STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reformed Church Home	1990 Route 18 North Old Bridge, NJ 08857

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and review of facility provided documents, it was determined that the facility failed to maintain proper kitchen sanitation practices to prevent the development of food borne illness. This deficient practice was evidenced by the following: On 4/21/26 at 9:50 AM, during a tour of the kitchen with the Food Service Director (FSD), the surveyor observed a stainless steel utility rack with stacked pans on each shelf, all turned upside-down. The FSD identified this as the pan rack. The surveyor observed the following:1. Eleven pans stacked together on the second shelf from the top. The FSD identified these as 2-inch full size pans. The FSD separated the 2nd and 3rd pans in the stack which revealed they were dripping a clear thin liquid. The pans were visibly wet on the inside and outside surfaces. The FSD acknowledged the pans should not be stacked together while wet, and acknowledged they were improperly wet-nested (the practice of stacking or storing recently washed dishes or kitchenware while still wet, creating a moist environment that promotes bacterial growth). The FSD removed the stack of pans to the pot washing area to be rewashed.2. Two pans stacked together on the top rack identified by the FSD as 4-inch-deep chafing pans. When removed from the shelf and separated by the FSD, these pans were visibly wet and dripping. The FSD stated his staff was responsible for putting items from the dishwasher onto a drying rack, then once dry, the pans were moved to the pan rack. The FSD acknowledged the chafing pans were still wet when stacked on the pan rack. The FSD removed them to the pot washing area to be rewashed. At 10:30 AM the surveyor observed seven (7) pans stacked together right-side-up on the counter in front of the cooking area. The FSD stated the pans were set there to be used for lunch and identified these as 2-inch half pans. The FSD separated the pans, which were visibly wet on the inside and outside surfaces between them. The FSD acknowledged they were wet-nested. The FSD removed them to the pot washing area to be rewashed. On 4/23/26 at 8:46 AM, in the presence of the FSD, the surveyor observed several pans stacked upside-down on the pan rack. The FSD separated a stack of pans identified as half pans on the second shelf from the top, which revealed visible moisture between the pans. The FSD acknowledged the pans were not completely dried before being stacked. The FSD removed the stack of pans to the pot washing area to be rewashed. On 4/27/26 at 10:27 AM, the Administrator and the Director of Nursing were made aware of the above concerns. A review of the facility policy provided by the Administrator, titled Sanitizing of Equipment last reviewed January 2008 reflected Policy: All personnel will follow standard procedures. to ensure the safety of food served.Purpose: To ensure equipment used in the meal preparation is thoroughly cleaned and sanitized preventing injury and food-borne illness.Procedure:.8. Remove equipment from sink and place on the clean drying rack ensuring that the solution will drain completely. Allow to air dry. Do not stack until completely dry. NJAC 8:39-17.2(g)

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to complete a background check for 1 out of 48 employees (Employee #1). This deficient practice was identified for newly hired employees reviewed since last survey of 12/11/24. This deficient practice was evidenced by the following:On 4/21/26 at approximately 10:16 AM, during the entrance conference, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), all newly hired employee files for active and inactive employees from 12/11/24 to the current date.A review of the employee personnel files revealed the following:For Employee #1, a Certified Nursing Assistant (CNA) with a date of hire 1/12/26, there was no evidence of a background check prior to the start of employment. On 4/24/26 at 12:02 PM, the surveyor interviewed the Staffing Coordinator who stated that Employee #1 was on orientation following a CNA on a unit with residents on 1/12/26. On 4/27/26 at 8:55 AM, the surveyor interviewed the LNHA who stated that background checks are to be completed for employees prior to hire. She further stated that This background check slipped by us. The LNHA acknowledged that for Employee #1 the background check should have been completed prior to the employee working on the unit for orientation. On 4/27/26 at 10:12 AM, the surveyor interviewed the Director of Human Resources who stated that Employee #1's background check was missed and wasn't completed prior to hire. She further stated that it was a human resources error. She acknowledged that the background check should have been completed prior to hire. On 4/27/26 at 10:16 AM, the LNHA and DON were made aware of the above concerns regarding background checks for newly hired employees. The LNHA stated that they had no additional information for the above concerns. On 4/27/26 at 10:24 AM, the LNHA stated that background checks should be completed prior to hire to ensure the employee can provide appropriate care for residents. A review of the facility's Human Resources policy, dated as reviewed 1/24 revealed.The Human Resources Department will coordinate the employment process for all new staff to include: candidate selection, background investigations, and references. to ensure that all employment related procedures are completed in a consistent and timely fashion.No offer of employment shall be made without completion of a criminal background check unless approved by the Director of Human Resources. The applicant must be informed that the offer is contingent upon successful completion of the background check. A review of the facility's Abuse Policy policy, dated as reviewed 2025 revealed .The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention.It is the policy of RCH to screen employees and volunteers prior to working with residents. Screening components include verification of references, certifications and verification of license and criminal background check.Before new employees are permitted to work with residents, the employment history provided by the prospective employee will be verified as well as appropriate board registrations and certifications regarding the prospective employee's background.A criminal background check (which includes the sex offender check) will be conducted by Human Resources, on all prospective employees. NJAC 8:39-9.3(b)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to ensure professional standards of nursing practice were followed by offloading (use of a device or specialized surface to decrease the risk of pressure injury) a resident's heels according to the physician's order. This deficient practice was identified for 1 of 1 resident (Resident #14) reviewed for prevention of pressure injury and 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 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. 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 4/22/26 at 10:03 AM, during the initial tour, the surveyor observed Resident #14 in their bed, without a cover over their legs. Resident #14 was wearing dark blue socks that went above their ankles, and pants with wide pantlegs. Resident #14 stated they had twisted their ankle during a fall in January and was receiving therapy to be able to walk again. The resident stated the staff had to assist with putting their pants and socks on. At 11:00 AM, the surveyor interviewed the Registered Nurse (RN #1) who stated Resident #14 needed extensive assistance with care and had no skin breakdown (damage to healthy skin and underlying tissues). RN #1 stated she provided care to Resident #14 to prevent skin breakdown. In the presence of the surveyor, RN #1 reviewed Resident #14's electronic treatment administration record (eTAR) and stated Resident #14 had heel booties (cushioned pillows that wrap around the foot, secured by velcro, to protect heels from pressure) to prevent breakdown. RN #1 acknowledged she signed off (entered her initials electronically) that the heel booties were in place that morning. RN #1 stated if her initials were on the eTAR, that meant the heel booties were on the resident. At 11:50 AM, in the presence of the surveyor, RN #1 went into Resident #14's room, where the heel booties were not observed. RN #1 looked on and under Resident #14's bed, in their bedside stand, and in their closet. RN #1 acknowledged she could not locate heel booties for Resident #14. At 11:58 AM, RN #1 spoke to the surveyor in the hallway, acknowledging my mistake, [Resident #14] didn't have them (heel booties), I am going to get them now. On 4/24/26 at 10:40 AM, the surveyor interviewed the Unit Manager (UM)/RN who acknowledged it was her responsibility to review and update the care plan for Resident #14. She stated Resident #14 does not have any skin breakdown or wounds. She stated to prevent breakdown the resident should have had heel booties to float their heels off the mattress. The UM/RN, in the presence of the surveyor, reviewed the eTAR for Resident #14. The UM/RN stated the nurse's initials on the eTARS indicated the heel booties were on the resident, and it was the nurse's responsibility to ensure they were on. The surveyor reviewed the electronic medical record (EMR) for Resident #14. A review of the Resident Face Sheet, an admission summary, reflected the resident was admitted with diagnoses which included but were not limited to syncope (temporary loss of consciousness/fainting) and collapse, pulmonary hypertension (high blood pressure in the arteries of the lungs), and sprain of unspecified ligament of left ankle. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 12/26/25, reflected the resident had a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident was cognitively intact. Further review of the MDS reflected the resident was at risk of developing pressure ulcers/injuries. A review of the Physician's (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Orders reflected an order dated 4/11/26 to apply heel protectors/booties when in bed. Check placement every shift. A review of the April eTAR reflected the order to apply heel protectors/booties when in bed. Further review reflected nurses' initials for each shift of each day starting on April 11, indicating the heel protectors/booties were applied when in bed and placement was checked. A review of the Care Plan Activity Report, an individualized comprehensive care plan, reflected a focus area for Skin effective 12/10/25.the resident was at risk for skin breakdown due to impaired mobility / impaired body movement.Interventions included heel protectors. A review of the undated facility-provided document titled Wound and Skin Care Protocols reflected the following:.Care interventions are directed toward minimizing and/or eliminating the effects of the causal/contributing factors pressure, moisture, friction/shear and nutrition.Pressure:.3. Heels are extremely vulnerable and must be elevated completely off bed surface. NJAC 8:39-27.1(e)

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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. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure professional standards of nursing practice were followed by administering oxygen therapy according to the physician's order. This deficient practice was identified for 1 of 1 resident (Resident #52) reviewed for respiratory care and 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 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.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 4/21/26 at 11:11 AM, during an initial tour, the surveyor observed No smoking, Oxygen (O2) in use signage at Resident #52's room door. The surveyor observed Resident #52 watching TV in their bed while receiving O2 via nasal cannula (NC) (a flexible tube placed in the nares) connected to an O2 concentrator (a medical device to provide supplemental O2 therapy to people who have lower O2 levels) which indicated a setting of 1 liter per minute (L/min). The resident did not speak to how much O2 they were on.On 4/22/26 at 12:23 PM, the surveyor observed Resident #52 sitting in their wheelchair receiving O2 via NC, which was connected to the O2 concentrator set at 1 L/min. The surveyor reviewed the electronic medical record (EMR) for Resident #52A review of the Resident Face Sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to; Acute (severe or sudden) and Chronic (a condition, disease or situation that lasts for a long time or is constant) respiratory failure (a serious condition where the lungs cannot properly move O2 into blood or remove carbon dioxide) with hypoxia (low levels of O2 in your body tissue), respiratory conditions due to smoke inhalation (breathing in), and shortness of breath. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 2/21/26, revealed the resident had a Brief Interview for Mental Status of 11 out of 15, indicating the resident had moderately impaired cognition. Further review of the MDS revealed the resident was receiving O2.A review of the Physician's Orders revealed a Physician Order (PO) dated 4/7/26 for: O2 via NC continuous at 2 L/min to maintain SpO2 (a measurement of how much O2 your blood is carrying as a percentage of the maximum it could carry) at 92% or higher.A review of the April 2026 Medication Administration Record (MAR) for Resident #52 revealed nurses' signatures for each shift indicating the resident was being administered continuous O2 at 2 L/min to maintain their SpO2 at 92% or higher. On 4/22/26 at 12:23 PM, the surveyor interviewed the Registered Nurse (RN) who stated they needed a PO for O2 administration, so they knew how much O2 was needed and whether it was to be administered continuously or as needed. The RN stated she had only one resident (Resident #52) who was on O2 at 2L/min and the resident was maintaining their SpO2 between 95-97%. The RN stated during her rounds at the beginning of her shift, she checked how much O2 Resident #52 was on. The surveyor accompanied the RN to Resident #52's room and observed the resident's O2 concentrator which indicated a setting of 1 L/min. The RN acknowledged that during rounds she should have made sure Resident #52's O2 was set to the amount that was ordered by the physician. The RN stated if the resident was on a low amount of O2, they could go into respiratory distress.On 4/22/26 at 12:50 PM, the surveyor interviewed the RN/Unit Manager (UM) who stated if a resident had shortness of breath and their SpO2 was low, they would notify the physician to obtain O2 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders. The surveyor reviewed Resident #52's O2 PO with the RN/UM and the RN/UM stated the resident should be on continuous O2 at 2L/min. The surveyor made the RN/UM aware of the above-mentioned concerns for Resident #52. The RN/UM stated the expectation for the nurses was to make sure the resident was on O2 at the right setting as per PO prior to signing the MARs. The RN/UM acknowledged that the O2 order was clearly for 2L and further stated technically oxygen is a medication, and they (the nurses) should be following POs.On 4/23/26 at 11:24 AM, the surveyor made the Director of Nursing (DON) aware of the above-mentioned concerns for Resident #52. The DON stated the nurses were signing off the MARs for how many liters of O2 the resident was getting. The DON further stated that the expectation for the nurses was to follow POs for O2 administration. On 4/23/26 at 12:04 PM, the survey team met with the Licensed Nursing Home Administration (LNHA) and the DON. The surveyor made the facility administration aware of the above-mentioned concerns for Resident #52. A review of the facility policy Oxygen Administration reviewed 2026 revealed under Procedure: 1. Check for MD (physician)/Nurse Practitioner (NP) order. A review of the facility job description titled, Staff Nurse provided by the DON included but was not limited to; Under Essential Functions: Communicates with physician/ Advanced Practice Nurse (APN) and transcribed, documents, and implements physician's orders. NJAC 8:39-11.2(b); 27.1(a)