STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315437	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Bay Health & Rehabilitation Center	32 Laurel Avenue Keansburg, NJ 07734

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43936 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed provide services with reasonable accommodation of resident needs specifically by failing to keep call devices within reach of the resident. The deficient practice was identified 2 of 2 residents (Resident #80 and Resident # 236) reviewed for call devices. On 12/30/2024 at 10:29 AM during the initial tour of the facility, surveyor # 1 observed Resident # 236's call device on the floor next to the night stand. It was connected to the wall input. On 12/31/2024 at 8:58 AM, surveyor # 1 observed Resident # 236's call device on the floor next to the night stand. It appeared to be in the same location as the previous observation. At that time during an interview with surveyor # 1, Resident # 236s said they would use it if he/she could find it. On 1/06/2025 at 11:44 AM during an interview with surveyor # 1, the Assistant Director of Nursing said they [call devices] are attached to the resident's bed, pillow, or sheet but we do have some that are wrapped around the rail or behind their head so when they lay down they can reach above. A review of the undated facility policy titled, Call Light System revealed that, Unless indicated in the care plan, each resident, when in their room or in bed, must have the call light placed within reach at all times, regardless of staff assessment of resident ability to use it. When resident is in bed, the call bell should be fastened to the side rail he/she is facing . 45209 On 12/31/2024 at 11:06 AM, surveyor #2 observed Resident #80 in their room on the bed. Surveyor #2 asked permission from Resident #80 to enter and was granted permission. Upon entering, surveyor #2 observed Resident #80's call device on the floor behind the bedside table. When asked if they knew where their call device was, Resident #80 denied. When asked if the call device was behind the dresser the resident responded that the call bell shouldn't be there. That doesn't make sense. It wouldn't help me if I needed it. The surveyor reviewed the medical record for Resident #80. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Malignant Neoplasm of Breast, Anxiety Disorder, and Depression. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/17/2024 included the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated the resident's cognition was moderately impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 12/2/2024, that the resident was at risk for falls [related to] gait/balance problems, psychoactive drug use/vision hearing problems. Interventions included: Be sure call light is within reach and encourage me to use it for assistance was needed. On 1/3/2025 at 10:24 AM, surveyor #2 interviewed CNA #2 who confirmed call devices are a fall intervention and that they should be clipped to the bed or pillow and within reach of the resident. On 1/3/2025 at 12:14 PM, surveyor #2 interviewed Licensed Nurse Practitioner (LPN #1) who confirmed that call devices are to be within reach of the resident at all times. LPN #1 further confirmed that she was aware of the call device previously being behind the dresser and moved it to bed. On 1/06/2025 at 11:44 AM during an interview with surveyor # 1, the Assistant Director of Nursing (ADON) advised that call devices are to be on the bed, pillow, or sheet. A review of the undated facility policy titled, Call Light System revealed that, Unless indicated in the care plan, each resident, when in their room or in bed, must have the call light placed within reach at all times, regardless of staff assessment of resident ability to use it. When resident is in bed, the call bell should be fastened to the side rail he/she is facing . NJAC 8:39-27.1 (a)

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(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** 43936 Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to keep all areas clean. The deficient practice was identified for 2 of 2 floors reviewed under the Environmental Task. The deficient practice was evidenced by the following: On 12/30/2024 at 10:31 AM, Surveyor # 1 observed room [ROOM NUMBER]. At that time, Surveyor # 1 observed water on the floor. No wet-floor sign was observed. On the same date at 10:37 AM, Surveyor # 1 observed Resident # 35 in their room. At that time, Surveyor # 1 observed spilled milk on the floor and no bag liner in the trash bin. On 12/31/2024 at 11:03 AM, Surveyor # 1 observed the first floor shower room across from room [ROOM NUMBER]. At that time, Surveyor # 1 observed brown stains on the floor, tile, and caulked areas. Exposed dry wall was also observed to be present behind the measuring scale. On 1/06/2025 at 11:44 AM during an interview with Surveyor # 1, the Director of Nursing (DON) said that resident rooms are cleaned on a daily basis. the DON also said that it is a shared responsibility to contain spills and pick up discarded items on the floor. 51232 B.) On 12/31/2024 at 9:43 AM, Surveyor #2 observed embedded black and gray marks on the bathroom floor in room [ROOM NUMBER] on the second floor. On 01/02/2025 at 9:12 AM, Surveyor #2 observed that the trash can in room [ROOM NUMBER] on the second floor was missing a bag liner. On 01/02/2025 at 10:04 AM, Surveyor #2 observed missing floor tiles on the second-floor shower room, which exposed a brown substance around the drain. There were also missing tiles at the entrance to the shower area. Additionally, several wall tiles around the heater vent and sink were absent, revealing a gray substance. The wall tile covered by a white board showed a hole in the wall. During an interview with Surveyor #2 on 12/06/2024 at 11:40 AM, the Director of Housekeeping (DOH) said that general cleaning of the facility is conducted daily and as needed. Housekeeping is responsible for changing trash can liners, while Certified Nursing Assistants (CNAs) are tasked with emptying trash and replacing liners if they fill the trash cans. Maintenance logs are kept and updated on the nursing units, and maintenance conducts regular walk-throughs to address any issues identified in the facility. The facility was unable to provide a policy regarding the environment conditions in the facility. N.J.A.C. 8:39-31.3(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209 Based on observation, interview, and record review it was determined that the facility failed to accurately assess the status of a resident in the Minimum Data Set (MDS), an assessment tool used to facilitate care. This deficient practice was identified for 1 of 23 residents (Resident #80) reviewed and was evidenced by the following: Upon initial tour of the facility on 12/30/2024 at 10:44 AM, Resident #80 was observed wandering by the 1st Floor nursing station. The surveyor observed an elopement device on the resident's left ankle. On 12/31/2024 at 11:06 AM, the surveyor observed Resident #80 sitting on their bed in their room. The surveyor asked permission from Resident #80 to enter and was granted permission. Resident #80 acknowledged the presence of the bracelet on the left ankle, but did not know what it was. The surveyor reviewed the medical record for Resident #80. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Malignant Neoplasm of Breast, Anxiety Disorder, and Depression. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/17/2024 included the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated the resident's cognition was moderately impaired. Section P0200 reflected that the resident was coded as 0 indicating there was no wander/elopement alarm. A review of the Electronic Medical Record included the following physician orders (PO): A PO, dated 8/23/2024, for [Elopement Device] to [Right] ankle. Check placement. A review of December 2024 Treatment Administration Record revealed a check and nurses initials confirming the physician's order of [elopement device] to [Right] ankle. Check placement. On 1/7/2025 at 9:13 AM, the surveyor interviewed the MDS Coordinator who confirmed that she completed section P of the MDS. The MDS Coordinator reviewed Resident #80's physician orders and confirmed an order for a Wanderguard on 8/23/2024. Upon reviewing the resident's Quarterly MDS dated [DATE], the MDS Coordinator confirmed the section was coded as 0 indicating there was no wander/elopement alarm. A review of the facility's MDS 3.0, dated 10/1/2010, policy included the following Purpose: the MDS 3.0 assessment will be conducted to identify problems in order to develop and implement an individualized and comprehensive plan of care that provides each resident with the care and services to attain or maintain their highest practicable physical, mental, and psychosocial well being. NJAC 8:39-11.1

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49712 Based on observation interview and record review, it was determined that the facility failed to develop and implement a care plan focus for 1 of 2 residents (Resident #68) reviewed for comprehensive care plans related to indwelling catheter care. This deficient practice was evidenced by the following: During initial tour on 12/30/2024 at 09:48 AM, the surveyor observed Resident # 68 resting in bed with a urinary drainage bag attached to the bed frame. A review of the Admission Record located in the Electronic Medical Record, Resident #68 was admitted to the facility with diagnoses including but not limited to: Functional Quadriplegia (the complete inability to move due to severe disability or frailty due to another medical condition, without injury or damage to spinal cord), and Dementia (a group of symptoms affecting memory, thinking, and social abilities). A review of the current Care Plan (CP) for Resident #68 did not include documentation of a CP focus area or interventions for the care of indwelling catheters. During an interview on 1/03/2025 at 10:50 AM with the surveyor, the Director of Nursing (DON) said CPs are updated quarterly and as needed if anything changes in the resident's medical care. When asked if Resident # 68 should be care planned for an indwelling catheter, the DON replied, Yes, it should have been updated the night she came back. A review of a facility provided policy titled Care Plans-Interdisciplinary revealed under section Procedure that, 3. The Interdisciplinary Care Plan will be periodically reviewed and revised after each resident's annual assessment, quarterly reviews, and upon any significant change in condition. The care plan shall also be updated warranted by a change of medications or treatments or other changes in condition. NJAC 8:39-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45209 Based on interview, record review and document review it was determined that the facility a) failed to follow a physician's placement order of an elopement device and b) signed the Treatment Administration Record (TAR) that identified correct placement of the elopement device per physician's order. This deficient practice was identified for 1 of 1 Residents (Resident #80) reviewed for elopement 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 or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes 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 state: 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 12/30/2024 at 10:44 AM, upon initial tour of the facility, Resident #80 was observed wandering by the 1st Floor nursing station. The surveyor observed an elopement device on the resident's left ankle. On 12/31/2024 at 11:06 AM, the surveyor observed Resident #80 sitting on their bed in their room. The surveyor asked permission from Resident #80 to enter and was granted permission. Resident #80 acknowledged that the bracelet was on their left ankle but did not know what it was. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Malignant Neoplasm of Breast, Anxiety Disorder, and Depression. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/17/2024 included the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated the resident's cognition was moderately impaired. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 8/23/2024, that the resident was at risk for elopement. Interventions included: Provide [elopement device] to right ankle. Check function every week on Friday 7-3 shift and check placement every shift. A review of the Electronic Medical Record included the following physician orders (PO): A PO, dated 8/23/20224, for [Elopement Device] to [Right] ankle. Check placement. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO, dated 8/30/2024, to check function of [elopement device] to right ankle. A review of December 2024 TAR revealed a check and nurses initials confirming the physician's order of [elopement device] to [Right] ankle. Check placement. On 1/3/2025 at 11:50 AM, the surveyor interviewed Licensed Nurse Practitioner (LPN #1) that the nurses will take the physician's orders and are responsible for ensuring that the orders are being accurately followed. On the same date and time, LPN #1 reviewed the elopement device orders for Resident #80. LPN #1 and the surveyor entered Resident #80's room with permission. At this time, LPN #1 confirmed that the elopement device was on the resident's left ankle. LPN #1 also acknowledged that the Treatment Administration Record was being checked off weekly confirming placement on the ankle. A review of the facility's undated Documentation Guidelines Policy included: 1. To chart in the medical record correctly; a. Documentation is to be done in the resident's medical record via the Electronic Medical Record (EMR); b. Entries are to be signed electronically by the staff member making the entry. A review of the facility's policy titled Wanderguard transmitter application, dated 9/19/2011, included: Orders will be written to check the placement of the transmitter every shift and check the function of the transmitter weekly. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43936 Based on observation, interviews, record review, and review of pertinent facility documents it was determined that the facility failed to ensure the resident's environment is free from accident hazards specifically by failing to place a fall mat beside the bed while the resident is in bed. The deficient practice was identified for 1 of 3 residents (Resident # 81) investigated for Falls and 1 of 1 residents (Resident # 75) investigated for Accident Hazards. The deficient practice was evidenced by the following: A review of Resident # 81's quarterly Minimum Data Set (MDS; An assessment tool) dated 11/07/2024 revealed that he/she had a fall without injury upon admission. A review of Resident # 81's physician's orders located in the Electronic Medical Record (EMR) revealed an order for an electric, low bed with a crash mat every shift. A review of Resident # 81's Care Plans located in the EMR revealed a focus for risk for falls related to deconditioning, incontinence, psychoactive drug use, and vision problems. The focus also revealed dates when Resident # 81 was found on the floor. The dates are as follows: 09-26-24 Found on crash mat. No injury 09-29-24 FOF [found on floor] off crash mat. S/T [skin-tear] arm 11-21-24 FOF No injury 11-22-24 FOF No injury 11-29-24 FOF No injury On 01/02/2025 at 9:31 AM while observing the resident in bed in their room, Surveyor # 1 observed the floor mat folded and resting upon the wall. At that time, Resident # 81 stated that he/she has rolled out of bed onto the floor in the past. On 01/06/2025 at 11:11 AM while observing the resident in their room, Surveyor # 1 observed the floor mat folded and placed on the side. On 01/06/2025 at 11:44 AM during an interview with Surveyor # 1, the Director of Nursing (DON) replied, When they are in bed. when the surveyor asked If a resident has an order or intervention for floor mats, where and when should they be placed. Lastly, the DON replied, It should not. when the surveyor asked should floor mats be folded up towards the wall when the resident is in bed. A review of the facility policy dated 2/4/20 titled, Falls revealed under section e that, If a resident tries to climb out of bed, bed should be adjusted to the lowest level and a floor mattress should be on the floor. One side of the bed, may be put against the wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45209 2.) During the initial tour of the unit on 12/30/2024 at 9:32 AM, surveyor #2 met Licensed Practical Nurse (LPN#1) and obtained basic information regarding the floor. LPN #1 explained that on the resident's name placard an orange dot would indicate a falls risk. On the same date at 9:48 AM, surveyor #2 observed Resident #75 in bed. Across from the bed, surveyor #2 observed a floor mat folded upright against the wall. On 12/31/2024 at 9:22 AM, surveyor #2 observed room [ROOM NUMBER] with an open door. Surveyor observed Resident #75 in bed and the floor mat folded upright against the wall. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Osteoarthritis (form of arthritis) right shoulder, injury of the head, and fracture of the right pubis. A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/7/2024 included the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated the resident's cognition as severely impaired. A review of the resident's individual comprehensive care plan (ICCP) included focus areas that revealed multiple falls with following dates: 6/29/24; 7/31/24; 8/12/24; 9/28/24. Interventions included: electric low bed with crash mat. A review of the Order Summary Report (OSR), dated as of 1/6/2025, included the following physician orders (PO): A PO, dated 10/12/2024, for electric low bed with blue mat on the floor every shift for safety. On 1/3/2025 at 10:24 AM, surveyor #2 interviewed CNA #2 who advised that they have received education on falls and fall prevention. CNA #2 explained that fall mats are to be placed on the floor whenever the resident is in bed. On 1/3/2025 at 11:50 AM, surveyor #2 interviewed Licensed Nurse Practitioner (LPN #1) who confirmed that Resident #75 was a fall risk and that they are to have a low bed with fall mat. When asked how the fall mat is to be applied, LPN #1 explained that when the resident is in bed the fall mat is to be on the floor. On 1/06/2025 at 11:44 AM, during an interview with surveyor # 1, the Director of Nursing (DON) confirmed that floor mats should not be folded up towards the wall when the resident is in bed. On 1/7/2025 at 8:35 AM, surveyor #2 interviewed the Infection Preventionist (IP) confirmed that ordered fall mats are to be on the floor next to the resident whenever they are in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Falls Policy, dated 2/4/2020, included under the Policy Statement: It is policy of Laurel Bay to maintain a highest possible safe environment for all resident to decrease and minimize the risk and incident of falls. The following was identified under the Interventions heading: e. If a resident tries to climb out of bed, bed should be adjusted to the lowest level and a floor mattress should be on the floor. One side of the bed may to be put again the wall. NJAC 8:39-33.1(d)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49712 Complaint # NJ00177022 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that there were a.) physicians orders for an indwelling catheter (tube inserted in the bladder to drain urine); b.) ensure urinary drainage bag were secured in manner to prevent contamination and infection control; c.) failed to document the urinary catheter output was collected as ordered by the physician. and that for 2 of 2 resident reviewed for an indwelling catheter. (Resident #68 and Resident #21). The deficient practice was evidenced by the following: 1. During the initial tour on 12/30/2024 at 09:48AM, surveyor #1 observed Resident # 68's urinary drainage bag not in a privacy bag and visable from the hallway. On 01/02/2025 at 09:40 AM surveyor # 1 observed Resident # 68's urinary drainage bag in a privacy bag touching the floor. According to the Admission Record, Resident #68 was admitted to the facility with diagnoses including but not limited to: Functional Quadriplegia (the complete inability to move due to severe disability or frailty due to another medical condition, without injury or damage to spinal cord), and Dementia (a group of symptoms affecting memory, thinking, and social abilities). A review of Resident # 68's Electronical Medical Record (EMR) did not reveal any physician orders related to an indwelling catheter. During an interview on 01/02/2025 at 10:20 AM with surveyor #1, the Infection Preventionist (IP) nurse said that urinary drainage bags should always be kept in a privacy bag and off the floor. During an interview on 01/03/2025 at 10:40 AM with surveyor #1, the Licensed practical Nurse #1(LPN) said that when a resident has an indwelling catheter there should be orders in the computer with the size of the catheter, to monitor the output and to change the catheter as needed. When asked if Resident #68 had orders the LPN looked in the computer and said, no but he/she should. During an interview on 01/03/2024 with surveyor #1, the Director of Nursing (DON) said there should have been an order place in the EMR when he/she returned to the facility. A review of a facility policy title Care of Urinary Leg Bags and Bedside Drainage Bags revealed under Procedure that, 6. Urinary drainage bags will be maintained below the level of the bladder in a privacy bag. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled Physician's orders revealed under, Procedure that, 1. All residents admitted to this facility shall be accompanied by physician's order adequate to provide immediate and essential care to the resident consistent with the resident's mental and physical status on admission. 2. If the physician's orders were not previously received and did not arrive with the resident, notify the physician, and obtain orders vial telephone within the admitting shift. N.J.A.C. 8:39-19.4(a) 45209 2.) During the initial tour of the unit on 12/30/2024 at 09:44 AM, Resident #21 was observed in bed with a urinary catheter drainage bag laying on top of the bed with no privacy bag, and visible from the hallway. It was not secured to the bed frame. On 12/31/2024 at 9:31 AM Resident #21 was observed in their motorized wheelchair in their room. Resident #21's urinary catheter drainage bag was observed in the privacy bag, but not secured to the wheelchair via the bag clip which resulted in the drainage bag being collapsed upon itself. The surveyor reviewed the medical record for Resident #21. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Amyotrohic Lateral Sclerosis (ALS- nervous system disease that affects nerve cells in the brain and spinal cord.) and Neuromuscular Dysfunction of the bladder (condition lacking bladder control due to a brain, spinal cord, or nerve condition). A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 11/7/2024 included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, revised on 4/20/2022 , that the resident [had] an indwelling [redacted] catheter: neurogenic bladder. Interventions included: The resident [had] #16 french [redacted] catheter. Position catheter bag and tubing below the level of the bladder [.]. A review of the Order Summary Report (OSR), dated as of 1/6/2025, included the following physician orders (PO): A PO, dated 10/31/2024, for #20 [indwelling] catheter with 5cc balloon to straight drainage for retention. Document output every shift for urinary retention. A review of Resident # 21's December 2024 Treatment Administration Record (TAR) revealed the below 4 blanks for the order to document output every shift or urinary retention: 12/9/2024 Day Shift 12/14/2024 Evening Shift 12/26/2024 Night Shift (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/28/2024 Night Shift On 1/3/2025 at 10:24 AM, surveyor #2 interviewed CNA #2 who confirmed that urinary drainage bags are to be to hung below the bladder for infection control, secured via provided clip, and in a privacy bag. When asked who is responsible for emptying, CNA #2 stated that they will empty the bag and inform the nurse who will document the output. On 1/3/2025 at 11:50 AM, surveyor #2 interviewed Licensed Nurse Practitioner (LPN #2) who confirmed that Resident #21 had an indwelling urinary catheter. LPN #2 described catheter care included maintaining the bag below the level of the bladder to prevent urinary tract infection and black flow of urine into the bladder. LPN #2 further explained that the drainage bags are to be emptied by the CNAs and reported to the nurses to document in the TAR. Upon reviewing Resident #21's electronic medical record, LPN #2 confirmed that there should not be any urinary output blanks on the TAR, the care plan incorrectly identified the resident urinary catheter size. On 1/06/2025 at 11:44 AM during an interview with another surveyor, the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) and Assistant Director of Nursing (ADON), confirmed that catheter drainage bags are to be secured below the level of the bladder to encourage drainage and prevent backflow into the bladder. When asked if the bag should be left on the resident's bed, the DON denied. On 1/7/2025 at 8:35 AM, surveyor #2 interviewed the Infection Preventionist (IP) who identified that urinary collection devices are to be hung below the level of bladder and secured to the bed with the provided bed clips. When asked why the devices are to be below bladder the IP responded, to prevent any return of urine to the bladder. When asked why the urinary collection device to is be hung with the clip the IP further explained that it is to ensure the bag stays in place in an upright position. A review of a facility policy title Catheter, Foley- Insertion, dated 10/20/17, revealed under Procedure: 1. Check physician order. Must include [.] and instruction to record output every shift [.]. A review of a facility policy title Care of Urinary Leg Bags and Bedside Drainage Bags, dated 10/15/17, revealed under Procedure: 13. The urinary drainage bag/leg bag shall be emptied at the end of each shift or sooner if needed by the CNA. Document the amount of urine emptied; 6. Urinary drainage bags will be maintained below the level of the bladder in a privacy bag. N.J.A.C. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43936 Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice specifically by leaving respiratory masks uncontained, exposed, open to air. The deficient practice was identified for 3 of 4 residents (Residents # 236, 29, 69) reviewed for Respiratory Care. The deficient practice was evidenced by the following: On 12/30/2024 at 10:30 AM during the initial tour of the facility, Surveyor # 1 observed Resident # 236 in bed. At that time, Resident # 236 was wearing a nasal cannula (tube used to deliver oxygen through the nostrils). Upon further observation, it was determined that the nasal cannula was not connected to the humidification bottle located on the oxygen concentrator (device used to produce oxygen) and instead directly connected to the concentrator itself. At that time, Surveyor # 1 also observed a a nebulizer face mask (mask used to deliver aerosolized medications) on top the night stand partially covered by a red towel. The face mask was not inside a container or bag exposing it to air. A review of Resident # 236's Electronic Medical Record (EMR) revealed under Orders that Resident # 236 was to received oxygen at four liters per minute through a nasal cannula every shift for shortness of breath. There was also an order for Albuterol Sulfate Nebulization Solution three milliliters to inhale orally via nebulizer every four hours as needed for shortness of breath. A review of Resident # 236's EMR revealed he/she had a diagnosis of but not limited to chronic obstructive pulmonary disease with (acute) exacerbation and hypoxemia (low oxygen in the blood). On 1/06/2025 at 11:44 AM during an interview with Surveyor # 1, the Director of Nursing said respiratory equipment should be stored in a zip-locked bag when not in use. She said, infection control as the reason. A review of the undated facility policy titled, Oxygen Administration revealed that, There are multiple State and Federal codes that address the storage, handling and administration of oxygen. Procedures must be strictly adhered to in order to assure compliance with these codes. 49712 2. On 12/30/2024 at 09:37 AM during initial tour, surveyor #2 observed Resident # 29's nebulizer (a machine that delivers medication into the lungs) tubing not labeled and left open to air sitting on the windowsill. On 01/03/2025 at 08:45 AM surveyor #2 observed the nasal cannula (a tube that delivers oxygen through the nose) had not been changed and was dated 12/26/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Admission Record, Resident #29 was admitted to the facility with diagnoses including but not limited to; Chronic obstructive pulmonary disease (an airflow limitation caused by airway narrowing and/or obstruction, loss, or elastic recoil, or both), Malignant neoplasm of Bronchus or Lung (cancer), and Emphysema (a lung disease which results in shortness of breath). A review of the Order Summary Report for resident # 29, revealed physician orders to change oxygen tubing and nebulizer tubing every night shift on every Wednesday. During an interview on 01/02/2025 at 10:20 AM with surveyor #2, the Infection Preventionist (IP) said that oxygen and nebulizer tubing should be labeled, dated, and changed weekly. The IP also said that all tubing should be kept in a labeled bag when not in use, not left open to air. A review of the facility policy titled, Oxygen Administration revealed under Policy that, All safety precautions and care of equipment shall be performed according to recommended State and Federal guidelines and facility procedures. 45209 3. On 12/31/2024 at 10:15 AM in room [ROOM NUMBER], upon initial tour of the facility, surveyor #3 observed an oxygen cylinder secured inside a cylinder cart. Resting on top of the oxygen cylinder was a nebulizer mask that was unbagged and exposed to air. The nebulizer tubing was not dated. The surveyor reviewed the medical record for Resident #69. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: Myocardial infarction (heart attack); Atherosclerotic Heart Disease (buildup of fat and cholesterol in the walls of the arteries); and Chronic Obstructive Pulmonary Disorder (COPD). A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/20/2024 included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. A review of the Order Summary Report (OSR), dated as of 1/6/2025, included the following physician orders (PO): A PO, dated 12/29/2024, for Ipratropium-Albuterol Solution 0.5miligrams (mg)/2.5 mililiters (mL) 1 vial inhale orally four times a day for COPD. On 1/3/2025 at 10:24 AM, surveyor #3 interviewed CNA #2 who confirmed that oxygen supplies and nebulizer supplies were to be in a bag when not in use. On 1/3/2025 at 11:50 AM, surveyor #3 interviewed Licensed Nurse Practitioner (LPN #1) who stated that nebulizers were to be stored in a bag and dated when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/06/2025 at 11:44 AM during an interview with Surveyor # 1, the DON confirmed that nebulizer masks should be stored in a zip-locked bag when not in use for infection control reasons. A review of the facility's undated Oxygen Administration Policy included: All safety precautions and care of equipment shall be performed according to the recommended State and Federal guidelines and facility procedure. N.J.A.C. 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** 51232 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On [DATE] from 9:25 AM to 10:07 AM, the surveyor, accompanied by the cook and later at 10:07 AM joined by the Dietary Director (DD), observed the following: 1.) In the refrigerator known as the Drink Refrigerator, there was a tray that contained 35 bowls of butterscotch pudding, along with a tray holding 7 cups of applesauce and 1 cup of cottage cheese. None of these items were labeled with preparation or use-by dates. The cook said that all the items should be labeled with both dates to ensure freshness and uphold food safety standards. 2.) In the dry storage area, there was an open 4-pound container of peanut butter that lacked both an open date and a use-by date. 1 loaf of raisin bread was labeled with a received date of [DATE]. The dietary director (DD) said that the peanut butter should be labeled with appropriate dates to ensure freshness and food safety. The DD also mentioned that bread has a 5-day expiration period after receipt, and any expired bread should be discarded as it is no longer fresh. 3.) In the refrigerator known as the Storage Refrigerator, there was an open 45-ounce container of butter with no open date, a half hotel pan of macaroni noodles labeled with a prepared date of [DATE] with no use-by date, a half hotel pan of sauteed onions with a prepared date of [DATE] and no use-by date, and a half hotel pan of meatballs with a prepared date of [DATE] and no use-by date. The dietary director (DD) said that all items should be properly labeled to ensure freshness and food safety. On [DATE] at 9:26 AM, the surveyor observed inside of the nourishment refrigerator and freezer located on the first floor behind the nursing station an open half-pint milk carton with spillage in the plastic tray. The nourishment freezer had a buildup of freezer frost (ice buildup in the freezer) and contained brown debris, as well as a food item in a plastic bag dated [DATE], which could not be identified. On [DATE] at 10:40 AM, during an interview with the surveyor, the Dietary Director (DD) said that nursing staff on the units are responsible for overseeing the pantries and nourishment refrigerators. On [DATE] at 9:30 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) said that housekeeping is responsible for maintaining the cleanliness of the nourishment refrigerators on the units, while the dietary staff ensures that the food inside is not expired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:45 AM, during an interview with the surveyor, the Director of Housekeeping (DOH) said that housekeeping is responsible for cleaning both the pantries and refrigerators on the nursing units. The DOH also mentioned that keeping the refrigerator clean is essential for maintaining sanitation and preventing illness. On [DATE] at 11:19 AM, during an interview with the surveyor, the Director of Nursing (DON) said that dietary staff is responsible for checking expiration dates on food items in both the pantries and refrigerators on the nursing units to ensure freshness, while housekeeping is tasked with maintaining the cleanliness of the refrigerators. A review of the dated facility policy [DATE], titled, Labeling and Dating Policy, revealed, If there is no printed manufactures date on product follow below dating protocol. Day 1 is first day labeling. Fresh breads, rolls, Danish, muffins 7 days. Portioned items 3 days. Leftovers (cooked, RTE) 3 days in cooler. A review of the undated facility policy titled, Handling of Food Bought in by Visitors for Residents, revealed under Policy, All food will be discarded after 48 hours or per the noted manufacturer expiration date. A review of the undated facility policy titled, Cleaning and Maintenance of Nourishment Refrigerators, revealed under Procedures number 4 Cleaning and Maintenance, Housekeeping staff will inspect the refrigerators on a daily basis and clean as needed, ensuring they are maintained to the highest hygiene standards. N.J.A.C 8:,d+[DATE].2 (g)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide a sanitary and comfortable environment regarding Enhanced Barrier Precautions that helped prevent the development and transmission of communicable diseases and infections. The deficient practice was identified on 1 of 2 floors within the facility. The deficient practice was evidenced by the following: 1.) On 12/30/2024 at 9:44 AM, upon initial tour of the second-floor sub-acute unit, surveyor #1 observed room [ROOM NUMBER] with an Enhanced Barrier Precaution (EBP) Sign on the door. Surveyor #1 put on personal protective equipment (PPE) including gloves and gown to enter the room. Surveyor #1 interviewed the two residents inside the room. Prior to exiting the room, surveyor #1took off the PPE but was unable to locate a designated PPE trash can. On the same date at 9:51 AM, surveyor #1 interviewed Certified Nursing Assistant (CNA #1) who confirmed that there was not a designated trash bin in the room for used PPE. CNA #1 further advised that upon exiting a room, used PPE should be discarded in a designated PPE bin. CNA #1 put gloves on and took surveyor #1's used PPE from them, placed in trash bag, and discarded in soiled utility room. On 1/3/2025 at 10:24 AM, surveyor #1 interviewed CNA #2 who confirmed that used PPE should be removed in the resident room and discarded in designated trash bin. On 1/3/2025 at 11:50 AM, surveyor #1 interviewed Licensed Nurse Practitioner (LPN #1) who confirmed that prior to exiting an Enhanced Barrier Room, PPE should be removed and thrown away in a isolation garbage can. On 1/7/2025 at 8:35 AM, surveyor #1 interviewed the Infection Preventionist (IP) who stated that Enhanced Barrier Protection included gown, gloves, and shield/mask depending on the task. Upon exiting the room, the IP confirmed that used PPE should be disposed in a separate and designated trash bin in the resident room. A review of the facility's undated Personal Protective Equipment policy, included: soiled gowns, aprons, and lab coats must be removed prior to leaving the work area and discarded into the appropriate receptacle in the work area. 51232 B.) On 12/31/2024 at 9:55 AM, Surveyor #2 observed Registered Nurse (RN) #1 pushing the second-floor treatment cart into the bedroom of Resident #10. At that time, Surveyor #2 noted a sign on the room door indicating that Resident #10 was on enhanced barrier precautions for a Multi-Drug Resistant Organism (MRDO) (bacteria and other microorganisms that have developed resistance to multiple antibiotics). A review of Resident #10's physician's orders located in the Electronic Medical Record revealed he/she had an order to maintain enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician notes from 12/27/2024, revealed that Resident #10 had a wound on the right ischium and sacrum, as well as a suprapubic catheter (tube that drains urine from the bladder through a small incision in the abdomen). On 12/31/2024 at 9:56 AM, during an interview with Surveyor #2, RN # 1 said that facility staff typically brings the treatment cart into the room for her to complete Resident #10 wound care. When Surveyor #2 asked RN #1 if the treatment cart should have been inside the room of Resident #10, who is on enhanced barrier precautions for an MRDO, RN #1 said that she was not sure. On 12/31/2024 at 10:17 AM, during an interview with Surveyor #2, the Infection Preventionist (IP) said that the treatment carts should not be in residents room on enhanced barrier precautions. On 01/07/2025 at 8:35 AM, during an interview with Surveyor #1, the IP confirmed that EBP are to be implemented for any resident with central lines, colostomy, urinary drainage devices, wounds, and MDROs. A review of a facility policy dated 01/09/2024 titled, MDROS, revealed, Enhanced Barrier Precautions (EBP), which involves residents known to be colonized or infected with an MDRO, as well as those at increased risk due to factors like open wounds or indwelling medical devices; this strategy aims to significantly reduce the transmission of MDROs within the facility. The Centers for Disease Control and Prevention (CDC) actively promotes the use of EBP in long-term care facilities to prevent MDRO spread. N.J.A.C. S 8:39-19.4(a)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49712 Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to ensure documentation in the resident's medical record of the information provided regarding the benefits and risks of immunization and the administration or the refusal of the vaccine, specifically the influenza vaccination (vaccine used to prevent influenza). The deficient practice was identified for 2 of 5 resident's reviewed for immunizations, (Resident #34 and Resident # 68). This deficient practice was evidenced by the following: 1. According to the Admission Record, Resident #34 was admitted to the facility with diagnoses including but not limited to: Diabetes Mellitus (DM) (a disease of inadequate control of blood levels of glucose) and Metabolic Encephalopathy (a change in the how the brain works due to an underlying condition). A Review of Resident #34's admission Minimum Data Set (MDS) an assessment tool used to facilitate care, dated 10/31/2024 revealed a Brief Interview for Mental status score of 12/15, indicating Resident #34 was moderately cognitively intact. Section 0250 indicated Resident #34's influenza vaccine was not received. The MDS further revealed that there was no reason the vaccine was not given. 2. According to the Admission Record, Resident #68 was admitted to the facility with diagnoses including but not limited to: Functional Quadriplegia (the complete inability to move due to severe disability or frailty due to another medical condition, without injury or damage to spinal cord), and Dementia (a group of symptoms affecting memory, thinking, and social abilities). A Review of Resident #68's admission Minimum Data Set (MDS) an assessment tool used to facilitate care, dated 11/04/2024 revealed a Brief Interview for Mental status score of o/15, indicating Resident #68 had severely impaired cognition. Section 0250 indicated Resident #68's influenza vaccine was not received. The MDS further revealed that there was no reason the vaccine was not given. During an interview on 01/07/2025 at 11:05 AM with the surveyor, the Infection Preventionist (IP) said that she had missed both residents' influenzas' vaccine. The IP said they were given on 01/06/2025, however they should have been given by end of October 2024. A review of an undated facility provided policy titled Resident Influenza Program, revealed under Procedure that. 1. The Influenza Vaccine will be offered annually to all residents at [Facility's name], October through March 31st, unless the immunization is medically contraindicated, or the resident has already been immunized during the time period. N.J.A.C. 8:39-19.4 (h)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48782 Based on observation and interview on 12/30/2025 in the presence of the Administrator and the Director of Maintenance (DOM), it was determined that the facility failed to ensure that the resident call bell system was properly functioning by notification of an activation when pressing the call bell button. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:22 PM revealed that the call bell system did not notify staff of a call bell system activation by visual and or audible notification for bed 1 in room [ROOM NUMBER] when the Administrator pressed the call bell button. In an interview at the time, the DOM confirmed that the call bell system light did not activate outside of the room and that notification at the nurse's station was not received. The DOM stated that the call bell button needed to be replaced, and they would make sure it was correct. N.J.A.C 8:39-31.2(e)