STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aster Creek Nursing and Rehabilitation Center	524 Wardell Road Tinton Falls, NJ 07753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45208 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain residents' living environment in a clean, comfortable, homelike manner. This deficient practice was identified on 1 of 2 nursing units reviewed for environment (300 unit), and was evidenced by the following: 1. On 10/1/23 at 12:24 PM, during initial tour of the facility, the surveyor entered onto a ramp that led to the 300 nursing unit, and observed the following: 1. The handrail on right side of wall going up the ramp had three areas where it was not connected to itself, which left a gap in the system where the metal framing was exposed. This presented a safety hazard for residents that were unsteady on their feet. 2. The wallpaper was peeling and bubbling throughout the entire entrance to the 300 nursing unit. 3. The threshold that connected the ramp to the 300 nursing unit corridor had tile removed, missing and uneven elevations in areas presenting a tripping hazard. 4. The entrance to 300 nursing unit's doorframe had a hole in the wall by the doorframe. and around the hole was white crumbling debris. On 10/3/23 at 12:02 PM, the surveyor toured the 300 nursing unit, and entered hallway vestibule entrance and observed the following: 1. To the left side of hall at two joining walls, there was a split in the wallpaper along the corner seam from the floor to approximately four feet. The area behind the wallpaper was black and had white dust debris. 2. On the right side of the 300 nursing unit hallway, there was an interior soffit enclosure that had a rectangular cutout hole that exposed the interior of the soffit. On 10/7/24 at 12:00 PM, the surveyor observed on the 300 nursing unit in Resident room [ROOM NUMBER], the doorway threshold had cracked and sunken tiles, which caused the entryway into the room to be uneven. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/7/24 at 12:00 PM, the surveyor observed on the 300 nursing unit in Resident room [ROOM NUMBER], the doorway threshold had cracked tiles that were lifted and created a lip to the entrance of the room. On 10/7/24 at 12:37 PM, the surveyor interviewed with Housekeeping Director (HKD), who stated that housekeeping staff was responsible for mopping and cleaning the floors. The HKD stated that the Maintenance Director (MD) and upper management were responsible for changing the tiles and flooring. On 10/7/24 at 1:15 PM, the surveyor and the Licensed Nursing Home Administrator (LNHA) toured the 300 nursing unit, and the surveyor showed the LNHA the identified concerns. The LNHA acknowledged he was aware of the identified concerns, and he stated that the facility planned to remodel the nursing unit, but there was no definitive date. The LNHA acknowledged that the residents could cut their hands on the handrail or trip on the elevated thresholds or missing tiles. The LNHA confirmed the flooring presented an issue with safety and was a tripping hazard. The Maintenance Director was unavailable for an interview during survey. 40744 2. On 10/1/24 at 9:40 AM, during the initial tour of the facility, the surveyor observed Resident room [ROOM NUMBER]. On immediate entrance into the room, the surveyor noted a thick buildup of a brown substance on the floor. There was also a twelve-inch by twelve-inch (12 x 12) tile that was sunken down on the right side adjoining to another tile which was unleveled that created a tripping hazard. The crack in the sunken down tile, between the two tiles had a dark brown substance. The surveyor then entered the bathroom in Resident room [ROOM NUMBER]. On entrance to the bathroom, the surveyor noted a small tile that was missing the corner edge creating a small hole. In front of the toilet there was a loose tile, and around the base of the toilet towards the front was a dark brown substance. When exiting the bathroom, the surveyor noted an area in the corner by the hinged side of the bathroom door, an area of a grayish brown substance on the floor and in the corner by the door jamb was a black and white substance on the floor and on the door jamb. On 10/7/24 at 12:25 PM, the surveyor interviewed the Housekeeping Director (HKD) regarding the process for cleaning resident rooms. The HKD stated that the worst rooms were cleaned first, and the housekeepers had a daily focus. The HKD stated that the floors were mopped daily or twice daily, and that the 300 nursing unit had one housekeeper and one porter (cleaned equipment and emptied trash). On 10/7/24 at 12:50 PM, the surveyor reviewed a room checklist provided by the HKD, and Resident room [ROOM NUMBER] was marked as unsatisfactory. The checklist was dated 10/7/24, after surveyor inquiry. On 10/8/24 at 11:00 AM, the surveyor requested from the LNHA and Acting Director of Nursing (ADON) a clean homelike environment policy. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/8/24 at 12:10 PM, the surveyor reviewed the maintenance request logs provided by the facility. On 9/19/24, there was a maintenance request submitted for water leaking in a bathroom. The room number was not identified on the log, and the details written by maintenance were that there were no leaks, and the floor was just dirty. No additional information was provided. A review of the undated facility's Maintenance Service policy included .1. the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at tall times. 2. functions of the maintenance personnel include but are not limited to a. maintaining the building in compliance with the current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards. 3. the Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner .8. maintenance is responsible for maintaining the following records/reports .a. inspection of the building, b. work order requests, c. maintenance schedules . NJAC 8:39-31.4(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40744 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to revise an individual comprehensive care plan for a resident with a history of falls at the facility. This deficient practice was identified for 1 of 1 resident reviewed for falls (Resident #53), and was evidenced by the following: On 10/1/24 at 10:17 AM, during the initial tour of the facility, the surveyor observed Resident #53 in bed with blankets over their head. On 10/2/24 at 11:30 AM, the surveyor observed Resident #53 in bed. Resident #53 told the surveyor that they liked to stay in bed and they ate meals in their room. The surveyor asked the resident if they had any history of falling, and the resident said yes, but did not say if they were every injured during a fall. The surveyor observed no fall mats. On 10/2/24 at 12:15 PM, the surveyor reviewed the medical record for Resident #53. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses which included but not limited to; depression, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), hypertension (high blood pressure), and low back pain. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 9/9/24, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 14 out of 15; meaning the resident was cognitively intact. A review of Section GG for functional status revealed no impairment of upper or lower extremities, and that the resident was independent with toileting and hygiene. On 10/3/24 at 10:56 AM, the surveyor reviewed incidents and accidents which indicated that Resident #53 had a fall on 8/19/24. The resident was found on the floor in the room by the staff. The resident told staff that they tripped over their shoes and did not hit their head. Staff documented that no injuries were observed; and neurological (neuro) checks (evaluation of a person's nervous system) were initiated; and the resident's family and physician were notified. On 10/7/24 at 10:19 AM, the surveyor reviewed the resident's individualized comprehensive care plan (ICCP) which included a focus area dated 12/8/21 and revised 5/14/24, that the resident was at risk for falls related to psychotropic drug use. Interventions included to leave call bell within reach; ensure the resident was wearing appropriate footwear; keep pathways clear; and physical and occupational therapy to evaluate and treat as needed. The ICCP did not include the fall from 8/19/24, and was not revised following the fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 12:08 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) regarding the facility's post falls process. The UM/LPN said if a resident's fall was unwitnessed, neuro checks were started, a physical therapy evaluation was ordered if appropriate, and then we meet as a team to add interventions. The UM/LPN said the ICCP was revised with new interventions to implement. The surveyor asked the UM/LPN to review Resident #53's ICCP, and verify if the ICCP was revised after the resident's fall in August 2024. The UM/LPN confirmed the ICCP was not updated after the resident's fall. On 10/8/24 at 11:00 AM, the Licensed Nursing Home Administrator, in the presence of the Acting Director of Nursing (ADON) and survey team, acknowledged Resident #53's ICCP was not updated post fall until surveyor inquiry. A review of the facility's Care Planning policy dated revised April 2024, included that care plan development, renewal and revision will be based upon results of the resident assessment .when a problem, goal, approach or target date is added, changed or resolved it is indicated in the care plan . NJAC 8:39-27.1(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49094 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who smoked cigarettes was assessed for safety. The deficient practice was identified for 1 of 5 residents reviewed for accidents (Resident #25), and was evidenced by the following: On 10/1/24 at 10:28 AM, during initial tour of the facility, the surveyor observed Resident #25 in their room watching television. Resident #25 stated that they were a smoker and went outside to smoke at 9:00 AM, 1:00 PM, and 4:00 PM. The resident also stated that the activities staff held on to their cigarettes and lighter. On 10/1/24 at 12:26 PM, the surveyor reviewed the medical record for Resident #25. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses including but not limited to; hypertension (high blood pressure), depression, and hyperlipidemia (abnormally high levels of lipids or fats in the blood). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 6/2/24, indicated the resident had a brief interview for mental status score of 15 out of 15, indicating a fully intact cognition. A further review in Section J Health Conditions reflected the resident was a current tobacco user. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 6/20/22, that the resident was a smoker. Interventions included that the resident required supervision while smoking; will be assessed quarterly for smoking safety; instruct the resident about smoking risks and hazards and about smoking cessation aids that are available; instruct the resident about the facility policy on smoking locations, times, and safety concerns; have smoking supplies stored with the activity department; observe the resident's clothing and skin for signs of cigarette burns; the facility smoking contract has been reviewed with the resident and they have signed it; and to notify the charge nurse immediately if it was suspected that the resident had violated the facility's smoking policy. A review of the Smoking Safety Screen, located in the electronic medical record (eMR). revealed the most recent smoking safety screen was completed on 5/31/24. The Smoking Safety Screen indicated that the resident was a smoker and could smoke safely with supervision. A review of the resident's Smoking Contract was signed by the resident on 6/25/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 12:14 PM, the surveyor interviewed the Activities Director (AD), who stated that residents were assessed upon admission, quarterly, annually, and if there was a significant change for smoking which included safety. The AD stated that Resident #25 was a smoker and provided the surveyor with the most recent Smoking Safety Screen dated 5/31/24. The AD stated that there should have been a smoking assessment completed the first week of September, and they could not speak to why there was no Smoking Safety Screen completed. The AD stated the importance of completing a Smoking Safety Screen was for the safety of the resident, and to determine if there were any changes such as needing a smoking apron. On 10/7/24 at 1:35 PM, the surveyor interviewed the Acting Director of Nursing (ADON), who stated Smoking Safety Screenings should be completed upon admission. The ADON could not speak to when Smoking Safety Screenings should be completed other than upon admission. On 10/8/24 at 11:00 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the ADON and survey team, stated that the Smoking Safety Screenings were completed quarterly, or if there was a significant change. The LNHA also stated that the Smoking Safety Screening was due when the facility was changing Activities Directors, and we missed the September screening. The LNHA further stated that Resident #25's Smoking Safety Screening was completed on 10/7/24, after it was brought to our attention. The LNHA acknowledge a Smoking Safety Screening should have been completed in September. A review of the facility's Resident Smoking Policy dated revised 8/30/23, included the resident will be evaluated upon admission, re-admission, and quarterly or upon any significant change to a residents physical or cognitive status . NJAC 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40744 Based on observations, interview, and review of pertinent facility documentation, it was determined that the facility failed to label, date, and initial a resident's oxygen tubing. This deficient practice was identified in 1 of 1 residents reviewed for respiratory therapy (Resident #49), and was evidenced by the following: On 10/1/24 at 10:07 AM, during initial tour of the facility, Resident #49 approached the surveyor in the main dining room on the second floor. During the observation, the resident had a walker and a portable oxygen tank. The tubing that supplied the oxygen that went from the resident to the tank did not have a date. The surveyor then entered the resident's room with the resident, and the resident had an oxygen concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95 % pure oxygen) in the room. The concentrator had oxygen tubing that went from the concentrator and into a bag. The resident told surveyor that they wore that when in bed. On 10/1/24 at 10:37 AM, the surveyor observed Resident #49 in the bed. The resident was being administered oxygen at three liters per minute from an oxygen concentrator. The resident's oxygen tubing was not dated. On 10/1/24 at 11:20 AM, the surveyor reviewed the medical record for Resident #49. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with medical diagnoses that included but not limited to; chronic obstructive pulmonary disease (common lung disease that makes it difficult to breathe), respiratory failure, and anxiety. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 9/4/24, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, meaning the resident was cognitively intact. A further review revealed the resident used oxygen. A review of the physician's orders (PO) included the following POs: A PO dated 12/15/23, for humidified oxygen when oxygen was in use every twenty-four hours as needed. To apply oxygen per nasal cannula (medical device that provides oxygen to a patient through their nose) at 3 liter per minute as needed every twenty-four hours for wheezing and shortness of breath. A PO dated 12/15/23, for the staff to change the oxygen tubing weekly and date the tubing and bag every night shift on Sunday. A review of the individual comprehensive care plan (ICCP) included a focus area dated 8/3/22 and revised 7/31/24, that the resident was able to apply the oxygen therapy when needed. Interventions included to change the oxygen tubing weekly. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 1:00 PM, the surveyor observed Resident #49 smoking under the supervision of the activities staff. The resident removed the oxygen prior to going outside to smoke and the oxygen remained in the building. Resident #49 went back into building and reapplied the oxygen. The surveyor observed that the tubing was not dated. On 10/7/24 at 12:16 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) regarding oxygen tubing. The UM/LPN stated that oxygen tubing was changed every Sunday night and the tubing was dated. The surveyor informed the UM/LPN that on Monday, Tuesday, Wednesday, and Thursday of last week, the surveyor observed that Resident #49's oxygen tubing was not dated. The UM/LPN could not speak to why the tubing was not dated. On 10/7/24 at 2:01 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Acting Director of Nursing (ADON) about the multiple observations of Resident #49's oxygen tubing not dated. No additional information was provided. A review of the facility's Oxygen Administration policy dated revised 7/10/23, included .staff were to date and initial tubing and humidifiers when changing each week . NJAC 8:39-27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) discard potentially hazardous foods past their date of expiration; b.) ensure potentially hazardous foods were stored at least six inches from the floor; c.) maintain multiuse food-contact surface cutting boards in a manner to prevent microbial growth; d.) maintain kitchen and storage areas in a sanitary manner; and e.) perform hand hygiene to prevent food borne illness. This deficient practice was evidenced by the following: Upon arrival to the facility on [DATE] at 8:45 AM, the surveyor observed eight boxes of bread that were delivered and placed directly on the ground in the parking lot. The bread boxes were stacked in two piles with two boxes directly on the pavement. On 10/1/24 at 8:50 AM, the surveyor accompanied by the Acting Director of Nursing (ADON) exited the facility and observed the bread delivery on the ground. The ADON confirmed food should not be stored directly on the ground. On 10/1/24 at 10:07 AM, the surveyor observed the Food Service Director (FSD) enter the kitchen, and the FSD stated he had just come from the stock room and hung up his coat. The surveyor interviewed the FSD, who stated that the bread company always delivered the bread and placed it directly on the ground in the parking lot outside the building. The FSD stated that it was acceptable for the bread to be stored on the ground since the bread was in a box. At that time, the surveyor and FSD began a tour of the kitchen. The surveyor observed no hand hygiene from the FSD after returning to the kitchen from the stock room and hanging up his coat. The FSD began to open the reach-in refrigerator, when the surveyor asked the FSD if he had just left the kitchen and hung up his personal jacket, was there anything he needed to do. The FSD acknowledged he should have performed hand hygiene. The FSD proceeded to perform hand hygiene using soap and water, lathering outside the flow of running water for twenty seconds, then used a paper towel to dry his hands. The FSD then obtained a clean paper towel to turn the sink faucet off, then used that paper towel to continue to dry his hands. The FSD then dropped the paper towel on the floor, picked it, disposed of it in the trash receptacle, and proceeded on the tour. The surveyor asked the FSD if he used the paper towel that he turned the faucet off with to dry his hands and then dropped it on the floor and picked it up, were his hands still clean? The FSD acknowledged he needed to perform hand hygiene again because his hands were considered dirty. On 10/1/24 at 10:18 AM, the surveyor and the FSD toured the kitchen and observed the following: 1. In the kitchen on the wall directly next to the reach-in refrigerator, a light powered bug trap. The bottom of the bug trap had over twenty dead bugs, and the area was opened, exposing the dead bugs to the kitchen area. The FSD acknowledged that the trap needed to be cleaned. 2. In the reach-in refrigerator, a container of egg salad with a use by date of 9/29/24. The FSD confirmed it needed to be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. In the reach-in refrigerator, a container of macaroni salad with a use by date of 9/22/24. The FSD confirmed it needed to be discarded. 4. In the reach-in refrigerator, a one-pound opened container of cottage cheese with no opened date and an expiration date of 11/18/24. The FSD stated the kitchen used cottage cheese for thirty days. At that time, the surveyor showed the FSD the cottage cheese packaging which indicated use within seven days of opening. 5. The inside of the microwave had caked on debris on the roof and sides as well as the plate. The FSD acknowledged it needed to be cleaned. 6. On a drying rack, one large green cutting board deeply pitted and discolored. The FSD stated the grooves caused cross-contamination and led to bacterial growth. The FSD acknowledged it should be discarded. 7. In dry storage on the active can rack, one six-pound twelve-ounce (oz) can of vegetarian bean and sauce and one six-pound twelve-ounce can of red kidney beans, both dented. 8. In the walk-in freezer, the vinyl strip curtains located in the entrance to the freezer were missing three strips on the outer sides of the doorway. These curtains protected the inside of the freezer from outside dust particles as well as kept the cold air from escaping the freezer when the door was opened. The FSD acknowledged the vinyl strips maintained temperature and prevented dust particles from entering the freezer. 9. On a storage rack in the kitchen, one large brown, one large yellow, one large white, one large blue, and one large red cutting boards all pitted and discolored. The FSD stated he usually changed the cutting boards every eight to nine months, and acknowledged these cutting boards were ready to be replaced. 10. Outside the kitchen, freezer chest #2 had a build-up of ice accumulation around the sides. The FSD stated the ice affects the temperature, and the facility cleaned every six months. 11. Outside the kitchen, freezer chest #1 had a build-up of ice accumulation along the sides. On 10/1/24 at 10:30 AM, the surveyor and FSD toured a food storage room located in the 200-unit hallway and observed the following: 12. The storage room floor was soiled with black colored build-up and the tiles were coming up. The FSD stated that there was a flood in the room that past summer, so the flooring came up. When the surveyor questioned about the flood, the FSD stated it was not a flood, the air conditioner (AC) was running all summer so there was condensation on the floor. 13. Directly on the soiled floor was a box of corn flakes cereal and the emergency water. The FSD acknowledged the cereal and water should not be stored directly on the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	14. Directly on the soiled floor was a twenty-five pound of Japanese breadcrumbs. The bottom of the bag had a discolored brownish area that appeared to be discoloration from sitting on liquid. The bottom of the bag was also ripped, had bugs flying around it, and patches of a green fur-like substance that the FSD identified as mold. The FSD acknowledged that the breadcrumbs were not store appropriately and needed to be discarded. 15. On a storage rack, a white condiment bottle pump that was caked on with brownish/black substance. The FSD stated it needed to be discarded. On 10/8/24 at 11:00 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the ADON and survey team, acknowledged the concerns. A review of the undated facility provided Stock Room Storage Policy included .boxes must be stored six inches above the [floor] . A review of the undated facility provided Refrigerator Storage Policy and Procedure included .check for out dated food. If any discard. A review of the facility provided Infection Control Policy Procedures 2020 included Handwashing/Hand Hygiene .1. vigorously lather hands with soap and water creating friction to all surfaces, for a minimum of 20 seconds [.] 2. rinse hands thoroughly under running water [.] 3. dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel 4. discard towels into trash . NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aster Creek Nursing and Rehabilitation Center	524 Wardell Road Tinton Falls, NJ 07753

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 38080 Based on observation and interview, it was determined that the facility failed to properly dispose and maintain waste in garbage dumpster areas. This deficient practice was identified for 1 of 1 garbage disposal areas, and the facility was previously cited for this during their last standard survey on 9/1/23. The evidence was as follows: On 10/1/24 at 10:46 AM, the surveyor and the Food Service Director (FSD) toured the facility's outside garbage disposal area and observed the following: 1. The cardboard dumpster had no lid and garbage debris was around it. The FSD stated the facility was trying to get the company to replace the lid. 2. The other three dumpsters had paper and food waste around it. 3. A storage container in the area had food and paper debris, wooden boards, and an unidentifiable large object around it. 4. The wooded area along the dumpster area had trash including food product, paper waste, broken wooden boards, and a mattress. 5. The fence along the inside of the garbage area had three pallets leaning against it, and the fence along the outside had an accumulation of both intact and broken pallets as well as other debris surrounding it. The fence itself was dirty and falling down. The FSD stated that someone came to pick up the pallets, but he did not know when. They had not come for the pallets in a minute. At the time of the observation, the surveyor interviewed the FSD who stated housekeeping staff maintained the garbage area, and it was important to maintain the area because of the woods and what comes out. The FSD acknowledged that the area needed to be cleaned. On 10/7/24 at 12:25 PM, the surveyor interviewed the Housekeeping Director (HKD), who stated both housekeeping and the kitchen maintained the garbage area. The HKD stated the day the surveyor identified the debris, housekeeping staff cleaned the area. The HKD stated that they tried to clean the area daily but sometimes forgot. The HKD stated that the guys who made deliveries threw the pallets by the fence and have been like that for a while; at least two or three months. The HKD stated it was important to maintain the garbage area, so no one got hurt or it did not attract rodents, and the HKD acknowledged the condition was unacceptable during the surveyor's observation. On 10/8/24 at 11:00 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Acting Director of Nursing (ADON) and survey team, stated all the surveyor's concerns were addressed. No additional information was provided. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Housekeeping - Outdoor Trash Area policy dated revised April 2024, included our nursing home is committed to maintaining a clean, safe, and hygienic environment for our residents, staff, and visitors .housekeeping staff are responsible for regularly cleaning and maintaining the outdoor trash area .the maintenance team will ensure the trash bins are in good condition and are adequately covered to prevent odors and pests. They will promptly repair or replace any damaged bins or equipment in the outdoor trash area. All staff members are expected to dispose of waste properly by placing it in designated trash bins. No littering is allowed in or around trash area .housekeeping staff will perform routine checks to ensure that the outdoor trash area is free of litter and debris. Any litter found in the vicinity will be promptly cleaned up to maintain a neat appearance . NJAC 8:39-19.3(a); 19.7(a)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49094 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to use appropriate hand hygiene and proper disinfection while providing wound care to a resident. The deficient practice was observed for 1 of 1 residents reviewed for pressure ulcers/injury (Resident #8), and was evidenced by the following: On 10/1/24 at 10:40 AM, during initial tour of the facility, the surveyor observed Resident #8 sleeping in their bed. The surveyor observed the resident wearing bilateral heel protectors. On 10/2/24 at 10:08 AM, the surveyor reviewed the medical record for Resident #8. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses including but not limited to; acute respiratory failure with hypercapnia (a condition where you do not have enough oxygen in the tissues in your body), metabolic encephalopathy (short- or long-term change in how your brain functions), and muscle weakness. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 8/13/24, indicated the resident had a brief interview for mental status score of 9 out of 15, indicating a moderately impaired cognition. A further review in Section M Skin Conditions reflected the resident had five venous and arterial ulcers present. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 3/25/24, that the resident had a potential for impairment to skin integrity/pressure injury development related to decreased mobility, dementia, and incontinence. In March 2024, the resident returned from the hospital with a sacral (lower back) wound, a left toe wound, and a left heal wound. Interventions included to monitor the resident for picking at their skin; podiatry consultation as indicated for foot care; pressure relieving mattress while in bed; weekly treatment documentation to include measurement of each area of the skin breakdown's width, length, depth, type of tissue and exudate (secretions), and any other notable changes or observations; wound consult as indicated; wound treatment as per physician orders. A review of the Physician Order Summary Report reflected the following physician's orders (PO):with a start date of 10/5/24: A PO dated 10/5/24, for Betadine External Solution 10% (povidone-iodine); apply to left dorsal foot (upper surface of the foot) arterial topically every day shift for wound care. First cleanse with Betadine; apply Betadine to base of the wound; leave open to air; and change daily. A PO dated 10/5/24, for Betadine External Solution 10% (povidone-iodine); apply to right dorsal foot arterial topically every day shift for wound care. First cleanse with Betadine; apply Betadine to base of the wound; leave open to air,; and change daily. A PO dated 10/4/24, for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dakins (1/2 strength) External Solution 0.25% (an antiseptic); apply to left lateral heel arterial topically every day and evening shift for wound care. First cleanse with 0.25% Dakins solution; apply skin prep to periwound (area around wound); apply Dakins moistened fluffed gauze to base of wound; secure with dry gauze and lightly rolled gauze; change twice a day (BID) and as needed soilage, or dislodgement. On 10/7/24 at 9:33 AM, the surveyor obtained verbal permission from Resident #8 to observe their wound care. The surveyor observed the Licensed Practical Nurse (LPN) began to perform wound care to the left and right foot. The LPN performed hand hygiene prior to donning (apply) gloves and gown at the start of the wound care. The LPN removed the old dressing and disposed of it in the trash receptacle. The LPN then doffed (removed) their gloves, and without performing hand hygiene, donned a new pair of gloves and cleansed the left dorsal foot wound with Betadine External Solution using a four-by-four (4 x 4) gauze. The LPN then cleansed the right dorsal foot wound with Betadine External Solution using a 4 x 4 gauze. The LPN then doffed her gloves and without performing hand hygiene, donned a new pair of gloves and cleansed the left heel wound with Dakins solution 25%, applied skin prep, applied 4 x 4 gauze moistened with Dakins solution, and gauze wrap to the left heel. The LPN then removed her gloves, and without performing hand hygiene donned a new pair of gloves and dated the dressing on the left heel. The LPN then removed both gloves once the wound care treatment was completed and performed hand hygiene. On 10/7/24 at 10:00 AM, the surveyor interviewed the LPN in the presence of the Unit Manager/LPN (UM/LPN), who stated that hand hygiene should have been completed in between each glove change. The LPN then acknowledged that they should have used alcohol-based hand rub or washed their hands using soap and water in between glove changes. The LPN acknowledge that they did not complete hand hygiene in between the glove changes during wound care. The UM/LPN confirmed that hand hygiene should have been performed in between glove changes. On 10/7/24 at 1:32 PM, the surveyor asked the Acting Director of Nursing (ADON) what their expectations were for staff for hand hygiene while performing wound care, and the ADON stated for the staff to do it properly. The ADON stated staff were to wash their hands prior to wound care, anytime they removed their gloves, and when wound care was finished. On 10/8/24 at 11:00 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the ADON and survey team, stated that the facility had began inservicing staff on handwashing. The LNHA acknowledge handwashing should be completed in between glove changes. A review of the facility's Infection Control Policy Procedures 2020 included Handwashing/Hand Hygiene . hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections . NJAC 8:39-19.4(a)