| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315416 | A. Building<br>B. Wing | 10/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Green Hill | 103 Pleasant Valley Way<br>West Orange, NJ 07052 |

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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | COMPLAINT # 423030Refer to F0689Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to notify the physician and the resident representative (RR) about an alleged fall reported by the resident. This deficient practice was identified for 1 of 2 residents, Resident #1, reviewed for incidents and accidents. This deficient practice was evidenced by the following:On 10/28/25 at 9:30 AM, the surveyor requested from the License Nursing Home Administration (LNHA) and the Director of Nursing (DON) all Facility Reported Event (FRE) investigations and a list of residents with falls and injuries in the last six months. On 10/28/25 at 11:20 AM, the DON provided the FRE investigations for the last six months. Resident #1 had one FRE investigation dated 5/2/25. The surveyor reviewed a facility provided investigation dated 5/2/25 which indicated Resident #1 had an injury of unknown origin for Resident #1 which occurred on 4/30/25. The investigation conclusion and incident note revealed the following:On 4/30/25 at 7:15 AM, Resident #1 was seen by a nurse practitioner (NP) at the bedside. At 7:50 AM, the primary nurse saw the resident and morning care was rendered by the Certified Nursing Assistant (CNA) with nothing unusual observed. At 9:30 AM, the Certified Occupational Therapist Assistant (COTA) visited the resident for a therapy session in their room and the resident reported to the COTA that he/she had a fall and complained of left arm pain. The COTA reported this to the resident's assigned Licensed Practical Nurse (LPN). The LPN went to check the resident. There was no bruising, or any previous fall reported. The LPN applied the resident's routine lidocaine topical cream to their left arm dialysis site which was due to be given prior to their outpatient dialysis treatments. The resident was sent out to their scheduled dialysis session. At approximately 3:00 PM, the facility received a call from the dialysis center stating that the resident was observed with bruising to their face and was transferred to the emergency room (ER) for further evaluation.A review of the facility's investigation revealed that the LPN did not initiate an investigation as per the facility's fall protocol at the time of the resident's reported fall. Additionally, there was no documentation that the physician or the RR was informed at the time that the resident reported falling. A review of the Electronic Health Record (EHR) revealed Resident #1 was not in the facility. The Resident #1's EHR revealed diagnoses which included but were not limited to metabolic encephalopathy (the brain does not function properly due to metabolic disturbance), end stage renal disease, and dependence on renal dialysis. A review of the April 2025 order summary revealed:A physician's order for hemodialysis (a treatment to remove waste products and excess fluids from the blood when the kidneys are not able to) on Monday, Wednesday, and Friday with a pickup time of 12:30 PM and their session was scheduled for 1:15 PM at the dialysis center. A physician's order for Lidocaine cream 2.5% that indicated to apply to the left arm dialysis site topically in the morning every Monday, Wednesday, and Friday for pain. A physician's order for skilled Occupational Therapy five times per week for four weeks.A review of the comprehensive Minimum Data Set (MDS), a facility assessment tool to facilitate the plan of care, dated 4/27/25 revealed the resident's cognition using a Brief Interview of Mental Status (BIMS) test. Resident #1 scored a 6 out of 15 which indicated the resident had severe cognitive impairment. On 10/28/25 at 2:40 PM, the surveyor interviewed the Registered Nurse (RN) Supervisor who stated if a resident had a new injury or a fall was reported, a skin assessment and vital signs were completed. The RN Supervisor explained the supervisor, the DON, the physician, and the RR were to be notified of the incident; and the resident's care plan would be updated; and an incident report started.On 10/29/25 at 12:09 PM, the surveyor interviewed the LPN, who was assigned to care for the resident on 4/30/25 for the 7AM to 3PM shift. The LPN stated she recalled the COTA informed her that Resident #1 stated that they fell, and she went to check on the resident. The LPN stated that there was no change or injury with the resident. The LPN further explained that she applied lidocaine topical cream to the resident's left arm dialysis access site as ordered and the resident was sent to dialysis in good condition. The LPN stated that the dialysis center called the facility and reported that the resident had a bruise on their face and was going to the ER for evaluation. The LPN confirmed that she did not report to the supervisor, the resident's physician and the RR that Resident #1 reported having a fall incident to a staff member. The LPN also confirmed that she did not initiate the facility's fall incident protocol. On 10/29/25 at 2:00 PM, the surveyor interviewed the COTA who confirmed that he treated Resident #1 in their room for a therapy session that day and the resident reported they had a fall. The COTA further explained Resident #1 couldn't say when the fall occurred or what happened. The COTA stated that the resident complained of left arm pain by the dialysis access site and observed no visible injury. On 10/29/25 at 3:10 PM, the surveyor informed the |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #2622045Based on observation, interview, and record review, it was determined that the facility failed to maintain residents' environment in a safe, clean, comfortable, and homelike surrounding. This deficient practice was identified for 1 of 9 residents reviewed, (Resident #3). The deficient practice was evidenced by the following:On 10/28/25 at 12:25 PM, the surveyor conducted the initial tour in the presence of the License Nursing Home Administrator (LNHA) and observed the following:1. In the family room, used by residents, near the first-floor unit, the surveyor observed one broken window blind on the window. The LNHA stated, I don't know how long it's been like that, but I will have maintenance look at it. The LNHA further stated that he made rounds every day. The surveyor requested from the LNHA for the Homelike Environment policy.2. At 12:32 PM, on the second floor, in the main resident dining room entrance, the door's frame had areas with broken wood on both of its sides. The LNHA confirmed observation of the damaged door frame and stated he would put in a maintenance work order. 3. In room [ROOM NUMBER], by the bathroom entrance, the carpet was observed torn and frayed; and a sharp plastic piece was broken off the frame of the bathroom entrance. The surveyor and the LNHA were joined by the Assistant Director of Nursing (ADON) who stated, she did not notice the environmental concerns. The ADON explained that the process for work orders was to let the receptionist know and they would contact maintenance staff. The LNHA added that they previously submitted work orders through an electronic system and were currently transitioning to a new system. The LNHA was not able to provide the surveyor documentation of any work orders entered for the issues observed in the main dining room and room [ROOM NUMBER].On 10/28/25 at 3:42 PM, the LNHA stated that they do not have a facility policy for Homelike Environment.4. On 10/29/25 at 11:00 AM, the surveyor observed room [ROOM NUMBER] on the first floor. The surveyor observed two ceiling tiles near the window loose and out of alignment. The surveyor observed Resident #3 lying in the bed and the resident stated that the tiles on the ceiling were loose and have been like that since February 2025. The resident stated that they're afraid it may fall down. On 10/29/25 at 11:15 AM, the License Practical Nurse (LPN) assigned to Resident #3 accompanied the surveyor to the room to observe the ceiling tiles. The LPN confirmed the observation of the broken ceiling tiles and stated, I've never noticed that. I will let maintenance know.The surveyor reviewed the Resident #3's medical records which revealed diagnoses which included but were not limited to bilateral osteoarthritis of knee, morbid obesity, anxiety and depression. A review of a Quarterly Minimum Data Set (MDS), a facility assessment tool that facilitates the plan of care, dated 9/30/25, revealed the resident's cognition was assessed using a Brief Interview Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. At 3:10 PM, the surveyor informed the LNHA and the DON of the observed concerns regarding homelike environment. There was no additional information provided to the surveyor. NJAC 8:39-31.4(a) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>COMPLAINT #423030 and #2620240Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to: a) conduct a thorough investigation to address an allegation of abuse; and b) maintain documentation that a thorough investigation was conducted for an allegation of abuse. This deficient practice was identified for 2 of 2 residents (Resident #1 and Resident #2), reviewed for abuse.This deficient practice was evidenced by the following:<br><br>1. On 10/28/25 at 9:30 AM, the surveyor requested from the License Nursing Home Administration (LNHA) and the Director of Nursing (DON) all Facility Reported Event (FRE) investigations and a list of residents with falls and injuries in the last six months.<br><br>On 10/28/25 at 11:20 AM, the surveyor reviewed the resident's electronic medical record (EMR) which revealed the following:<br><br>Resident #1 had diagnoses which included but were not limited to metabolic encephalopathy (the brain does not function properly due to metabolic disturbance), end stage renal disease, and dependence on renal dialysis. Resident #1 was no longer residing in the facility.<br><br>A review of the May 2025 physician's order revealed an order for hemodialysis (a treatment to remove waste products and excess fluids from the blood when the kidneys are not able to) on Monday, Wednesday, and Friday with a pickup time of 12:30 PM and their session was scheduled for 1:15 PM at the dialysis center.<br><br>A review of a comprehensive Minimum Data Set (MDS), a facility assessment tool to facilitate the plan of care, dated 5/13/25 revealed the resident's cognition was assessed using a Brief Interview of Mental Status (BIMS) test. Resident #1 scored a 6 out of 15 which indicated the resident had severe cognitive impairment.<br><br>A progress note dated 5/23/25 at 3:07 PM, written by Registered Nurse (RN) #1, indicated Resident #1's RR called and reported that the resident was noted at dialysis with a bruise to their left foot and complained of pain to the site. The note further revealed that the resident had been seen prior to dialysis by the physician and a body assessment was done by RN #1 with no bruise noted resident with no complaint of pain to lower extremities.<br><br>On 10/28/25 at 2:40 PM, the surveyor interviewed the Registered Nurse (RN) Supervisor on the process for new skin changes or bruising. The RN Supervisor stated that if a resident was reported to have bruising or any new skin changes, the resident would be assessed; the supervisor, the DON, the physician, and the RR would be notified; and the resident's care plan would be updated.<br><br>On 10/28/25 at 4:30 PM, the surveyor requested from the DON any investigation for Resident #1 regarding the left foot bruise reported by the RR on 5/23/25.<br><br>On 10/28/25 at 5:03 PM, the DON informed the surveyor that she could not find any investigation for the report of Resident #1's left foot with a bruise. The DON stated the nursing staff should have called the dialysis center to follow up and completed a full investigation which was the facility's protocol for any injury found or reported.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/29/25 at 9:00 AM, the DON provided a body check assessment form for Resident #1 dated 5/23/25, which was completed by RN#2. The assessment revealed the body check was completed on 3PM to 11PM shift and documented no swelling or bruising noted, patient denies pain.<br><br>On 10/29/25 at 12:25 PM, the surveyor interviewed the primary License Practical Nurse (LPN) #1, who the DON confirmed was assigned to Resident #1 on 5/23/25 during the 7AM to 3PM shift. She stated that she did a skin assessment before the resident left for dialysis and when they returned from dialysis. LPN #1 stated the resident did not complain of left foot pain or have any bruising before leaving and when they arrived back from dialysis.<br><br>On 10/29/25 at 12:35 PM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who was assigned to Resident #1 on 5/23/25 for the 7AM to 3PM shift. CNA #1 stated the facility's protocol was to report immediately any bruising, or skin tears. She further stated that the RR called from the dialysis center to say that Resident #1 had bruising on their foot.<br><br>On 10/29/25 at 12:50 PM, the DON informed the surveyor that there were no fall or incident investigations found for Resident #1 for 5/23/25.<br><br>On 10/29/25 at 3:10 PM, the surveyor informed the LNHA and the DON of the concern that there was no investigation completed regarding the RR's report that Resident #1 had bruising to their left foot. The DON acknowledged that a thorough investigation should have been completed.<br><br>2. On 10/28/25 at 12:56 PM, the surveyor reviewed the EMR of Resident #2.<br><br>The admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, Alzheimer's disease, hypertension (high blood pressure), depression, and bipolar disorder (a chronic mood disorder that causes intense shifts in mood, energy levels, and behavior).<br><br>A quarterly MDS assessment, an assessment tool to facilitate the management of care, with an Assessment Reference Date of 7/15/25, indicated the facility assessed the resident's cognition using a BIMS test. Resident #2 scored an 8 out of 15, which indicated the resident had moderate cognitive impairment.<br><br>A progress note dated 9/17/25, written by LPN #2 indicated approximately 2:10 PM, one of Resident #2's representative reported to the nurse that the resident was hit by a black male last night. The resident was assessed and had a scratch mark on their forehead with no redness, bleeding or pain. The LPN documented .Area around the forehead appears lightly discolor. and the Director of Nursing (DON), the physician, and the Licensed Nursing Home Administrator (LNHA) were notified. The resident was transferred to the hospital for further evaluation and treatment.<br><br>A follow up progress note dated 9/18/25 indicated the resident was admitted to the hospital with a diagnosis of bruising of unknown origin.<br><br>The surveyor reviewed the facility provided investigation for the 9/17/25 incident which included the following:<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -A summary of the investigation which included interventions and a conclusion. The summary indicated the RR stated Resident #2 told them a black mail [male] aid [aide] hit them. The summary documented a 72 hour look back was initiated all staff were interviewed. Additionally, two CNAs (CNA #2 and CNA #3) who fit the description of the alleged perpetrator and were assigned to care for resident during the 72-hour lookback were suspended pending the investigation on 9/17/25.<br><br>-A completed AAS-45, a Reportable Event Record/Report, dated 9/18/25 to the New Jersey Department of Health (NJDOH) which indicated the incident was called in to the NJDOH by the facility on 9/17/25 at 4 PM.<br><br>- The facility's investigation included statements from LPN #2, Registered Nurse/Nurse Supervisor (RN/NS), CNA #2, and interviews with seven residents on the unit regarding care by CNAs.<br><br>There was no statement by CNA #3 and there were missing statements with the investigation for the 72-hour lookback of the incident as follows:<br><br>The surveyor did not see a statement from the nurse who cared for the resident on 9/14/25, 7-3 shift.The surveyor did not see a statement from the nurse who cared for the resident on 9/14/25, 3-11 shift.The surveyor did not see a statement from the CNA who cared for the resident on 9/14/25, 7-3 shift.The surveyor did not see a statement from the CNA who cared for the resident on 9/14/25, 3-11 shift.The surveyor did not see a statement from the CNA who cared for the resident on 9/14/25, 11-7 shift.The surveyor did not see a statement from the nurse who cared for the resident on 9/15/25, 3-11 shift.The surveyor did not see a statement from the nurse who cared for the resident on 9/15/25, 11-7 shift.The surveyor did not see a statement from the CNA who cared for the resident on 9/15/25, 7-3 shift.The surveyor did not see a statement from the CNA who cared for the resident on 9/15/25, 3-11 shift.The surveyor did not see a statement from the CNA who cared for the resident on 9/15/25, 11-7 shift.The surveyor did not see a statement from the nurse who cared for the resident on 9/16/25, 3-11 shift.The surveyor did not see a statement from the CNA who cared for the resident on 9/16/25, 7-3 shift.The surveyor did not see a statement from the CNA who cared for the resident on 9/17/25, 7-3 shift.<br><br>On 10/28/25 at 12:53 PM, the surveyor interviewed the LNHA who stated the facility went back 72 hours prior to the incident to interview and obtain statements from the staff who were assigned to the resident. The surveyor informed the LNHA of the concern that the statement for CNA #3 and additional staff statements was not found with the investigation. The LNHA stated that they did obtain CNA #3's statement, all staff were interviewed and that there should be written statements. The LNHA stated he would provide additional information.<br><br>On 10/29/25 at 9:40 AM, the LNHA provided a statement by CNA #3. There were no additional statements provided by the LNHA.<br><br>On 10/29/25 at 1:50 PM, the LNHA and DON met with the surveyors. The LNHA and the DON confirmed for a 72-hour lookback, statements from all staff interviewed should be obtained. The LNHA stated that he did interview all staff but did not obtain written statements from them. There was no additional information provided by the facility's management.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The surveyor reviewed the facility's policy titled Freedom from Abuse Neglect and Exploitation with a last revised date of October 2022 revealed, The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation, or mistreatment: Thoroughly investigate the alleged violation.<br><br>Under Policy Interpretation and Implementation revealed: .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.and providing complete and thorough documentation of the investigation.<br><br>NJAC 8:39-4.1(a)(5) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #423030, and #2622045Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that proper incontinence care was provided to 1 of 3 residents (Resident #5) reviewed for incontinence care.This deficient practice was evidenced by the following:On 10/28/25 at 10:46 AM, the surveyor conducted incontinence (loss of bladder/bowel control) rounds with the Assistant Director of Nursing (ADON) on randomly selected residents who were incontinent. Resident #5 was observed resting in their bed covered with blankets. The resident was alert, verbally responsive, and agreeable to speak with the surveyor. Resident #5 stated that they were waiting for their assigned Certified Nursing Aide (CNA) to return to provide hygiene care. Resident confirmed they were incontinent, wore incontinent briefs, and required staff assistance for hygiene care. The surveyor asked Resident #5 when they last received hygiene care and had their incontinent brief changed. The resident replied, last night and could not recall the exact time. The surveyor asked the resident if they were changed this morning. The resident replied not yet, and that the CNA was returning to provide care. Resident #5 was agreeable for the ADON with the surveyor present to check their incontinent brief. Upon the ADON removing the blanket off the resident, the surveyor and ADON observed the resident had on two incontinent briefs. The outer brief was green in color and the inner brief was yellow in color. The yellow incontinent brief was saturated with dark yellow in color urine. The ADON asked the resident if they requested to have two diapers. The resident stated that the CNAs used the two incontinent briefs, and the resident was ok with it because they don't get changed frequently at times and was worried of soiling outside of their brief. The surveyor asked Resident #5 if the resident initially requested to have the two incontinent briefs applied. The resident replied that they did not initially request to have two incontinent briefs, that the CNA would apply the two briefs, and they thought it was ok. After exiting the room, the ADON stated that some residents may request to use two incontinent briefs at a time and would have to check if it was documented in the resident's care plan. The ADON provided the CNA assignment for the shift which included important information about the residents such as, their assistant needs, incontinent brief size, and other pertinent information. There was no documentation that indicated Resident #5 preferred or requested the use of two incontinent briefs. On 10/28/25 at 11:03 AM, the surveyor interviewed Resident #5's assigned CNA, who stated that at the start of the shift, after receiving her assignment, she would round to check on assigned residents to make sure they were ok and if they were soiled, she would come back to clean them. The surveyor asked the CNA how often she rounded on assigned residents to check if residents needed incontinence care. The CNA replied two to three times on the shift. The surveyor asked the CNA about Resident #5. The CNA confirmed she was the resident's assigned CNA and that on morning rounds the resident was checked and didn't need any assistance. The CNA further explained she answered the resident's call light at approximately 10:38 AM. The CNA stated that Resident #5 thought they had the urge to move their bowels, but it went away, and the CNA told the resident that she would return to provide hygiene care as she was taking care of another resident. The surveyor asked the CNA if she checked the resident's incontinent brief at that time. The CNA replied that she did. The surveyor asked the CNA how she checked the resident's brief. The CNA replied that she felt the outside of the two incontinent briefs. The CNA further explained that she knew the resident was dry from the outside of the two incontinent briefs because if they were soiled it would feel heavy. The surveyor asked the CNA about the use of two incontinent briefs. The CNA replied that staff were supposed to use one incontinent brief, but the residents could request two. The CNA further explained some residents have special requests and Resident #5 liked to wear a liner and an incontinent brief. On 10/28/25 at 11:45 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #5. The admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, right lower leg laceration, right lower leg contusion (bruise), generalized muscle weakness, type 2 diabetes, urinary tract infection, congestive heart failure, and chronic obstructive pulmonary disease (a group of lung diseases that cause long-term breathing problems).A quarterly Minimum Data Set (MDS) assessment, an assessment tool to facilitate the management of care, with an Assessment Reference Date of 7/24/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #5 scored a 15 out of 15, which indicated the resident was cognitively intact. A BIMS assessment dated [DATE] revealed Resident #5 scored a 15 out of 15, indicating the resident |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315416 | A. Building<br>B. Wing | 10/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Green Hill | 103 Pleasant Valley Way<br>West Orange, NJ 07052 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | COMPLAINT # 423030Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to comprehensively investigate a resident reported fall to ensure resident safety according to the facility's policy. This deficient practice was identified for 1 of 1 resident (Resident #1) reviewed for falls and accidents. This deficient practice was evidenced by the following:On 10/28/25 at 9:30 AM, the surveyor requested from the License Nursing Home Administration (LNHA) and the Director of Nursing (DON) all Facility Reported Event (FRE) investigations and a list of residents with falls and injuries in the last six months. On 10/28/25 at 11:20 AM, the DON provided the FRE investigations for the last six months. Resident #1 had one FRE investigation dated 5/2/25 for an injury of unknown origin which occurred on 4/30/25.The surveyor reviewed a facility provided investigation dated 5/2/25 which indicated Resident #1 had an injury of unknown origin for Resident #1 which occurred on 4/30/25. The investigation conclusion and incident note revealed the following:On 4/30/25 at 7:15 AM, Resident #1 was seen by a nurse practitioner (NP) at the bedside. At 7:50 AM, the primary nurse saw the resident and morning care was rendered by the Certified Nursing Assistant (CNA) with nothing unusual observed. At 9:30 AM, the Certified Occupational Therapist Assistant (COTA) visited the resident for a therapy session in their room and the resident reported to the COTA that he/she had a fall and complained of left arm pain. The COTA reported this to the resident's assigned Licensed Practical Nurse (LPN). The LPN went to check the resident. There was no bruising, or any previous fall reported. The LPN applied the resident's routine lidocaine topical cream to their left arm dialysis site which was due to be given prior to their outpatient dialysis treatments. The resident was sent out to their scheduled dialysis session. At approximately 3:00 PM, the facility received a call from the dialysis center stating that the resident was observed with bruising to their face and was transferred to the emergency room (ER) for further evaluation. The family was in the dialysis center when the resident was transferred to the hospital, and then the physician was made aware by the facility of the resident's ER transfer.A review of the facility's investigation revealed that the LPN did not initiate an investigation as per the facility's fall protocol at the time of the resident's reported fall. Additionally, there was no documentation that the physician or RR was informed at the time that the resident reported falling. A review of the Electronic Health Record (EHR) revealed the Resident #1 was not in the facility. Resident #1's EHR revealed diagnoses which included but were not limited to metabolic encephalopathy (the brain does not function properly due to metabolic disturbance), end stage renal disease, and dependence on renal dialysis. A review of the comprehensive Minimum Data Set (MDS), a facility assessment tool to facilitate the plan of care, dated 4/27/25 revealed the resident's cognition using a Brief Interview of Mental Status (BIMS) test. Resident #1 scored a 6 out of 15 which indicated the resident had severe cognitive impairment. A review of the April 2025 order summary revealed:A physician's order for hemodialysis (a treatment to remove waste products and excess fluids from the blood when the kidneys are not able to) on Monday, Wednesday, and Friday with a pickup time of 12:30 PM and their session was scheduled for 1:15 PM at the dialysis center. A physician's order for Lidocaine cream 2.5% that indicated to apply to the left arm dialysis site topically in the morning every Monday, Wednesday, and Friday for pain. A physician's order for skilled Occupational Therapy five times per week for four weeks.On 10/28/25 at 2:40 PM, the surveyor interviewed the Registered Nurse (RN) Supervisor who stated if a resident had a new injury or a fall was reported, a skin assessment and vital signs were completed. The RN Supervisor explained the supervisor, the DON, the physician, and the RR were to be notified of the incident; and the resident's care plan would be updated; and an incident report started.On 10/29/25 at 11:52 AM, the surveyor interviewed the CNA, who was assigned to Resident #1 on 4/30/25, 7AM to 3PM shift. The CNA confirmed that she was assigned to care for the resident and stated that the resident had no bruising before they left for their appointment.On 10/29/25 at 12:09 PM, the surveyor interviewed the LPN, who was assigned to care for the resident on 4/30/25 for the 7AM to 3PM shift. The LPN stated she recalled the COTA informed her that Resident #1 stated that they fell, and she went to check on the resident. The LPN stated that there was no change or injury with the resident. The LPN further explained that she applied lidocaine topical cream to the resident's left arm dialysis access site as ordered and the resident was sent to dialysis in good condition. The LPN stated that the dialysis center called the facility and reported that the resident had a bruise on their face and was going to the ER for evaluation. The LPN confirmed that she did not report to the supervisor, the resident's physician and the RR that Resident #1 reported having a fall incident to a staff member. The LPN also confirmed that she did not initiate the facility's fall incident protocol |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Repeat DeficiencyBased on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to ensure a resident's dietary preferences were honored for 1 of 4 residents (Resident #4) reviewed for food concerns. This deficient practice was evidenced by the following:On 10/28/25 at 10:40 AM, the surveyor accompanied by the Assistant Director of Nursing (ADON) were conducting incontinence rounds. Resident #4 was observed lying in their bed with the head of the bed elevated. The resident was alert, and verbally responsive. Resident #4 had a meal tray on their overbed table positioned in front of them. Resident #4 stated they only received cereal and biscuit on their tray and nothing else. The resident further explained that they were also supposed to receive pancakes on their tray and another staff already went to follow up with the kitchen. Resident #4 stated that this was not the first time that they did not receive food items ordered on their meal tray. The ADON informed the resident she would follow up with the staff regarding their pancakes. On 10/28/25 at 12:56 PM, the surveyor reviewed the electronic medical record (EMR) of Resident #4.The admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to hypertension and generalized muscle weakness. A quarterly Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated 9/23/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #4 scored a 15 out of 15, which indicated the resident was cognitively intact. A physician's order dated 9/11/25 revealed the resident was on a regular texture, and regular (thin) liquid diet. On 10/29/25 at 10:19 AM, the surveyor interviewed the ADON to follow up on the resident's breakfast yesterday. The ADON stated after following up with the kitchen, the resident did not receive pancakes. The ADON further explained that the kitchen did not have it, and the resident was given a sandwich as a substitute. The ADON acknowledged the resident should have received what was listed on the meal ticket for their meal.On 10/29/25 at 2:18 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON) of the above concern for Resident #4 not receiving the food ordered and what was listed on their meal ticket for their breakfast meal. The LNHA stated the resident's food was substituted. The surveyor asked if prior to receiving their breakfast tray, was the resident informed that their pancakes were not available and provided substitution options as the resident had received their meal tray without pancakes or its substitute. There was no further verbal response from the facility at this time.On 10/29/25 at 3:59 PM, the LNHA and the DON met with the survey team. There was no additional information provided to the surveyor. The surveyor reviewed the facility provided policy titled, Dining and Food Preferences with a last review date of October 2022. Under Policy Statement revealed: Individual dining, food, and beverage preferences are identified for all residents/patients. Under Procedures revealed: .The alternate meal and/or beverage selection will be provided in a timely manner.NJAC 8:39-17.4 (e); 27.1 (a) |