| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315419 | A. Building<br>B. Wing | 01/23/2026 |

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| N J Eastern Star Home | 111 Finderne Avenue<br>Bridgewater, NJ 08807 |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on interview, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to a.) complete reference checks for 2 out of 52 employees (Employee #4, #5); b.) complete background checks for 3 out 58 employees (Employee #1, #12, #13); and c.) complete license checks for 2 out of 58 employees (Employee #3, #8). This deficient was identified for newly hired employees reviewed since last survey from 9/27/2024 and was evidenced as follows:1.) A review of the employee personnel files revealed the following:For Employee #4, a Certified Nursing Assistant (CNA) with a start date of 6/28/25, there was no evidence of a reference check prior to the start of employment.For Employee #5, a CNA with a start date of 9/25/24, there was no evidence of a reference check prior to the start of employment.2.) A review of the employee personnel files revealed the following:For Employee #1, a housekeeper with a start date of 3/3/25, there was no evidence of a background check prior to the start of employment.Employee #12, activities support staff with a start date of 10/7/24, there was no evidence of a background check prior to the start of employment.Employee #13, a dietician with a start date of 11/20/24, there was no evidence of a background check prior to the start of employment.3.) A review of the employee personnel files revealed the following:Employee #3, a Registered Nurse (RN) with a start date of 10/27/25, there was no evidence of a license check prior to the start of employment. Employee # 8, an RN with a start date of 10/9/24, there was no evidence of a license check prior to the start of employment. On 1/22/26 at 2:01 PM, in the presence of the survey team, the surveyor made the Infection Preventionist (IP), Assistant Administrator (AA), and the Minimum Data Set Coordinator (MDS Coordinator) were made aware of the concerns regarding employee background checks, reference checks and license checks prior to hire. The AA acknowledged that the background checks, reference checks and license checks should be completed prior to hire in accordance with their abuse policy. The AA further stated that human resources complete the background check. The department head will complete the two reference checks. On 1/23/26 at 11:00 AM, the surveyor interviewed the Director of Administer Services and Human Resources, who stated that background checks, reference checks, and license checks should be completed prior to the employees hire. She further stated that the head of the department that the employee is hired will complete the reference checks. The human resources department will complete the background checks prior to hiring.A review of the facility's Abuse policy, revised 9/30/25.our facility will not knowingly hire any individual who has a history of abusing other persons. We will conduct employment background screening checks, reference checks and criminal background checks, as required, on all individuals who are offered employment within the New Jersey Eastern Star Home. Human resources (or other person as directed by the Administrator) will conduct employment background checks, 2 reference checks, and criminal conviction checks (including fingerprinting as required by law) on persons upon offer of employment.The appropriate professional licensing board will be contacted for any licensed individual who may have direct contact with residents to ensure there are no prior convictions for abuse or related offenses. A review of the facility's Comprehensive Recruitment and Hiring Policy, revised 8/14/25. Policy: the NJESH is committed to maintaining a comprehensive set of procedures for the recruitment and hiring of new<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | employees to ensure efficiency and fairness in the selection process.All potential new hires must follow the process below: The HR manager will review the application and conduct a background check. Once the background check is completed and the potential new hire is cleared, the HR manager will advise the Department Head to schedule a physical and drug test. The Department of Head must contact at least 2 references and fill out the reference form . Once the new hire passes the physical/drug test and the reference checks have been done and if the new hire accepts the offer, then they must see the HR Manager for the new hire paperwork packet. The new hire cannot start until the HR manager receives the new hire paperwork packet and it's complete. This includes the reference checks from the Department Head.NJAC 8:39-9.3(b) |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives.<br><br>READY TO BE REVIEWEDBased on observation, interview, and record review, it was determined that the facility failed to document the code status (medical instructions regarding resuscitation and other lifesaving measures in the event of a medical emergency) for 2 of 3 residents reviewed (Resident #30 and # 73) for advanced directives.This deficient practice was evidenced by the following:1.On 1/21/26 at 9:38 AM, during the initial tour, the surveyor observed Resident #30 in bed with their eyes closed. The resident did not respond to the surveyor.The surveyor reviewed Resident #30's electronic medical record (EMR).A review of the resident's admission Record Face Sheet (FS; an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; dementia (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions), anemia (the lack of red blood cells resulting in reduced oxygen transport to organs) and urinary tract infection (a bacterial infection in the bladder, kidneys or urethra).A review of the resident's EMR revealed the following physician orders (PO) with the start date of 1/6/26: Hospice Eval and treatment with [Name Redacted] Hospice; Resident was evaluated and admitted to [Name Redacted] Hospice. Further review of the residents' EMR and hybrid paper chart did not reveal a PO for the resident's code status. A review of the resident's hybrid paper chart revealed a New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form, dated 7/13/19. The POLST documented the resident had an advance directive that they desired do not attempt resuscitation/DNAR and Do not intubate (DNI). The form was signed by the resident and a physician. A review of the resident's Care Plan (CP) included a focus area which indicated I need comfort care related to terminal prognosis secondary to my current medical condition, preference for DNH (do not hospitalize)/DNR (do not resuscitate) code status and my enrollment to Hospice care program. The CP had an initiation date of 1/6/26.2.On 1/20/26 at 11:15 AM, during the initial tour, the surveyor observed Resident #73 sitting in their wheelchair.A review of the resident's FS revealed the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, anemia and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities).A review of the resident's hybrid paper chart included a NJ POLST form, dated 11/15/22. The POLST documented the resident had advance directives that they desired do not attempt resuscitation/DNAR and Do not intubate (DNI). The form was signed by the resident representative and a physician.A review of the residents' EMR and hybrid paper chart revealed there was no PO for the resident's code status. A review of the resident's CP did not reflect a focus area to indicate resident's DNR/DNI code status.On 1/22/26 at 12:13 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) about code status (advance directives). The LPN stated if the resident's code status was a full code, there would not be any PO in the EMR. The surveyor inquired what if the resident had DNR/DNI code status. The LPN stated that there would be POs entered in the EMR, the code status would be reflected in the CP, and it would display in the dashboard (where you would see basic information about the resident). The LPN stated it was important to have a resident's code status in the EMR so that all the staff have same information in order to take care of the resident. In the presence of the surveyor, the LPN reviewed the EMR for Resident #30 and Resident #73 and acknowledged there were no POs for their code status, and their code status was not reflected in their dashboard. The LPN stated Resident #30 was receiving hospice services and the code status was not updated after the resident returned from the hospital. At that time, after reviewing Resident #73's EMR in the presence of the surveyor, the LPN stated, there is no DNR/DNI orders that means the resident is a full code. The LPN then reviewed the paper chart for Resident #73 and read the POLST form and further stated that the resident's code status should be DNR/DNI. The LPN further reviewed the CP for Resident #73 and acknowledged that the care plan was not updated with the code status and should have been updated.On 1/22/26 at 2:05 PM, the<br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | survey team met with the Assistant Licensed Nursing Home Administrator (Asst LNHA), Infection Preventionist (IP) and Minimum Data Set (MDS) Coordinator. The surveyor informed the administration of the above-mentioned concerns.On 1/23/26 at 9:49 AM, the Asst LNHA, IP and MDS Coordinator met with the survey team. The Asst LNHA stated the code status was reviewed for Resident #30 and Resident #73. The Asst LNHA acknowledged the POs should have been entered in EMR for both residents.A review of the facility provided policy titles, POLST signed and dated 3/11/21 indicated under Procedure: F. The DNI, DNR, DNH must be placed in the appropriate field in the EMR.N.J.A.C. 8:39-9.6 (a) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a low air loss mattress was functioning properly and accurately setup according to the resident's weight in accordance with a physician's order for a resident who was previously identified to have had an alteration in skin integrity.This deficient practice was identified for 2 of 2 residents (Resident #15 and Resident #38) reviewed for pressure ulcers and was evidenced by the following:a.) On 1/20/26 at 10:58 AM and 12:09 PM, the surveyor observed Resident #15 lying in bed, sleeping, on an air mattress. The resident's air mattress pump was observed to be set to a weight of 250 pounds.On 1/21/26 at 9:26 AM, the surveyor observed Resident #15 lying in bed, awake, eating breakfast, the air mattress pump was noted to be set to a weight of 250 pounds.On 1/22/26 at 9:27 AM, the surveyor observed the air mattress pump set to a weight of 250 pounds. The resident was in bed sleeping, at that time.A review of the admission Record, an admission summary, revealed the resident had diagnoses which included but were not limited to; Alzheimer's disease (type of dementia that affects memory, thinking and behavior), dementia (loss of memory, language, problem-solving), polyosteoarthritis (degeneration of cartilage and the underlying bone within a joint, leading to pain, stiffness, and impaired movement), and fusion of cervical spine (surgical procedure that permanently joins two or more vertebrae in the neck).A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 10/16/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS, indicated that the resident was at risk to develop a pressure ulcer/injury, and on that date had two Stage 3 pressure ulcers (full-thickness skin loss) present. Additional review of the MDS, revealed the Skin and Ulcer/Injury Treatments section included a pressure reducing device for the bed and pressure ulcer/injury care. The resident's weight was noted to be 132 pounds.A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 1/16/24, the resident had a potential for skin breakdown development related to decrease mobility secondary to the disease process. Interventions included: pressure relieving/reducing device on bed and to reposition the resident in bed in a way that shearing is reduced. Another focus area dated 10/2/25, revealed that the resident had actual skin breakdown to the right buttock related to fragile skin. Interventions included: administer treatments per physician orders and monitor its effectiveness, provide the resident with preventive care. A record review revealed ongoing weekly wound assessment with recommendations by wound care consultants were completed, the wound showed improvement.A review of the Order Summary Report included the following physician orders (PO):A PO, dated 7/29/24, for moisture barrier to the sacral area topically every shift for prophylaxis.A PO, dated 9/15/25, for 30 milliliters (ml) of Protein Supplement two times a day for wound healing.A PO, dated 9/18/25, for a low air mattress, check placement and functioning every shift for wound healing. b.) On 1/20/26 at 11:03 AM, the surveyor observed Resident #38 lying in bed, sleeping, on an air mattress. The resident's air mattress pump was observed to be set to a weight of 325 pounds (lbs).On 1/21/26 9:28 AM, the surveyor observed Resident #38 lying in bed, awake, on an air mattress. The resident's air mattress pump was observed to be set to a weight of 325 pounds.On 1/22/26 9:29 AM, the surveyor observed Resident #38 lying in bed, awake, on an air mattress. The resident's air mattress pump was observed to be set to a weight of 325 pounds. A review of the admission Record revealed the resident had diagnoses which included but were not limited to; dementia (loss of memory, language, problem-solving), primary generalized osteoarthritis (degenerative joint disease involving cartilage loss), and low back pain.A review of the resident's most recent comprehensive MDS, an assessment tool dated 12/10/25, included the resident was unable to complete the interview for BIMS, indicating the resident's cognition was severely impaired and their cognitive skills for daily decision making were moderately impaired. Further review of the MDS, indicated that the resident was at risk to develop a pressure ulcer/injury, (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and on that date had one unstable pressure ulcers (full-thickness skin and tissue loss where the wound's depth is hidden by slough) present. Additional review of the MDS, revealed that the Skin and Ulcer/Injury Treatments section included a pressure reducing device for the bed and pressure ulcer/injury care. The resident's weight was noted to be 148 pounds.A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 9/23/24, the resident had a potential for skin breakdown development related to decreased mobility secondary to the diagnosis. Interventions included: pressure relieving/reducing device on the bed and to reposition the resident in bed in a way that shearing was reduced. Another focus area dated 12/15/25, revealed that the resident had actual skin breakdown to the sacrococcyx (tailbone) related to pressure injury. Interventions included: administer treatments per physician orders and monitor its effectiveness, and to use pressure reduction mattress.A record review revealed ongoing weekly wound assessment with recommendations by wound care consultants were completed, the wound was noted to be chronic but in a stable state.A review of the Order Summary Report included the following POs:A PO, dated 10/4/24, for moisture barrier to the sacral area topically every shift for prevention.A PO, dated 9/10/25, for a low air mattress, check placement and function every shift for wound healing.A PO, dated 10/21/25, for 30 milliliters (ml) of Protein Supplement two times a day for wound healing.On 1/22/26 at 10:52 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding Resident #15's and Resident #38's mattress settings. The LPN stated an air mattress function was to offload pressure on their sacral wounds and to alleviate pressure for at-risk residents. When asked about the importance of assessing whether a mattress worked properly and maintained the correct air pressure, the LPN replied that the air mattress goes by the resident's weight because we don't want it to be too soft or too firm for the resident's skin integrity. He stated that if it was set to the wrong setting, then it would defeat the purpose of having an air mattress. The LPN further stated wound care recommends the air mattress, the nurse or vendor would set the air mattress up for the resident. The nurse was responsible for checking the air mattress setting when they complete their normal rounds every shift. At 11:01 AM, the surveyor and the LPN went to Resident #15's room. The surveyor asked whether the pump was set correctly for Resident #15's weight; the LPN stated that the resident weighed 129.6 pounds on 12/20/25 but the air mattress was set to 250 pounds. The surveyor and the LPN went to Resident #38's room. The LPN confirmed that Resident #38's weight on 12/20/25 was 142 pounds and the air mattress was set to 325 pounds. The LPN acknowledged that it should have been set according to the residents' weight and that he will check the settings for all residents on air mattresses to ensure they are on the correct weight.On 1/22/26 at 2:01 PM, in the presence of the survey team, the surveyor made the Infection Preventionist (IP), Assistant Administrator (AA), and the Minimum Data Set Coordinator (MDS Coordinator) aware of the concerns regarding Resident #15's and Resident #38's air mattress. The AA acknowledged that the air mattresses should be set according to a resident's weight to prevent skin breakdown.On 1/23/26 12:24 PM, the Charge Nurse/Licensed Practical Nurse (UM/LPN), stated that there were no facility policies on resident air mattresses. She further stated that moving forward the facility would implement a policy on air mattresses.A review of the manufacturers Operation Manual for the air mattress and pump provided to the surveyor by the facility states: Step 4.0 system package: Weight (lbs) simply press weight button to adjust patient, weight 100 lbs to 325 lbs according to patient weight.A review of the facility's Skin Integrity Program policy, reviewed 4/25/24, included. use pressure relieving devices such as special mattresses .NJAC 8:39-27.1(a) |

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| 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>Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to follow physician orders (PO) for fall prevention as written on the Physician Order Summary. This deficient practice was identified for 1 of 3 residents (Resident # 2) reviewed for accidents and was evidenced by the following:On 1/21/26 at 9:56 AM, the surveyor observed Resident #2 with their eyes closed in their bed. The surveyor observed a floor mat (specialized pads placed beside a resident's bed to reduce injury severity from falls) folded up, leaning against the wall under the window. On 1/21/26 at 10:13 AM, the surveyor interviewed the Certified Nurse Aide (CNA) in the presence of the Licensed Practical Nurse (LPN#1). The surveyor inquired about the floor mat for Resident #2 and the CNA stated, it might be something new, and it is for nighttime. The surveyor reviewed the electronic medical record for Resident #2. A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; displaced (bone fragments have moved out of their normal alignment) intertrochanteric fracture (a common type of hip fracture) of right femur (thigh bone), unspecified injury of left ankle, history of falling, and difficulty in walking. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/29/25, revealed a Brief Interview for Mental Status score of 9 out of 15, which indicated that the resident had moderate impaired cognition. Further review of the MDS indicated that Resident #2 was coded as Yes as having a fall history in the last month prior to their admission. A further review of section J revealed that the resident had fractures related to a fall prior to admission. A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area of at risk for falls related to gait/balance problems secondary to diagnoses of right femur fracture, left ankle injury, fall, ambulatory dysfunction (a condition that makes it difficult or impossible to walk), dated 12/23/25. Further review of the ICCP reflected a focus area of the resident had a fracture of right hip related to diagnosis of fall, initiated on 12/23/25. A review of the Order Summary Report (OSR) reflected an active PO dated 12/26/25 for floor mat to left side of bed, monitor placement every shift for prevention. On 1/22/26 at 9:35 AM, the surveyor interviewed LPN#2, who stated that Resident #2 was a fall risk when the resident was admitted to the facility. LPN#2 also stated that the importance of the floor mat was for protection when the resident was getting out of bed without assistance in the evenings. On 1/22/26 at 2:10 PM, during a meeting with the survey team, the Assistant Licensed Nursing Home Administrator (ALNHA), Infection Preventionist, and MDS Coordinator were made aware of the above mentioned concerns. No additional information was provided. A review of facility's undated Fall Prevention Program policy, revealed. While the falls care plan may include potentially effective interventions, it is staff compliance that will reduce fall risk. A program's success or failure can only be determined if staff actually implement the recommended interventions. Resident response must also be monitored to determine if an intervention is successful. Changes in care and alternate interventions should be decided based on continued assessment. A review of facility's Physician Orders Policy, revised 2/10/25, revealed .Nursing supervisors or designees will audit orders periodically for accuracy, timeliness, and compliance. NJAC 8:39-27.1(a) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observations, interview, and review of facility policy, it was determined that the facility failed to appropriately label medications in accordance with professional standards of practice. The deficient practice was identified for 1 of 5 medication carts (the Subacute Rehab Side 2 medication cart) inspected during the Medication Storage task. The deficient practice was evidenced by the following:On 01/22/2026 at 9:40 AM, the surveyor inspected the Subacute Rehab side 2 medication cart with the Registered Nurse (RN) on D wing. The surveyor observed five syringes of Enoxaparin 30mg/3mL (a prescription drug used to prevent and treat blood clots, especially after surgery or serious illness) were lying in the third drawer, with no resident label or date and were not in a bag. The syringes were in their original packaging. The RN stated, I'm going to be honest, they are not stock, they should be labeled. The RN then disposed of the syringes in the sharps container on the right side of the cart. The RN stated the pharmacy checks the carts but did not know how often. The RN was unaware if nursing staff checked the carts. Further review of the cart revealed a bottle of liquid protein supplement was present in the bottom drawer. The bottle was opened and not labeled with the open date. The RN stated, they are good for 30 days.On 01/22/2026 at 2:10 PM, during a meeting with the survey team, the Assistant Licensed Nursing Home Administrator (ALNHA), Infection Preventionist, and MDS Coordinator were made aware of the above mentioned concerns. On 01/23/2026 at 12:40 PM, in a phone interview with the Pharmacy Consultant (PC), the PC stated the PC makes sure the facility is compliant with medication storage and labeling. If Enoxaparin is in the cart, it should have a patient specific label on it. If it is found without a label, I would inquire with nursing, find out who the resident was and put it in the labeled box. It is not stock and should not be floating unlabeled. The PC also stated he did a formal medication pass observation and medication cart check a couple of weeks ago.A review of the facility policy titled Cleaning and Disinfection of Medicine Carts, dated 03/15/2023 provided by the Assistant Licensed Nursing Home Administrator (ALNHA) revealed Policy Statement. Medication carts are considered shared medical equipment and shall be maintained in a clean, sanitary, and safe condition at all times. Scope: This policy applies to all licensed nursing staff, nursing supervisors, and the Infection Preventionist. N.J.A.C. S 8:39-29.4 (a) (h) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure the required committee members, the Infection Preventionist (IP), was present for one of five Quality Assurance and Performance Improvement (QAPI) meetings. This deficient practice was evidenced by the following:On 01/20/2026 at 09:34 AM, during entrance conference, the surveyor requested the QAPI sign-in sheets from the last survey date of 9/27/2024 to present. On 01/23/2026 at 10:49 AM, the surveyor reviewed the QAPI Meeting Sign In Sheet dated 04/07/2025, which revealed the IP did not sign the sheet. On 01/23/2026 at 10:49 AM, during a meeting with surveyor, the Assistant Licensed Nursing Home Administrator (ALNHA) reviewed the QAPI Meeting Sign In Sheet dated 04/07/2026 and confirmed the IP did not sign the sign in sheet. The ALNHA stated in the absence of the IP, the Director of Nursing (DON) would review the IP information. On 01/23/2026 at 12:32 PM, a review of the QAPI Minutes dated 04/07/2025 at 10:40 AM revealed under the Nursing section skill competencies. Further review did not reveal infection control was not presented. On 01/23/2026 at 12:35 PM, in the presence of the survey team, the ALNHA acknowledged the QAPI Minutes provided were the full minutes, and there was nothing additional to add. A review of the facility's Quality Assurance & Performance Improvement (QAPI) policy dated 07/30/2025, revealed Purpose: New Jersey Eastern Star Home will participate in an effective, comprehensive, data driven QAPI process that focuses on systems of care, outcomes, and services for residents and staff.Facility governing body will ensure that the QAPI program is defined, implemented, and maintained, addressing identified priorities. Procedure: A. The QAPI committee is comprised of: .4) Infection Control/Preventionist. NJAC 8:39-33.1(b); 33.2(c)(7) |