8/25; Transfer to for evaluation related to hypernatremia, dated 9/8/25.A review of the nursing progress note (PN) dated 9/8/25 revealed, Licensed Practical Nurse #1 (LPN #1) documented. wound to sacrum needing wound consult supervisor made aware.<br><br>On 3/5/26 at 12:52 PM, S#1 reviewed the hard chart and the electronic medical records (EMR) which revealed:<br><br>-admission Nursing Assessment revealed no pressure injury<br><br>-Wound Consult dated 9/3/25 revealed no pressure injury<br><br>-Interact Communication Form dated 9/8/25 revealed wound to sacrum open area to sacrum redness present, cleaned and covered<br><br>-Universal Transfer Form ( UTF) dated 9/8/25 revealed under skin conditions No wounds.<br><br>-nursing PN dated 9/8/25 for any skin assessment, incident or investigation, no documentation found<br><br>On 3/6/26 at 10:10 AM, S #1 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that if a CNA found a skin impairment, they notified the nurse, the nurse would measure the area, put a note in the PN, initiate a treatment and wound team would assess that resident, inform the Resident Representative (RR), the DON, and the doctor. The LPN/UM stated that they did not use a Formal Skin Assessment Tool, and no incident report was done.<br><br>On 3/6/26 at 10:26 AM, S #1 interviewed the LPN/UM and Registered Nurse/Infection Preventionist (RN/IP), who was on duty on 9/8/25 at 3-11 shift. The UTF was reviewed which indicated no wounds and the RN/IP confirmed that she did not see the actual wound and should have assessed it. She further stated that the expectation was to look at the wound, It's a must and the UTF form was completed incorrectly.<br><br>On 3/6/26 at 10:41 AM, S #1 interviewed Certified Nursing Aide #1 (CNA #1) on the 2nd floor, regarding the process when a new skin change or impairment was observed. CNA #1 stated that she reported the new finding to the nurse.<br><br>On 3/6/26 at 11:31 AM, S #1 reviewed the CNA Task in the EMR which revealed: Rolling Left and Right-no signatures plotted on day shift from 8/30/25-9/8/25; Toileting Hygiene-no signatures plotted for 8/30/25-9/8/25 on day shift.<br><br>On 3/6/26 at 12:40 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding concerns with facility acquired wound had no assessment completed, no PN describing the wound, no investigation, incorrect UTF, MDS coding a Formal Assessment Tool and CNA Task were not filled out completely.<br><br>On 3/9/26 at 12:42 PM, in the presence of the survey team, the LNHA and the DON responded regarding the PU/PI concerns. The DON responded that they we will be revising their policy to start a Formal Skin Assessment Tool, education on CP, wound treatment, and agency CNAs completing their Tasks in the EMR.<br><br>2. On 3/3/26 at 11:05 AM, S #1 observed Resident #118 in the 3rd floor family room. The resident was<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | sitting in a wheelchair (w/c) with a cushion, not able to answer questions but said hello to S #1.<br><br>S #1 reviewed the medical records of Resident #118 which revealed:<br><br>A review of the AR reflected diagnoses that included but not limited to; unspecified dementia unspecified severity without behavioral disturbance, psychotic, mood and anxiety disturbances; malignant neoplasm of unspecified bronchus or lung; bladder cancer and congestive heart failure.<br><br>A review of the quarterly MDS (qMDS) with an ARD of 12/27/25, revealed a BIMS score of 6 out of 15 indicating severe impaired cognition. The qMDS also included that the resident had indwelling catheter, frequently incontinent of bowels, pressure reducing device for chair and bed, toileting hygiene and transfer moderate assistance, rolling side to side supervision, non-ambulatory, Formal Assessment tool coded; risk for developing pressure injury, and no pressure injury.<br><br>A review of the CP revealed impaired cognitive function/dementia or impaired thought processes r/t dementia, date initiated 6/16/25; suprapubic catheter r/t history of bladder cancer, date initiated 10/17/25; potential for pressure ulcer development and skin impairment r/t immobility and use of anticoagulant, date Initiated 6/16/2025. There was no CP for an actual left buttock PU/PI.<br><br>A review of the PO revealed:<br><br>-Santyl External Ointment 250 unit/gm (unit/gram), apply to left buttock topically every day shift for PU for 14 Days. Cleanse wound with normal saline (NS) or skin integrity wound cleanser, pat dry, apply Santyl ointment & cover with dressing, revised on 1/18/26.<br><br>-Silvadene External Cream 1 %, apply to Left Buttock topically every day shift for PU for 14 Days. Cleanse wound with NSS or skin integrity wound cleanser, pat dry, apply Silvadene & cover with dressing, start date 1/30/2026, discontinued date 2/12/2026.<br><br>-Same order renewed on 2/12/26 and 2/26/26; Zinc Oxide External Ointment 20 %, Apply to Left Buttock topically every shift for Skin Protection. Apply post hygienic care, start date 3/4/26.<br><br>On 3/4/26 at 10:11 AM, S#1 interviewed the 3rd floor Registered Nurse/Unit Manager (RN/UM), regarding the left buttock wound and the CP who confirmed the wound was facility acquired and stated that she was responsible for implementing the CP for nursing. S #1 asked where the CP for the left buttock wound was and she stated, I don't see it, I missed it.<br><br>On 3/4/26 at 2:20 PM, S#1 interviewed the DON who stated the left buttock wound first occurred on 1/14/26. S #1 reviewed the EMR for a Formal Skin Risk Assessment, as indicated in the MDS that it was completed and none found on admission or when the wound was first observed. S #1 reviewed the Nursing admission Assessment which indicated redness to the sacral on admission and in the nursing, PN indicated resident with red heels. S #1 reviewed the PN and no nursing notes on 1/14/26 regarding left buttock wound. No evidence of staff documenting or reporting any changes or finding of left buttock wound on 1/14/26.<br><br>A review of the Wound Consult notes on 1/14/26, revealed, left buttock PU stage 3 (full thickness extending to the subcutaneous fat), 2.5 cm x 4 cm x 0.3 cm (centimeters), unstageable PU obscured full-thickness skin and tissue loss, exudate small serous; no odor; no pain; 60% slough-yellow dead tissue, 40% granulation-pink, new skin tissue; and order to cleanse with saline, Santyl, dry dressing<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | daily and as needed (PRN).<br><br>A review of the Wound Consult notes dated 2/25/26, revealed, improving; 1 cm x 1 cm x 0.2 cm; small sero-sanguineous exudate; no pain or odor; 100% dermis-middle layer of skin, partial thickness, healing stage 3 PU.<br><br>On 3/5/26 at 9:37 AM, the 3rd floor RN/UM stated that the resident and RR gave consent for S #1 to observe wound treatment. S #1 observed License Practical Nurse #2 (LPN #2) performed wound treatment to the left buttock with Certified Nursing Assistant (CNA) assisting and RN/UM. S #1 observed during the wound treatment LPN #2 with gloves sprayed with cleanser to clean the wound, inside and out (left buttock wound healing, not open), LPN #2 with the same gloves on proceeded to apply the Zinc Oxide as ordered and covered with dressing. LPN #2 then removed her gloves and washed hands for 30 seconds. LPN #2 returned to the bedside without any gloves on, took out a black marker from her pocket and dated the dressing and returned the marker back in her pocket without disinfecting the marker before and after use. LPN #2 removed the spray bottle and Zinc Oxide tube and gave it to the RN/UM who was outside the room and the RN/UM placed it inside the treatment cart without disinfecting the bottle or the tube. LPN #2 removed the blue drape, (chuck) on the overhead side table and put it in the garbage and did not disinfect the overhead table. LPN #2 removed her Personal Protective Equipment (PPE) before leaving the room and proceeded to the medication cart without using hand sanitizer. The resident was on Enhanced Barrier Precaution (EBP) due to the wound, and an alcohol-based hand sanitizer (ABHS) must be used before and after entering room.<br><br>On 3/5/26 at 10:43 AM, S #1 interviewed the RN/UM and LPN #2 regarding wound treatment observation. S #1 asked what should be done after cleaning the wound with gloves on and the RN/UM stated hand hygiene should be done. LPN #2 confirmed, I did not do that, I should have wiped the marker with an antimicrobial before I put it in my pocket. The RN/UM confirmed that the spray bottle and Zinc Oxide tube should have been disinfected before putting it back in the cart. Both the RN/UM and LPN #2 confirmed that the table should have been sanitized and ABHS should have been used when LPN #2 left the room.<br><br>On 3/5/26 at 10:53 AM, LPN #2 stated when they find a new wound, they inform the doctor, and the wound team, they check the wound and do an assessment. The RN/UM stated that she needed to clarify with the DON if there was a form that they use to complete an assessment. The RN/UM stated that they document in the PN, do not complete an incident report or investigation for new wounds, and do not have a Formal Assessment tool. S #1 reviewed the resident's hard chart and the electronic health records with the RN/UM who confirmed no skin assessment was found, and no nursing PN were found. The RN/UM further confirmed that there was no CP and that she did not notify the RR, There was no excuse for that. The RN/UM stated that the treatment was changed yesterday to Zinc Oxide because wound was resolved.<br><br>On 3/5/26 at 12:40 PM, S #1 interviewed the DON regarding a Formal Skin Assessment tool, and she stated, they did not use a risk assessment tool and that the staff should document in the nursing PN.<br><br>On 3/6/26 at 12:32 PM, S #1 notified the LNHA and the DON of the concerns regarding the facility acquired wound on the left buttock with no documentation in the nursing PN, no description, no investigation or incident, no CP completed, and MDS coding a Formal Assessment Tool was used and discussed concerns with wound treatment observation.<br><br>3. On 3/3/26 at 11:04 AM, Surveyor #2 (S #2) observed Resident #17 seated in a w/c with head down.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident #17's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to type 2 diabetes mellitus (a chronic condition causing high blood sugar due to insulin resistance and relative insulin deficiency) and gout (a painful form of inflammatory arthritis caused by high levels of uric acid (hyperuricemia) in the blood, which form needle-shaped crystals in joints).<br><br>A review of Resident #17's most recent aMDS, with an ARD of 2/3/26, reflected that the resident had a BIMS score of 15 out of 15, which indicated that Resident #119's cognition was intact. Further review of the MDS reflected that the resident did not have any PU and that a formal assessment instrument/tool (e.g., Braden, [NAME], or other) was used to determine the pressure ulcer/injury risk.<br><br>A review of Resident #17's February 2026 electronic Treatment Administration Record (eTAR) included the following PO:<br><br>-Silvadene Cream 1 % , Apply to b/L (bilateral) buttocks topically every day shift for Stage 2 pressure injury for 14 Days Cleanse affected area with skin itegrity. Pat dry. Apply Silvadene Cream 1 %. Cover with clean, dry dressing once daily with a start date of 2/13/26.<br><br>A review of Resident #17's hybrid medical record (MR) did not include any documented evidence that a Braden Scale assessment was done on admission. A review of Resident #17's clinical admission did not include a Braden Scale assessment.<br><br>A review of Resident #17's PN did not include any documentation of when the new skin impairment was discovered and there were no descriptions or measurements of the new skin impairment.<br><br>A review of Resident #17's wound consultant notes included that on 2/18/26, an initial exam of a Stage 3 PI (Pressure Injury) to the sacrum which measured 5.5 x 9.5 x 0.3 cm was done. Further review reflected that Resident #17 was also seen by the wound consultant on 2/25/26 and 3/4/26.<br><br>Further review of Resident #17's PN reflected that on 2/14/26, 2/20/26, 2/22/26 and 2/23/26, the nurse documented there were no skin issues identified even though the resident had received a wound treatment since 2/13/26 and was seen by the wound consultant since 2/18/26.<br><br>A review of Resident #17's individualized CP included the following: Resident #17 has potential impairment to skin integrity r/t decline in mobility and weakness with an initiated date of 1/27/26. Further review of the CP did not include an actual impairment to the skin.<br><br>On 3/4/26 at 9:38 AM, S #2 interviewed the Registered Nurse (RN) who stated that a skin assessment and wound care by consultant was done every Wednesday. The RN stated that if a Certified Nursing Assistant (CNA) found a new impairment that the nurse would assess it and notify the doctor for a treatment. She added that it should be documented and that she thought an incident report was done. The RN stated that she did not do the CP that the unit manager would update it. She added that a Braden scale was part of the clinical admission.<br><br>On 3/4/26 at 10:29 AM, S #2 asked the LNHA for any incidents or investigations that were done for Resident #17.<br><br>On 3/4/26 at 12:39 PM, the LNHA provided one incident report which was for a fall. The LNHA stated<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | that there were no other incident reports for Resident #17. The LNHA did not provide an incident report or investigation for Resident #17's facility acquired PU.<br><br>On 3/4/26 at 1244 PM, S #2 observed Resident #17 seated in a w/c. Resident #17 stated that the PU happened here when they were unable to get out of bed. Resident #17 stated that the PU was getting better and that they were leaving [the facility] tomorrow morning.<br><br>On 3/4/26 at 1:11 PM S #2 interviewed Certified Nursing Assistant #2 (CNA #2) who stated that when Resident #17 first came to the facility that the resident was not doing much because they were in terrible pain and that now was getting up and doing much better. CNA #2 stated that Resident #17 had a sore on their backside that the nurse was doing a treatment.<br><br>On 3/4/26 at 1:16 PM, S #2 interviewed the 2nd floor Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that on admission a clinical admission was done in the computer and a complete head to toe skin check was done to check for any wounds. She added that a weekly skin assessment was done as an order in the computer. S #2 asked the LPN/UM if a Braden Scale assessment was done on admission. The LPN/UM stated that they did not do one and that it was not part of the clinical admission. The LPN/UM stated that if a resident had a new impairment, then the nurse would assess the wound, notify the physician for a treatment and have wound care team to see them. She added that the nurse would write a PN that described the wound and included measurements. The LPN/UM stated that the CP would be updated to an actual impairment.<br><br>On 3/4/26 at 1:29 PM, S #2 asked the LPN/UM if an incident report or investigation was done to determine the cause if a new impairment was found, and she stated yes.<br><br>On 3/4/26 at 1:36 PM, S #2 interviewed the DON who stated that on admission a skin check was part of the assessment which included a drawing. The DON stated that the Braden Scale was not part of the assessment and that they used to do it on paper prior to the new computer system. The DON stated that if a new impairment was identified that they just started about two months ago doing an incident report and investigation and that the CP should be updated with the change. The DON stated that a PN would be done with the new impairment. S #2 notified the DON that Resident #17's hybrid medical record did not include a Braden Scale assessment, a PN with their new impairment and an updated CP. new open called doctor new treatment. S #2 also notified the DON that the LNHA did not provide the surveyor an incident report for Resident #17's new impairment.<br><br>On 3/5/26 at 10:16 AM, the DON stated that the CNA found the new impairment and notified the nurse and an order for silvadene was obtained on 2/13/26. The DON confirmed that there was not a PN with the new impairment and that there should have been one with the measurement. The DON stated that the resident was seen by the wound doctor on 2/18/26. The DON stated that they were still working on the new computer system to include the Braden Scale. The DON stated that the CP should have been updated. S #2 asked the DON if the documentation on the skilled evaluations that were after 2/13/26 should have had no skin issue identified. The DON stated that the nurse that wrote that was on the 3-11 shift and was not the staff that was doing the treatment.<br><br>On 3/6/26 at 12:42 PM, S #2 notified the LNHA and DON, the concern that Resident #17 did not have the following: a Braden Scale Assessment, documentation of a newly identified PU (PN and an incident report with investigation), an updated CP with an actual impairment and inaccurate documentation in the PN.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/9/26 at 12:44 PM, in the presence of the LNHA, the DON stated that they revised the policy to make sure a clinical assessment and formal assessment, an incident report and a CP were done.<br><br>The LNHA did not provide any additional information.<br><br>4. On 3/5/26 at 10:23 AM, Surveyor #3 (S #3) reviewed the medical records of Resident #131 and revealed:<br><br>A review of the UTF, revealed, Resident #131 was transferred from the hospital to the facility on 1/2/26, with stage 2 PU in the coccyx measurement was 4 x 2 cm, and with moisture damage (MASD) to b/l groin.<br><br>A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease unspecified, and chronic ischemic heart disease unspecified.<br><br>A review of the Discharge Return Not Anticipated MDS (DRNAMDS) with an ARD of 1/5/26, revealed in Section M that Resident #131 had a PU, a scar over bony prominence, or a non-removable dressing/device=was coded, a formal assessment instrument/tool (e.g., Braden, [NAME], or other) was coded yes, and unhealed PU was coded yes. The assessment indicated that the resident had Stage 3 PU and MASD (moisture associated skin damage) that was present upon admission.<br><br>A review of the PN, with an effective date of 1/2/26 at 10:50 PM, that was electronically signed by the Registered Nurse (RN), Resident #131 arrived at 5:30 PM via w/c from the hospital, skin assessment noted Stage 3 MASD to groin and perennial area.<br><br>A review of the PN, with an effective date of 1/4/26 at 7:02 PM, that was electronically signed by the RN, under skin assessment, skin issue type: Moisture associated skin damage (MASD). MASD: Other Moisture Associated Damage. Wound was present on admission.<br><br>A review of the Assessment tab in the electronic medical record, with an admission date of 1/5/26 and was locked on 1/16/26. Under Nursing Services, answer each question with information provided by resident, transfer papers, Resident Representative in admission and readmission to the facility. Once complete, Save/Sign and Lock the tool. B. Safety/Risk. B1. Does the resident have impaired skin integrity at admission, was answered No.<br><br>Further review of the Assessment tab revealed that there was no formal assessment/tool was done, no Braden scale (a widely used, evidence-based tool for assessing a patient's risk of developing PU) as indicated in the DRNA MDS with ARD of 1/5/26.<br><br>A review of January 2026 Orders, eMAR, and eTAR revealed the following PO:<br><br>-Silvadene External Cream 1 %, apply to coccyx topically every day and evening shift for PU for 14 Days after cleansing with NS, pat dry, cover with dry dressing-Start Date 1/3/26. [plotted day and evening and signed by nurses as administered]<br><br>-Zinc Oxide External Ointment 20 %, apply to bilateral buttock & sacrum topically every shift for Moisture Dermatitis for 14 Days apply post hygienic care-Start Date 1/2/26. [plotted day, evening, and night; signed by nurses as administered]<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the CP revealed that there was no CP initiated with regard to Resident #131's coccyx PU and MASD.<br><br>On 3/5/26 at 12:12 PM, S #3 interviewed the LPN/UM who informed S #3 that it was the RN/MDSC who was responsible for baseline CP, reviewing, and updating the CP.<br><br>On that same date and time, the LPN/UM stated that she and the nurses were responsible for reviewing the UTF including medication list from the hospital.<br><br>On 3/5/26 at 12:13 PM, S #3 notified the Registered Nurse/MDS Coordinator (RN/MDSC) of the concern that Resident #131's MDS with an ARD of 1/5/26 was coded for Stage 3 present on admission when there was no treatment order for stage 3, the UTF was stage 2 coccyx, and MASD b/l groin.<br><br>On 3/6/26 at 12:21 PM, the survey team met with the LNHA and the DON, and S #3 notified them of the above findings and concerns with regard to Residents #131's MDS, discrepancy with the PN regarding presence of stage 2 and stage 3 PU, assessment, CP, and no Braden scale.<br><br>A review of the undated facility's Comprehensive Assessments and the Care Delivery Process Policy that was provided by the LNHA, revealed under policy statement, comprehensive assessments will be conducted to assist in developing person-centered CP. Policy Interpretation and Implementation: comprehensive assessment, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions.Comprehensive assessments are conducted and coordinated by an RN with appropriate participation of other health professionals.<br><br>A review of the facility's Wound Care & Pressure Injury Management Policy that was provided by the LNHA, revealed under policy, that the facility to provide comprehensive assessment, prevention, and treatment of wounds and pressure injuries for all residents in accordance with current clinical standards and regulatory requirements.Procedure: 1. Risk Assessment, residents will be assessed for pressure injury risk using a validated tool such as the Braden Scale upon admission, quarterly, and with significant change in condition. Any new skin issue will be documented and evaluated by the licensed nurse. #10 Documentation, All wound assessments and treatments will be documented in the resident's medical record following completion .<br><br>A review of the undated facility's Special Skin Care Policy revealed, A pressure injury is a break in the skin and underlying tissue due to pressure or friction .Under Preventative Measures revealed, Repot and chart symptoms of pressure sores .A review of the facility's Incidents and Accidents Policy dated 4/2023, revealed under Compliance Guidelines #2. Licensed staff to report incidents/accidents and assist with completion of any investigative information to identify root causes . #5. The following incidents/accidents require an .report but not limited to: Pressure injuries/ulcers. #13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions<br><br>A review of the facility's Hand Hygiene Policy dated 2/2018, revealed under Purpose, Hand hygiene is the single most important strategy to reduce the risk of transmitting organisms from one person to another or from one site to another on the same patient . Under B. Indications for Hand-rubbing revealed .an alcohol-based hand rub may be used for routinely decontaminating hands in the following clinical situations: When moving from a contaminated body site to a clean body site during patient<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | care. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. After removing gloves .<br><br>On 3/9/26 at 12:37 PM, the survey team met with the LNHA and the DON who stated that the CP would be part of QAPI the Lead MDSC will be responsible to do CP and update/revise CP because for long time, the 2nd floor Unit Manager was an LPN and CP was not her responsibility.<br><br>NJAC 8:39-11.2(i);19.4(l)(n); 25.2(c); 27.1(a)(e) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure that residents that received oxygen (O2), and nebulizer treatments received the necessary respiratory care and services, according to the standard of clinical practice, specifically that respiratory equipment were stored in accordance with infection control measures and develop an individualized care plan for 4 of 4 residents reviewed for respiratory care (Resident #5, #76, #119 and #130). This deficient practice was evidenced by the following:<br><br>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.<br><br>1.On 3/3/26 at 10:30 AM, Surveyor #1 (S #1) observed Resident #5 in room [ROOM NUMBER]A lying in bed. Enhanced Barrier Precautions signage was observed on the door and personal protective equipment was hanging on the back of the door.<br><br>At that same time, S #1 observed an O2 concentrator administering O2 via nasal cannula (n/c). The O2 concentrator was observed set at 6 liters per minute (lpm). The n/c was not properly positioned in the resident's nares and was resting on the resident's cheek. S #1 further observed that the O2 tubing and humidifier were not dated.<br><br>S #1 interviewed the resident who reported no concerns regarding care.<br><br>At that same time, S #1 asked the Registered Nurse/Infection Preventionist (RN/IP) to accompany S #1 to the resident's room. The RN/IP confirmed S #1's findings that the O2 concentrator was set at 6 lpm, the n/c was not properly positioned in the resident's nares, and the O2 tubing and humidifier were not dated. The RN/IP stated that she would address the concerns immediately. S #1 observed the RN/IP repositioned the n/c into the resident's nares and replaced the O2 tubing and humidifier with equipment that was properly dated.<br><br>On 3/4/26 at 11:10 AM, S #1 again observed Resident #5 in bed in his room. The O2 concentrator was observed set at 4 lpm via n/c, and the n/c was properly positioned in the resident's nares. The O2 tubing was observed dated.<br><br>S #1 located the Director of Nursing (DON), who accompanied S #1 to the resident's room and confirmed that the O2 concentrator had previously been set at 6 lpm rather than the physician ordered 4 lpm.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | S #1 reviewed the resident's medical record.<br><br>A review of the physician orders (PO) revealed an active PO dated 2/21/26 for O2 at 4 lpm via n/c continuously every shift for COPD.<br><br>A review of the PO also revealed an order dated 2/22/26, to change O2 tubing once weekly on night shift every Sunday.<br><br>A review of the resident's Minimum Data Set (MDS) revealed the assessment triggered for O2 therapy.<br><br>A review of the resident's care plan (CP) revealed an intervention that included O2 at 4 lpm via n/c continuously every shift for COPD.<br><br>2. On 3/3/26 at 10:49 AM, Surveyor #2 (S #2) observed Resident #76 seated in a wheelchair (wc) in their room. The resident was not receiving O2. S #1 observed that there was an O2 concentrator in the corner of the room and that a n/c was attached to the concentrator and the other end of the tubing with the nasal prongs was laid over the call bell cord. Resident #76 stated that they did not use the O2 since Saturday (2/28/26). The n/c was not stored in a bag.<br><br>A review of Resident #76's admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to asthma (a chronic, often lifelong, lung disease characterized by inflamed, narrow airways that produce excess mucus, causing wheezing, breathlessness, chest tightness, and coughing) and chronic obstructive pulmonary disease (COPD, a progressive, incurable lung disease that causes severe breathing problems due to damaged airways and trapped air).<br><br>A review of Resident #76's most recent admission Minimum Data Set (aMDS), with an Assessment Reference Date (ARD) of 2/23/26, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that Resident #76's cognition was mildly impaired.<br><br>On 3/4/26 at 9:25 AM, S #2 observed Resident #76 seated in a wc in their room. S #1 observed that the n/c was still attached to the concentrator and that the other end of the tubing with the nasal prongs was laid over the top of the concentrator. The n/c was not stored in a bag.<br><br>On 3/4/26 at 9:28 AM, S #2 interviewed the Registered Nurse (RN) who stated that when the n/c was not in use it was stored in a bag.<br><br>On 3/4/26 at 9:36 AM, S #1 asked the RN to observe Resident #76's O2 concentrator. The RN confirmed that the O2 tubing was placed over the concentrator and was not appropriately stored. She confirmed that it was dated 2/26/26.<br><br>On 3/4/26 at 9:45 AM, S #1 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the O2 n/c was usually changed weekly on 11-7 shift and that when not in use should be placed in a plastic bag or blue pouch when not in use.<br><br>On 3/6/26 at 12:41 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and DON, the concern that Resident #76's O2 tubing was not stored in a bag on two separate days.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. On 3/3/26 at 10:47 AM, S #2 observed Resident #119 sitting up in bed receiving O2 at 3 lpm via n/c. S #1 observed an open dresser drawer which had a nebulizer (neb) treatment machine in the drawer. Attached to the machine was Resident #119's neb treatment mask which was laid on top of a plastic bag in the drawer that was open. The mask was not stored in a plastic bag.<br><br>A review of Resident #119's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to asthma and COPD.<br><br>A review of Resident #119's most recent quarterly MDS (qMDS), with an ARD of 2/12/26, reflected that the resident had a BIMS score of 12 out of 15, which indicated that Resident #119's cognition was moderately impaired.<br><br>On 3/4/26 at 9:28 AM, S #2 interviewed the RN who stated that neb mask should be stored in a bag.<br><br>On 3/4/26 at 9:45 AM, S #2 interviewed the LPN/UM who stated that the neb mask should be stored in a bag.<br><br>On 3/6/26 at 12:42 PM, S #2 notified the LNHA and DON, the concern that Resident #119's neb mask was not stored correctly in a bag.<br><br>On 3/9/26 at 12:45 PM, in the presence of the LNHA, the DON stated that the staff were inserviced on storing respiratory equipment.<br><br>The LNHA did not provide any additional information.<br><br>4. Surveyor #3 (S #3) reviewed the medical records of Resident #130 and revealed:<br><br>A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; moderate protein calorie malnutrition, major depressive disorder recurrent unspecified, and Alzheimer's disease unspecified.<br><br>A review of the November and December 2025 Order Summary Report (OSR) revealed a PO as follows:<br><br>Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/3 ml (milligram/milliliters), 3 ml inhale orally via nebulizer (neb) every 6 hours for shortness of breath (SOB)-Start Date 10/28/25-D/C (discontinue) Date12/19/25.<br><br>Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/3 ml, 3 ml inhale orally via neb every 2 hours as needed (PRN) for SOB-Start Date 10/27/25-D/C Date12/19/25.<br><br>O2 at 2L/min (liters/minute) via n/c every shift-Start Date 10/28/25-D/C Date12/19/25.<br><br>Further review of the above PO revealed that there was no order for when to change O2 n/c and neb tubing.<br><br>A review of the CP revealed that there was no CP about use of O2, neb, and care for respiratory equipment.<br><br>A review of the Significant Change in Status MDS with an ARD of 11/18/25, revealed under Section<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | C-Cognitive Patterns, Cognitive Skills for Daily Decision Making was coded as 3, severely impaired.<br><br>On 3/6/26 at 12:21 PM, the survey team met with the LNHA and the DON, and S #3 notified them of the above findings and concerns with regard Residents #130's O2 and neb.<br><br>A review of the undated facility's Oxygen Therapy Policy that was provided by the LNHA, revealed under Guidelines for use and care of O2, pre-filled humidifier must be dated and initialed. O2 tubing changed every seven days. Date when changed.Department: Nursing, revealed the following: Under Policy, the policy indicated, O2 therapy is administered only as ordered by a physician .The PO will specify the rate of O2 flow .<br><br>A review of the undated Nebulizer Therapy Policy that was provided by the LNHA, revealed under Care of the equipment, 8. Change neb tubing every 72 hours or per facility policy.<br><br>On 3/9/26 at 12:37 PM, the survey team met with the LNHA and the DON who stated that they hired an MDS Lead to ensure MDS were done accordingly including the CP.<br><br>No further information was provided by the LNHA.<br><br>NJAC 8:39-25.2(a)(3)(6); 27.1(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure 3 of 22 residents (Residents #1, #10, and #96) call bells were within reach and able to use to accommodate residents' needs.This deficient practice was evidenced by the following:On 3/3/26 at 10:09 AM, during an initial tour of the facility, the surveyor observed Resident #10, seated in a chair, with the call bell device wrapped around a siderail, and hung down past the bed between the bed and the wall. On that same day at 10:31 AM, the surveyor observed Resident #96, in bed with a breakfast tray. The surveyor observed the call bell device hung off the bed near the floor. The surveyor asked the resident how they call for help if they need it, and the resident stated that they use the button, and someone comes. While the surveyor was in the resident's room, a Certified Nurse Aide (CNA) from an outside provider and assigned to Resident #96 entered the room and greeted the resident. The CNA took the call bell and placed it on the resident's bed where it was within reach.On the same day at 11:21 AM, the surveyor observed Resident #1 in bed, asleep. The surveyor observed the call bell device hung off the back of the bed, just above the floor. On 3/4/26 at 10:58 AM, the surveyor observed Resident #10 in bed, with the call bell device hung in the same way it was on 3/3/26.On the same day at 11:00 AM, the surveyor observed Resident #1 in bed, with the call bell device hung in the same way it was on 3/3/26.On 3/4/26 at 11:18 AM, the surveyor in the presence of the Registered Nurse/Unit Manager (RN/UM) for the 1st floor observed the call bell for Resident #10, and the RN/UM adjusted the call bell, so it was on the bed.At 11:20 AM, the surveyor in the presence of the RN/UM observed the call bell for Resident #1, and the RN/UM adjusted the call bell, so it was next to the resident. The RN/UM stated that Resident #1 may not be alert enough to use it. The RN/UM also stated that they would inform the staff to look closer at the call bells, and be sure the residents can reach them.The surveyor reviewed the electronic medical record (EMR) for Resident #1 which revealed the following:A review of the admission Record (AR; an admission summary) that reflected that the resident had diagnoses of but not limited to, osteomyelitis (an infection and inflammation of the bone) and epilepsy (a brain condition that causes recurring seizures).A review of Resident #1's quarterly minimum data set (qMDS), an assessment tool, with an assessment reference date (ARD) of 1/15/26, reflected that the resident had a brief interview for mental status (BIMS) that could not be obtained due to the resident's severe cognitive impairment.The surveyor reviewed the EMR for Resident #10 which revealed the following:A review of the AR that reflected that the resident had diagnoses of but not limited to, essential hypertension (high blood pressure) and difficulty walking.A review of Resident #10's qMDS, with an ARD of 12/8/25, reflected that the resident had a BIMS score of 0 out of 15, which indicated the resident had severe cognitive impairment.The surveyor reviewed the EMR for Resident #96 which revealed the following:A review of the AR that reflected that the resident had diagnoses of but not limited to; essential hypertension and chronic kidney disease, stage 4 (a condition when the kidneys are moderately or severely damaged and are not properly filtering waste from your blood).A review of Resident #96's qMDS, with an ARD of 12/8/25, reflected that the resident had a BIMS score of 12 out of 15 which indicated the resident had moderate cognitive impairment.On 3/6/26 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified the LNHA and DON of the concerns with call bell placement and accessibility.On 3/9/26 at12:37 PM, the survey team met with the LNHA and the DON stated that the staff was educated on proper placement of the call bells, and an audit was done.The LNHA did not provide any further pertinent information.A review of the undated facility's Call Bell: Accessibility & Timely Response Policy, reflected under 5. Staff will ensure the call light is within reach of resident and secured, as needed. NJAC 8:39-27.1(a); 29.2(d); 31.8(c)(9) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure that a Significant Change in Status Assessment (SCSA) was completed for 2 of 25 residents, (Residents #1 and #130), reviewed for Minimum Data Set (MDS).This deficient practice was evidenced by the following:According to the CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, updated October 2025 showed:An SCSA must be completed within 14 days of determining a significant change from baseline.The resident's condition is not expected to return to baseline within two weeks.Comparison with the most recent comprehensive and quarterly assessments is crucial.Criteria for SCSA include two areas of decline or improvement, or IDT (Interdisciplinary team) recommendation.Documentation of criteria met is essential in the resident's medical record.Required for various scenarios like hospice enrollment, a consistent pattern of changes, etc.1.On 3/6/26 at 8:04 AM, the Surveyor reviewed the medical records of Resident #1 and revealed:A review of the admission Record (AR; an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; type 2 diabetes mellitus without complications, other seizures, dementia in other diseases classified elsewhere, unspecified severity, and difficulty in walking, not elsewhere classified.A review of the Misc (miscellaneous) tab in electronic medical records revealed a Visit Report dated 10/15/25, a wound visit notes, that the sacrum wound measurement was 2 x 3.5 x 0.2 cm (centimeter) and was a stage 3 (unhealed).A review of the weight records revealed, on 10/15/2025, Resident #1's weight was 117.2 pounds (lbs), with 7.5% change [Comparison Weight 7/21/2025, 128.2 lbs, -8.6% , -11.0 lbs]-10.0% change [Comparison Weight 5/8/2025, 133.5 lbs, -12.2% , -16.3 lbs].A review of the annual MDS (aMDS) with an assessment reference date (ARD) of 10/15/25, revealed in Section C Cognitive Patterns that resident's cognitive skills for daily decision making was coded as 3, severely impaired. Section K: Nutrition reflected that the resident's weight was 117 lbs, with a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, was coded 2, which reflected yes, not on prescribed physician-prescribed weight-loss regimen.Further review of the above aMDS revealed under Section M-Skin Conditions, Resident #1 had a stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone tendon or muscle is not exposed. Slough may be present but not obscure the depth of tissue loss. May include undermining and tunneling), which was not present upon admission (facility acquired wound).A review of the quarterly MDS (qMDS) with an ARD of 7/15/25, revealed that Resident #1 had a weight loss and no facility acquired wounds.There was no documented evidence that a SCSA was done to reflect the two areas of decline of Resident #1 according to the RAI Manual.On 3/6/26 at 9:03 AM, the Surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC), who informed the surveyor that the facility followed RAI manual for MDS. She also stated that SCSA should have been done if there were two or more improvement and/or decline in resident's status. The surveyor notified the RN/MDSC of the above findings and concerns, and she responded that she would get back to the surveyor.2. The surveyor reviewed the medical records of Resident #130 and revealed:A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; moderate protein calorie malnutrition, major depressive disorder recurrent unspecified, and Alzheimer's disease unspecified.A review of the November 2025 Order Summary Report revealed a physician order dated 11/5/25, resident admitted [name] to hospice care.A review of the Care Plan with a focus that Resident #130 was under the care of hospice, date initiated 11/5/25A review of the SCSA with an ARD of 11/18/25, revealed under Section O-Special Treatments, Procedures, and Programs, hospice was not checked off to indicate that the resident was on hospice.On 3/4/26 at 2:29 PM, the RN/MDSC informed the Surveyor that the SCSA, if a resident was admitted for hospice, usually between 11 and 13 days that she would do the assessment. She also stated that we follow the RAI manual for doing MDS for SCSA<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | when resident was enrolled to hospice.At that same time, the surveyor notified the above findings and concerns that the SCSA on 11/18/25 did not reflect that the resident was on hospice care. The RN/MDSC responded that she was not familiar with the resident, and she would have to check. On 3/4/26 at 2:41 PM, the RN/MDSC informed the surveyor that she looked at the MDS that was discussed, it was the per diem MDS person who did the MDS, the hospice should have been checked off for ARD 11/18/25, and the MDS was modified after surveyor's inquiry.On 3/6/26 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns with regard Residents #1 and #130's MDS's.A review of the undated facility's Assessment Frequency/Timeliness Policy that was provided by the LNHA, revealed under policy, the purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual.Policy Explanation and Compliance Guidelines: 3. Within 14 days after the facility determines or should have determines there has been significant change in the resident's physical or mental condition, a significant change in status assessment will be completed.On 3/9/26 at 12:37 PM, the survey team met with the LNHA and the DON who stated that they did all the modifications for MDS and the facility had hired an MDS Lead to ensure MDS were done accordingly.NJAC 8:39-11.2(i) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on interviews and record review, it was determined that the facility failed to transmit the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within 14 days as required, for 2 of 25 residents, (Residents #1 and #131), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following:According to the CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, updated October 2025, revealed:The Entry tracking record, the transmission date no later than entry date + 14 calendar days.The Discharge Return Not Anticipated (DRNA), the transmission date no later than the MDS completion date + 14 calendar days.1. The Surveyor reviewed the medical records of the following residents and their MDS and revealed:A review of Resident #1's Entry MDS with an assessment reference date (ARD) of 12/26/25, was completed on 1/2/26, and transmitted on 1/10/26. The transmission date was two days late.A review of Resident #131's DRNA MDS with an ARD of 1/5/26, was completed on 1/19/26, and was transmitted on 2/6/26. The transmission date was nine days late.On 3/6/26 at 9:03 AM, the Surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC), who informed the Surveyor that she followed the RAI Manual for completing and transmitting MDS. She also stated that if the resident was under Medicare, I tried to hold off the transmission for five days, especially if the Resident would be coming back to the facility. The Surveyor asked how long you transmit discharge MDS, and she responded within 14 days.At that same time, the Surveyor notified the above concerns with Resident #1 and Resident #131's late transmission of MDS. She also confirmed that if the MDS was in red, it meant the MDS was late. She acknowledged that the two residents' MDSs were in red, and they were late.On 3/6/26 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns with regard Residents #1 and #131's MDS's.A review of the undated facility's Assessment Frequency/Timeliness Policy that was provided by the LNHA, revealed under policy, the purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual.Further review of the above policy did not include information on when the assessments should have been transmitted.On 3/9/26 at 12:37 PM, the survey team met with the LNHA and the DON who stated that they did all the modifications for MDS and the facility had hired an MDS Lead to ensure MDS were done accordingly.NJAC 8:39 - 11.1 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 5 of 25 residents, (Residents #1, #4, #119, #131, and #133), reviewed for MDS accuracy.This deficient practice was evidenced by the following:<br><br>1.On 3/6/26 at 8:04 AM, Surveyor #1 (S #1) reviewed the medical records of Resident #1 and revealed:<br><br>A review of the admission Record (AR; an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; type 2 diabetes mellitus without complications, other seizures, dementia in other diseases classified elsewhere, unspecified severity, and difficulty in walking, not elsewhere classified.<br><br>A review of the Misc (miscellaneous) tab in electronic medical records revealed a Visit Report dated 10/15/25, a wound visit notes that the sacrum wound measurement was 2 x 3.5 x 0.2 cm (centimeter) and was a stage 3 (not healed).<br><br>A review of the Misc tab revealed Visit Report dated 1/14/26, a wound visit note that the sacrum wound measurement was 2 x 0.5 x 0.3 cm and was stage 3 (not healed).<br><br>A review of the annual MDS (aMDS) with an assessment reference date (ARD) of 10/15/25, revealed in Section C Cognitive Patterns that resident's cognitive skills for daily decision making was coded as 3, severely impaired. Section M-Skin Conditions revealed that Resident #1 had a stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone tendon or muscle is not exposed. Slough may be present but not obscure the depth of tissue loss. May include undermining and tunneling), which was not present upon admission (facility acquired wound).<br><br>A review of the Discharge Return Anticipated MDS (DRAMDS) with an ARD of 12/23/25, revealed that Resident #1 had a stage 3 pressure ulcer (PU) that was not present upon admission.<br><br>A review of the quarterly MDS (qMDS) with an ARD of 1/15/26, revealed that the resident had a stage 3 PU that was present upon admission. Section N-Medications revealed that the resident did not receive insulin injections during the lookback period.<br><br>A review of the December 2025 Order Summary Report (OSR) revealed that the resident had treatment order for Silvadene External Cream 1 %, apply to sacrum topically every day shift for PU for 14 Days, with a start date of 12/19/25.<br><br>A review of the January 2026 OSR revealed that the resident had a Humalog KwikPen Solution Pen-injector 100 unit/ml (milliliters), inject as per sliding scale: if 0 - 150 = 0 units call MD (Medical Doctor) for blood sugar less than 50; 151 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 -400 = 5 units; 401+ = 7 units call MD for blood sugar above 400, subcutaneously before meals and at bedtime for diabetes. This was transcribed to the electronic Medication Administration Record (eMAR) and signed as administered by nurses.<br><br>Further review of the January 2026 OSR revealed and order for Silvadene External Cream 1 %, apply to sacrum topically every day shift for PU for 14 Days after cleansing with saline and cover with dry<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dressing, with a start date of 1/14/26.<br><br>A review of the qMDS with an ARD of 1/15/26 and January 2026 OSR and eMAR, revealed that the insulin injections were not coded in Section N of the MDS.<br><br>Further review of the DRAMDS with an ARD of 12/23/25 and the qMDS with an ARD of 1/15/26, revealed, stage 3 PU was coded inaccurately.<br><br>On 3/6/26 at 9:03 AM, S #1 interviewed the Registered Nurse/MDS Coordinator (RN/MDSC), who informed S #1 that the facility followed RAI manual for MDS. S #1 notified the RN/MDSC of the above findings and concerns with regard to accuracy of MDS of Resident #1, and she responded that she would get back to S #1.<br><br>2. On 3/5/26 at 10:23 AM, S #1 reviewed the medical records of Resident #131 and revealed:<br><br>A review of the UTF (Universal Transfer Form), revealed, Resident #131 was transferred from the hospital to the facility on 1/2/26, with stage 2 PU in the coccyx measurement was 4 x 2 cm, and with moisture damage (MASD) to bilateral groin.<br><br>A review of the AR reflected that the resident was admitted with diagnoses that included but were not limited to; type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease unspecified, and chronic ischemic heart disease unspecified.<br><br>A review of the Discharge Return Not Anticipated MDS (DRNAMDS) with an ARD of 1/5/26, revealed in Section M that Resident #131 had Stage 3 PU and MASD (moisture associated skin damage) that was present upon admission.<br><br>A review of the Progress Notes (PN), with an effective date of 1/2/26 at 10:50 PM, that was electronically signed by Registered Nurse #1 (RN #1), Resident #131 arrived at 5:30 PM via wheelchair from the hospital, skin assessment noted Stage 3 MASD to Groin and perennial area.<br><br>A review of the PN, with an effective date of 1/4/26 at 7:02 PM, that was electronically signed by RN #1, under skin assessment, skin issue type: Moisture associated skin damage (MASD). MASD: Other Moisture Associated Damage. Wound was present on admission.<br><br>A review of the Assessment tab in the electronic medical record, with an admission date of 1/5/26 and was locked on 1/16/26. Under Nursing Services, answer each question with information provided by resident, transfer papers, Resident Representative in admission and readmission to the facility. Once complete, Save/Sign and Lock the tool. B. Safety/Risk. B1. Does the resident have impaired skin integrity at admission, was answered No.<br><br>A review of January 2026 Orders, eMAR, and electronic Treatment Administration Record (eTAR) revealed the following orders:<br><br>-Silvadene External Cream 1 %, apply to coccyx topically every day and evening shift for PU for 14 Days after cleansing with NS (normal saline), pat dry, cover with dry dressing-Start Date 1/3/26. [plotted day and evening and signed by nurses as administered]<br><br>-Zinc Oxide External Ointment 20 %, apply to bilateral buttock & sacrum topically every shift for<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Moisture Dermatitis for 14 Days apply post hygienic care-Start Date 1/2/26. [plotted day, evening, and night; signed by nurses as administered]<br><br>On 3/5/26 at 12:13 PM, the RN/MDSC informed S #1 that she reviewed resident's medical records when answering Section M and also look for the wound reports. S #1 notified the RN/MDSC of the concern that Resident #131's MDS for ARD 1/5/26 was coded for stage 3 present on admission when there was no treatment order for stage 3, the UTF was stage 2 coccyx and MASD bilateral groin. S #1 asked the RN/MDSC if she considered that accurate assessment if the assessments and PN did not match, and she stated that she would get back to the surveyor.<br><br>On 3/5/26 at 12:37 PM, the RN/MDSC acknowledged that the note was confusing because MASD should not have a stage and probably the nurse forgot to put a comma between the Stage 3 and MASD. S #1 then asked which one was stage 3 and she did not respond. The RN/MDSC further stated that at the time of assessment, she did not see the UTF and hospital records that was why she did not see stage 2. S #1 then asked the RN/MDSC if she still considered the MDS accurate for coding it as stage 3, and she stated that she relied on the notes.<br><br>On 3/6/26 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and S #1 notified them of the above findings and concerns with regard to Residents 1 and #131's MDS's.<br><br>On 3/9/26 at 12:37 PM, the survey team met with the LNHA and the DON who stated that they did all the modifications for MDS and the facility had hired an MDS Lead to ensure MDS were done accordingly.<br><br>3. Surveyor #2 (S #2) reviewed the medical records of Resident #4 which revealed:<br><br>A review of the AR reflected that the resident was admitted to the facility with diagnoses which included but not limited to unspecified dementia (when a patient exhibits clear symptoms of cognitive decline of unknown cause) and dysphagia (difficulty swallowing).<br><br>A review of the comprehensive MDS (cMDS) with an ARD of 1/22/26, revealed in Section H, Bladder and Bowel, that Resident #4 did not have a urinary catheter (a device or tube either internal or external that aids the body in voiding urine from the bladder).<br><br>A review of the PN with an effective date of 1/16/26 at 10:05 PM, that was electronically signed by RN #2, reflected Hospice Note and FC (foley catheter) intact.<br><br>A PN with an effective date of 1/16/26 at 7:58 AM, that was electronically signed by RN #2, reflected Foley intact and patent draining yellow output.<br><br>A review of January 2026 eTAR revealed the following order:<br><br>Enhanced Barrier Precautions every shift for FC -Start Date-1/20/26. The eTAR reflected that this order was electronically signed as carried out for the dates of 1/20/26 through 1/31/26 inclusive, for three shifts.<br><br>A Psychiatric Consult, dated 1/15/26, which reflected, .currently had a FC in place .<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | S #2 reviewed the medical records of Resident #133 which revealed:<br><br>A review of the AR reflected that the resident was admitted to the facility with diagnoses which included but not limited to hypertension (high blood pressure) and asthma (a chronic, lifelong inflammatory disease of the airways).<br><br>A review of the Medicare 5-day MDS, ARD of 12/28/25, revealed in Section H, that Resident #133 did not have a urinary catheter.<br><br>A PN with an effective date of 12/21/26 at 9:55 PM, reflected Foley intact and draining, 400 ml (milliliters) urine emptied.<br><br>A PM with an effective date of 12/23/25 at 4:00 PM, reflected Foley intact and patent out 600 ml.<br><br>A PN with an effective date of 12/24/25 at 7:40 AM, reflected Foley catheter intact and draining.<br><br>A PN with an effective date of 12/25/25 at 6:53 AM, reflected foley catheter intact, patent and draining. output 250 ml.<br><br>A PN with an effective date of 12/29/25 at 6:01 AM, reflected FC was removed at 6:00 AM.<br><br>On 3/6/26 at 9:17 AM, S#2 interviewed the RN/MDSC and informed them of Resident #4 and #133 not coded for a catheter but had a FC. The RN/MDSC stated that if a resident has FC on admission or any time within the look back period it should be coded as yes.<br><br>On 3/6/26 at 1:31 PM, the RN/MDSC stated that the FC for Resident #4 was outside of the lookback period.<br><br>On 3/9/26 at 12:37 PM, the survey team met with the LNHA and DON, S #2 notified the LNHA and DON of the concern with Residents #4 and #133 MDS coding for catheters, and that there were notes, an order, and a consultation that referenced Resident #4 with a Foley catheter during the lookback period.<br><br>4. On 3/3/26 at 10:47 AM, Surveyor #3 (S #3) observed Resident #119 sitting up in bed receiving oxygen (O2) at 3 lpm (liters per minute) via nasal cannula (n/c).<br><br>A review of Resident #119's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to asthma (a chronic, often lifelong, lung disease characterized by inflamed, narrow airways that produce excess mucus, causing wheezing, breathlessness, chest tightness, and coughing) and chronic obstructive pulmonary disease (COPD, a progressive, incurable lung disease that causes severe breathing problems due to damaged airways and trapped air).<br><br>A review of Resident #119's most recent qMDS, with an ARD of 2/12/26, reflected that the resident had a BIMS score of 12 out of 15, which indicated that Resident #119's cognition was moderately impaired. Further review of the MDS indicated under Section O that the resident was not receiving O2 services.<br><br>A review of Resident #119's February 2026 eTAR included the following order:<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | O2 at 3 L/min (liters/minute) via n/c every shift with a start date of 2/2/26. The order was administered each shift for the month.<br><br>On 3/6/26 at 9:35 AM, S #3 interviewed the RN/MDSC who stated that she reviewed the resident's eTAR to see if O2 was being used and then would put it on the MDS. She added that she would check Resident #119's eTAR to see if the resident utilized O2.<br><br>On 3/6/26 at 12:42 PM, S #3 notified the LNHA and DON, the concern that Resident #119's quarterly MDS was not coded accurately related to O2 services.<br><br>On 3/6/26 at 1:32 PM, the RN/MDSC stated that she was not the one that had done Resident #119's MDS and that it was done wrong. She added that she was going to modify it.<br><br>On 3/9/26 at 12:54 PM, in the presence of the LNHA, the DON stated that Resident #119's MDS was modified.<br><br>The LNHA did not provide any additional information.<br><br>N.J.A.C. 8:39-11.2, 33.2 (d) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure expired resident-use supplies were removed from medication (med) storage areas and med storage areas were maintained in accordance with professional standards of nursing practice. This deficient practice was identified in 2 of 2 med rooms reviewed for med storage and label review.The deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On [DATE] at 12:16 PM, during the med storage and label review task, the surveyor inspected the 2nd floor med room and observed three urinary leg drainage bags with a use before date of [DATE].At that same time, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) regarding the urinary leg drainage bags. The LPN/UM confirmed that the items were for resident use. The surveyor identified the urinary leg drainage bags as expired durable medical equipment (DME) supplies.On [DATE] at 12:16 PM, the surveyor inspected the 1st floor med room and observed seven toothpaste with an expiration date of [DATE].At that same time, the surveyor interviewed the Unit Manager, who confirmed that the items were for resident use.On [DATE] at 12:21 PM, the survey team met with the Director of Nursing (DON) and the LNHA, and the surveyor notified them of the above findings and concerns.NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure residents who received enteral feeding received care in accordance to standard of practice by failing to, a.) properly label enteral feeding equipment and b.) total volume was documented and order was clarified. This deficient practice was identified for 2 of 3 residents (Residents #5 and #11) reviewed for enteral feeding.This deficient practice was evidenced by the following:<br><br>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.<br><br>1.On 3/3/26 at 10:30 AM, Surveyor #1 (S #1) observed Resident #5 in their room lying in bed, with an Enhanced Barrier Precautions signage, and personal protective equipment was hung on the back of the door. S #1 observed enteral feeding formula being administered via pump. S #1 observed that the enteral feeding formula bag had no resident name or date labeled on the bag. The resident reported no concerns regarding care.<br><br>At that same time, S #1 located the Registered Nurse/Infection Preventionist (RN/IP) at the nursing station and requested that she accompany S #1 to the resident's room. The RN/IP confirmed S #1's findings that the enteral feeding formula bag had no resident name or date labeled on the bag and stated that she would address the concern immediately.<br><br>S #1 reviewed the resident's medical record.<br><br>A review of the physician orders (PO) revealed active orders dated 2/21/26, related to (r/t) enteral feeding which included flushing the feeding tube with 250 milliliters (mls) of water every four hours, flushing the G-tube with 30 mls of water before and after each medication (med) pass, flushing the G-tube with 10 mls of water between each med, checking tube placement before initiation of formula, med administration and flushing the tube, and elevating the head of the bed 45 degrees during feeding and for one hour after feeding.<br><br>A review of the resident's Minimum Data Set (MDS) revealed the assessment triggered for feeding tube.<br><br>A review of the facility's Labeling of Tubing & Lines Policy, Department: Nursing, revealed under policy, All resident care tubing and administration sets must be labeled with the date, time, and staff<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | initials when initiated or replaced .Under Enteral Feeding Tubing, Enteral feeding administration set must be labeled with date, time, and staff initial; Enteral feeding bags - every 24 hours .<br><br>2. On 3/3/26 at 10:40 AM, Surveyor #2 (S #2) observed Resident #11 seated up in bed receiving nutritional formula via a tube feeding pump (Pump designed to deliver formula through a tube placed in a stomach). S #2 observed that the container that the nutritional formula was in was not labeled with the formula or date and time it was started.<br><br>On 3/4/26 at 9:53 AM, S #2 observed Resident #11's nutritional formula's container was labeled with the formula and date and time it was started.<br><br>On 3/4/26 at 9:56 AM, S #2 interviewed the Registered Nurse (RN) who stated that Resident #11's tube feeding was started at 6:00 PM and that it should be labeled with what formula it was, time it was started and the initials of who hung it. She added that sometimes the resident's tube feeding was disconnected for the resident to go to the therapy department. The RN stated that the tube feeding was stopped when the resident received the amount ordered was infused. She added that if Resident #11 received the 1000 mls on her shift then she would disconnect the tubing. S #2 showed the RN the picture of Resident #11's tube feeding that was not labeled on 3/3/26. The RN stated that it should have a label and that she had endorsed to the nurse that had hung it to put a label.<br><br>On 3/4/26 at 10:07 AM, S #2 interviewed the 2nd floor Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the resident's name, room number, formula name, date and nurses initial should be on the label. S #2 showed the LPN/UM the picture of Resident #11's tube feeding that was not labeled. She stated that it should be labeled.<br><br>A review of Resident #11's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; gastrostomy (a procedure to create an opening in the stomach to insert a feeding tube (G-tube) for long-term nutritional support), cerebral infarction (also known as ischemic stroke, is a medical emergency caused by blocked blood flow to the brain, leading to tissue necrosis and oxygen deprivation) and type 2 diabetes mellitus (a chronic condition characterized by insulin resistance and relative insulin deficiency, leading to high blood sugar).<br><br>A review of Resident #11's most recent discharge return anticipated MDS reflected that the resident's cognitive skills for daily decision making was moderately impaired. In Section K (Swallowing/Nutritional Status), Resident #11 was coded as receiving nutrition through a feeding tube while a resident.<br><br>A review of Resident #11's March 2026 electronic Medication Administration Record (eMAR) included the following PO:<br><br>Enteral Feed Order in the evening Continuous Feeding: Jevity 1.5 cal (calorie) at 50 ml/hr (milliter/hour) , start at 6:00 PM and run for 20 hrs (hours) or until 1000 ml infused. Total volume (TV) of 1000 ml/day .with a start date of 2/26/26, and was plotted to be administered at 1800 (6:00 PM).<br><br>Stop the Feeding via PEG tube after 20 hrs or TV of 1000 ml is infused completely at 50 ml/hr rate in the afternoon with a start date of 2/26/26 which was plotted to be administered at 1300 (1:00 PM).<br><br>There was no documentation in the eMAR for how much TF TV was infused each shift. There was no documentation to indicate if the TF was stopped at 20 hours or if the TV infused was 1000 ml. The (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | order was not clarified as to when the TF should be stopped.<br><br>On 3/5/26 10:28 AM, S #2, in the presence of the DON, interviewed the LPN/UM who stated that the order was written by the dietician who calculated. S #2 asked about the TV infused. The LPN/UM stated that the TV infused was on the pump. S #2 asked about the order. The DON stated that it was either or and that the pump was set at 1000 ml. The LPN/UM stated that the resident went to therapy and that if the TF was stopped at 740 then when the resident returned the TF was restarted and when it reached 1000 ml was stopped. The DON stated that the pump was set to reach 1000 ml. She added that there was no documentation by the nurses of how much was infused. The DON stated that the nursed were not going to stop the feeding before it reached 1000 ml.<br><br>On 3/5/26 at 11:49 AM, S #2 observed that Resident #11 was not in the room and that the TF container still had 600 ml left. The resident would not receive 1000 ml if the TF was stopped after 20 hours as the order indicated.<br><br>On 3/5/26 at 11:50 AM, S #2 interviewed the RN who stated that even though the order to stop the TF was scheduled for 1:00 PM, it would not be stopped until it reached 1000 ml. She added that the resident was at therapy and that the next shift would continue the TF until 1000 ml. S #2 asked about the order that had stop at 20 hours or 1000 ml infused. The RN stated that she was concerned about it since if stopped at 20 hr, the resident may not get all of the volume ordered.<br><br>On 3/5/26 at 11:56 AM, S #2 interviewed the LPN/UM who stated that the order for stopping the TF should have been clarified.<br><br>On 3/6/26 at 12:43 PM, S #2 notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), the concern that Resident #11's TF was not labeled, there was no documentation of TV infused on each shift and there was no clarification of an order as to when to stop the TF.<br><br>On 3/9/26 at 12:55 PM, in the presence of the LNHA, the DON stated that they revised the policy to include putting the amount infused and staff were in-serviced about labeling.<br><br>The LNHA did not provide any additional information.<br><br>A review of the undated facility's Gastrostomy Tube Feeding-Administration Policy included the following: Objective: To give accurate and regulated flow of liquid nutritional supplement through a feeding tube into the gastro-intestinal tract.Procedure:.For continuous tube feeding, attach the tubing to the Gastronomy tube. Assure the pump is programmed correctly. All bags/containers and tubing are to be dated and changed every 24 hours.Record procedure, type and amount of feeding, resident's response, and any pertinent observations in the medical record.<br><br>N.J.A.C. 8:39-27.1(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>Based on interviews and review of other facility documentation, it was determined that the facility failed to ensure that the physicians must review the residents' total program of care including medications and treatments and write and sign history and physical and other succeeding visit notes. This deficient practice was identified for 1 of 25 residents, (Resident #131), reviewed for physician services.This deficient practice was evidenced by the following:On 3/5/26 at 10:23 AM, the surveyor reviewed the medical records of Resident #131 and revealed:A review of the hospital discharge medication (med) list revealed that Resident #131 to Continue taking this med and follow the directions you see here for med furosemide 40 mg (milligram) tablet (tab), take 0.5 tab (20 mg total) by mouth one time each day.A review of January 2026 Orders, electronic Medication Administration Record (eMAR) did not reflect an order for furosemide 40 mg tab.Further review of the medical records revealed there was no documentation as to why the furosemide was not ordered. There was no documented evidence that the physician came to the facility to review hospital records and physician orders that were reflected in the eMAR and the electronic Treatment Administration Record (eTAR). In addition, there was no documented evidence that the History and Physical (H&P) and other succeeding visit notes were done by the physician and APN (Advance Practice Nurse).A review of the admission Record (an admission summary) reflected that the resident was admitted with diagnoses that included but were not limited to; type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease unspecified, and chronic ischemic heart disease unspecified.A review of the Discharge Return Not Anticipated Minimum Data Set (DRNAMDS) with an assessment reference date (ARD) of 1/5/26, revealed in Section C-Cognitive Patterns a brief interview for mental status (BIMS) score of 12 out of 15, which reflected that the resident's cognitive status was moderately impaired.On 3/5/26 at 12:12 PM, S #3 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who informed S #3 that it was her and the nurses who were responsible for reviewing the hospital records including med list and relaying to the physician the med list if medications (meds).On that same date and time, the LPN/UM further stated that the check mark in the meds in the med list meant that the physician agreed to continue the meds, if the physician did not want to continue the med, there would be a note on the side of the med to indicate not to continue. The surveyor then showed to the LPN/UM the copy of the hospital records med list and she confirmed that the furosemide was missed and should have been relayed to the physician. The LPN/UM acknowledged that there was no check mark nor a note beside the furosemide to determine the med was relayed to the physician. Furthermore, the LPN/UM stated that it was an expectation for the physician to do H&P, sign the orders, and do follow up notes. The LPN/UM further stated that the physician should sign all the orders within 24-48 hours post admission it was expected that the physician would write their H&P at that same time.On 3/6/26 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns with regard to Residents #131's orders, H&P, and succeeding visit notes. The LPN/UM after reviewing the electronic medical records, stated that she did not find H&P was done and orders were signed by the physician. A review of the undated facility's Physician's Services Policy that was provided by the LNHA, revealed under purpose, to provide medical care and healthcare services for residents. Procedure: 2. Each provider shall comply with applicable federal laws, rules and regulations as well as facility policies and standards of nurse professional practice.8. A physician, physician assistant or APN shall provide orders for each resident's care beginning on the day of admission.The APN or physician assistant may visit the resident before the resident is seen by the physician but only if the visit is medically necessary before the physician is able t see the resident.On 3/9/26 at 12:37 PM, the survey team met with the LNHA and the DON who stated, with regard to the physician visits, we will be sending a letter to all physicians reminding them of<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | regulation to come here to do H&P, sign orders, and we will put it in Quality Assurance Performance Improvement (QAPI). The DON confirmed that there was no negative effect to the resident.NJAC 8:39-11.2(a)(b)(c); 23.2(a)(b) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication by documenting an incorrect indication or diagnosis (Resident #4) and failure to monitor requested laboratory results (Resident #7) for 2 of 5 residents reviewed for unnecessary medications.The deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.1. The surveyor reviewed Resident #4's hybrid medical record (paper and electronic) and revealed the following.A review of the admission Record (AR: an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to unspecified dementia (when a patient exhibits clear symptoms of cognitive decline of unknown cause) and dysphagia (difficulty swallowing).A review of Resident #4's Comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 1/22/26, had a Brief Interview Mental Status (BIMS) score of 3 out of 15, which indicated the resident has severe cognitive impairment.A review of the resident's Physician orders (PO) revealed an Order Summary Report (OSR), which reflected the following orders:risperidone oral tablet (tab) 0.25 mg (milligram), give1 tab by mouth one time a day for Bipolar Dated 1/9/26.risperidone oral tab 0.5 mg, give 1 tab by mouth at bedtime for Bipolar Dated 1/9/26.A review of the resident's comprehensive care plan revealed a focus that the resident uses psychotropic medications (Risperdal medications) r/t (related to) disease process (Bipolar) Date Initiated: 1/12/26.A review of a Psychiatry Consult for Resident #4 dated 1/15/26, did not reflect any diagnosis of Bipolar or past medical history of Bipolar. The Psych Consult did reveal a diagnosis of Dementia.A review of the resident's list of diagnoses did not reveal any diagnosis of Bipolar. The list did reflect a diagnosis of Dementia. 2. The surveyor reviewed Resident #7's hybrid medical record and revealed the following.A review of the AR reflected that the resident was admitted to the facility with diagnoses which included but not limited to chronic atrial; fibrillation (long-term heart rhythm disorder) and unspecified dementia (when a patient exhibits clear symptoms of cognitive decline of unknown cause).A review of Resident #7's quarterly MDS (qMDS), with an ARD of 2/19/26, reflected a BIMS score that was unable to be obtained due to the resident's cognitive impairment.A review of a Psychiatry Consult for Resident #7 dated 1/22/26, reflected under Diagnosis and Plan: 4. Please add Depakote level with next lab (laboratory) draw.Further review of Resident #7's paper medical record did not show a current lab order or result for a Depakote level.On 3/6/26 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the above concerns. On 3/9/26 at 8:30 AM, the DON provided the surveyor with a copy of a lab result with a Depakote level for Resident #7. The lab results reflected a date of 11/3/25.On the same day at 9:40 AM, the surveyor reviewed Resident #7's medical records in the presence of the Registered Nurse/Unit Manager (RNUM) for the unit where Resident #7 resided. The RN/UM accessed the list of lab results for Resident #7 that were done after 1/22/26. The list reflected two instances where the resident did have a blood draw from the lab, specifically 2/2/26 and 2/16/26, and no Depakote level was ordered or done.On 3/9/26 at12:37 PM, the survey team met with the LNHA and the DON stated they could not locate any other reason for the diagnosis of Bipolar for Resident #4, and a Psychiatric Consult would be ordered for clarification. The DON further stated that they had provided a lab result for Resident #7. The surveyor notified the DON that the lab result provided was dated before the Psychiatric consult that requested a level. The surveyor also notified that there were two opportunities that level could have been<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | done.The LNHA did not provide any further pertinent information.A review of the facility's Psychoactive medication Policy, dated as revised 3/2018, the policy reflected, under Procedure: 1.an appropriate diagnosis is obtained from the resident's physician. 5. When a resident is admitted on a psychoactive medication, a diagnosis is placed in the medical record.A review of the undated facility's Laboratory Services and Reporting Policy, the policy reflected, the facility must provide obtain laboratory services when ordered.2. The facility is responsible for the timeliness of the services.NJAC 8:39-27.1(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store and secure medications per standards of practice. This deficient practice was identified in 1 of 6 medication carts (med cart) observed during the medication pass (med pass) observation and 1 of 6 med carts observed while touring the facility.This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 3/5/26 at 1:54 PM, the surveyor, toured the 1st floor, observed a med cart, later identified as District 1 med cart, that was unattended and did not have the lock engaged. The surveyor was able to open the med cart and access the contents. At this time, the 1st floor Unit Manager (UM1) approached the surveyor who notified UM1 that the med cart was open and unattended. The surveyor asked UM1 if the med cart should be left open and unattended. UM1 stated no, it should be locked.On 3/6/26 at 7:55 AM, during med pass, the surveyor observed the Licensed Practical Nurse assigned to the District 2 med cart on the 3rd floor cart (LPN3) leave the med cart open and unattended on two occasions. The surveyor asked LPN3 if the med cart should be locked when left unattended. LPN3 stated yes, they should have locked it when entering a resident's room.On 3/6/26 at 10:00 AM, the surveyor spoke to the facility Consultant Pharmacist (CP) by telephone. The surveyor asked the CP if med carts should be locked or secured when unattended. The CP stated yes, the med carts should always be locked when unattended.On 3/6/26 at 12:21 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the concerns with med carts being left unlocked while unattended. The surveyor asked the DON if the 1st floor has residents that have dementia and may wander. The DON stated yes, there may be. The surveyor asked the DON if med carts should always be secured when unattended. The DON stated yes, they should be locked.On 3/9/26 at12:37 PM, the survey team met with the LNHA and the DON stated that the staff were educated about the importance of keeping all med carts locked when not in use.The LNHA did not provide any further pertinent information.A review of the undated facility's Medication Storage Policy, reflected under Procedure: .all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by the facility policy.NJAC 8:39-29.4(d)(g) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene for 1 of 2 soiled utility rooms (room [ROOM NUMBER]) and b.) ensure that the eyewash stations were maintained clean and scheduled flushing was followed for 2 of 2 eyewash stations (rooms [ROOM NUMBERS]) and follow appropriate infection control practices, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and facility's policy.This deficient practice was evidenced by the following:According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient .Before moving from work on a soiled body site to a clean body site on the same patient .After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal.1.On 3/4/26 at 9:25 AM, both the surveyor and the Registered Nurse/Unit Manager (RN/UM) went to room [ROOM NUMBER] (R347) Soiled Utility Room with information outside the door for Eyewash Station. Inside R347, both the surveyor and the RN/UM observed there was no soap in the dispenser, the eyewash nozzles in the sink was observed uncovered. The RN/UM stated that the plastic cover that was hung was intended to cover the eyewash nozzles if not in use. The RN/UM confirmed that the cover was broken, and the other one had a brownish substance inside the plastic cover, and she stated that it should have been cleaned.At that same time, both the surveyor and the RN/UM observed a posted paper inside a plastic titled Eyewash Station-Flush for 5 mins for 2025. The months of October, November, and December 2025 were blank and there were no signatures. The RN/UM acknowledged the eyewash posted sign had no signatures and nothing for 2026.On 3/4/26 at 10:04 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) of above concerns about R347 eyewash station and the log that there were no signatures on October, November, and December 2025, and there were no log for 2026. 2. On 3/4/26 at 11:40 AM, both the surveyor and the Licensed Practical Nurse/Unit Manager (LPN/UM) went to room [ROOM NUMBER] (R247) Soiled Utility Room with posted sign outside for eyewash station. Inside R247, the posted sign for Eyewash Station-Flush for 5 Mins was for 2025, and the months of October, November, and December were blank and there were no signatures. The LPN/UM acknowledged the eyewash posted sign had no signatures and nothing for 2026.On 3/4/26 at 11:47 AM, the surveyor notified the LNHA of the above concerns about R247 eyewash station log that there were no signatures on October, November, and December 2025 and there were no log for 2026.On 3/4/26 at 12:15 PM, the Director of Maintenance (DM) said that he had a log for eyewash flushing and he would show the log to the surveyor. The DM further stated that the one the surveyor had observed in the units were old and he was not using it anymore.On 3/4/26 at 12:32 PM, the surveyor reviewed the provided log by the DM for 2025 and 2026, weekly sink flush/eyewash stations/bather sink and shower (flush for 5 minutes), revealed the following weeks with no signatures:-10/22/25, 10/29/25-11/5/25, 11/26/25-12/3/25For 2025 and 2026, R247 and R347 where the eyewash stations were, were not being flushed according to the facility provided log above.On 3/6/26 at 11:14 AM, the surveyor interviewed the DM regarding the concern with eyewash station that there were dates that was not checked off. The DM informed the surveyor that if there was no check, it meant that it was not done. He stated, probably due to winter storm and they were outside removing snow at that time. He also stated that he was made aware of the concern with the brown stain in the cover of the eyewash cover and no soap, and broken cover for eyewash after surveyor's inquiry. He stated that the cover should be cleaned, and I did change the cover the broken one and there should be soap in the dispenser now. On 3/9/26 at 11:12 AM, the surveyor interviewed Registered Nurse/Infection Preventionist (RN/IP) regarding the eyewash station. The RN/IP stated<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that it was an expectation that the soap was refilled, it was her and responsibility during environmental round and other IDT (interdisciplinary team) to ensure that there was soap in the dispenser in order for the staff to wash their hands. She also acknowledged that the eyewash nozzles should be covered when not in use to prevent dust entering the eyewash.On 3/6/26 at 12:21 PM, the survey team met with the Director of Nursing (DON) and the LNHA, and the surveyor notified them of the above findings and concerns with regard to eyewash stations and empty soap in the dispenser in the soiled utility rooms.A review of the undated facility's Eyewash Station Policy that was provided by the LNHA, revealed under purpose, to ensure eyewash stations throughout the facility are properly maintained, accessible, sanitary, and fully operational to provide immediate emergency eye irritation for employees who may be exposed to hazardous chemicals. Policy.Environmental Services and/or Maintenance staff are responsible for ensuring eyewash stations are accessible, clean, and maintained.Cleaning and Sanitation, environmental services staff are responsible for maintaining eyewash stations in a clean and sanitary condition.3. Protective dust covers on eyewash nozzles must remain clean and intact.All inspections shall be documented on the Eyewash Station Inspection Log.A review of the facility's Hand Hygiene Policy that was provided by the LNHA, with a revised date of 2/18, revealed under purpose.Hand hygiene is the single most important strategy to reduce the risk of transmitting organisms from one person to another or from one site to another on the same patient. Cleaning hands promptly and thoroughly between patient contact and after contact with blood, body fluids, secretions, excretions, equipment and potentially contaminated surfaces is an important strategy for preventing healthcare-associated infections.Procedure: Indications for handwashing and hand-rubbing. A. Indications for Handwashing. 1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water.On 3/9/26 at 12:37 PM, the survey team met with the DON and the LNHA who stated that we did the Quality Assurance Performance Improvement (QAPI) for environmental rounds after surveyor's inquiry, we will be doing rounds in a monthly basis, and we will be checking housekeeping issues.N.J.A.C. 8:39-19.4(a)(1)(l) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315413 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Peace Care St Ann's | 198 Old Bergen Road<br>Jersey City, NJ 07305 |

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 0944<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program.<br><br>Based on interview, and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's QAPI (quality assurance and performance improvement) program for 2 of 5 Certified Nursing Assistants (CNAs) reviewed for mandatory education. This deficient practice was evidenced by the following:On 3/4/26 at 12:06 PM, the surveyor requested from the License Nursing Home Administrator (LNHA) five randomly selected CNA files. On 3/5/26 at 1:55 PM, the surveyor reviewed the mandatory annual education hours for five randomly selected CNA files, which were provided by the facility. The Staff In-service Logs revealed the following: CNA #1, date of hire (DOH) of 8/1/22, Transcript Hours did not include QAPI training. CNA #2, DOH of 10/3/2018, Transcript Hours did not include QAPI training.On 3/6/26 at 9:35 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the Director of Staff Educator was responsible for CNA education. On 3/6/26 at 1:04 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the DON of the above findings and concerns.On 3/6/26 at 1:13 PM, the surveyor interviewed the Director of Staff Development who stated she was responsible for the mandatory education, and the staff were trained through their electronic system software. She further stated that she was familiar with the regulations for the CNA mandatories. She confirmed that CNA #1 and CNA #2 were not listed on the QAPI education for 2025, then they did not get it.On 3/9/26 at 1:00 PM, the surveyor notified the LNHA and the DON of the concern with CNA annual QAPI mandatory education. The DON stated that they would monitor the mandatory CNA education, and the educator will present it to QAPI.On 3/9/26 at 1:30 PM, the LNHA and DON provided no additional information.A review of the undated facility's Required training, certification and continuing education of certified nursing assistant (CNA) Policy revealed under Policy, it is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. Under Policy Explanation and Compliance Guidelines #6. Minimum training will include: d). Elements and goals of the facility's QAPI program .NJAC 8:39-33.4 |