STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315452	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peace Care St Joseph's	537 Pavonia Avenue Jersey City, NJ 07306

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 3 of 6 residents (Resident #22, #109, and #87) observed for incontinence care on 1 of 3 units, the 4th floor Unit. This deficient practice was evidenced by the following: a. On 11/4/24 at 11:55 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) on the 4th floor unit. CNA #1 stated that she had 8 residents on her assignment and was also helping another aide with some of their residents. On 11/4/24 at 12:00 PM, the surveyor and CNA #1 entered Resident #22's room and observed the resident in bed. CNA #1 stated that she had not provided care to Resident #22 yet as she was very busy all morning. The CNA exposed Resident #22's incontinence brief which was saturated with urine. At that time when CNA #1 exposed the incontinence brief another incontinence brief was observed which was also saturated with urine. CNA #1 acknowledged the two briefs were saturated with urine and stated that no residents should be wearing two incontinence briefs. CNA #1 stated that it was the night CNA who double-diapered the resident. A review of Resident #22's Admission Record reflected the Resident was admitted to the facility with diagnoses which included but were not limited to anxiety, kidney failure, and legal blindness. A review of Resident #22's quarterly Minimum Data Set (MDS) an assessment tool dated 10/11/24 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 1 out of 15 which indicated Resident #22 had a severe cognitive impairment. The MDS further assessed Resident #22 required extensive assistance from staff for personal hygiene and was always incontinent of bowel and bladder. The surveyor reviewed Resident #22's Individual Care Plans (ICPs) which revealed there were no care plans initiated that focused on the resident's Bowel and Bladder Incontinence. b. On 11/4/24 at 12:15 PM, the surveyor and CNA #1 observed Resident #109 in bed. CNA #1 stated that she had not provided care for Resident 109 until this time. The CNA exposed the resident's incontinence brief which was saturated with urine. CNA #1 acknowledged that she should have provided incontinence care for Resident #109 every two hours but stated that she had been too busy. (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: 315452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Peace Care St Joseph's		STREET ADDRESS, CITY, STATE, ZIP CODE 537 Pavonia Avenue Jersey City, NJ 07306	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #109's Admission Record reflected the Resident was admitted to the facility with diagnoses which included but were not limited to hemiplegia (mild or partial weakness or loss of strength on one side of the body), hemiparesis (severe or complete loss of strength or paralysis on one side of the body) and dysphagia. A review of Resident #109's quarterly MDS dated [DATE] revealed Resident #109 had a BIMS score of 1 out of 15 which indicated Resident #109 had a severe cognitive impairment. The MDS further assessed that the resident required maximum assistance from staff for personal hygiene, and he/she was always incontinent of bowel and bladder. The surveyor reviewed Resident #109's ICPs which revealed there were no care plans initiated that focused on the resident's Bowel and Bladder Incontinence. c. On 11/4/24 at 12:30 PM, the surveyor observed Resident #87 in bed. The resident stated that she/he had not been changed or bathed all morning and further stated that she/he wanted to get washed up and changed. On 11/4/24 at 12:35 PM, the surveyor interviewed CNA #2 who stated that Resident #87 was on her assignment. CNA #2 confirmed she had 10 Residents on her assignment and had not yet provided care to Resident #87. At that time, CNA #2 and the surveyor entered Resident #87's room. CNA #2 exposed Resident #87's incontinence brief which was wet, and both the surveyor and CNA #2 observed the resident had a bladder pad inserted within the incontinence brief. CNA #2 stated that she doesn't use bladder pads, that it was the night CNA that put it there. A review of Resident #87's Admission Record reflected Resident #87 was admitted to the facility with diagnoses which included but were not limited to dementia, diabetes mellitus, and chronic kidney disease. A review of Resident #87's Admission MDS dated [DATE] revealed Resident #87 had a BIMS score of 12 out of 15 which indicated Resident #87 had a moderate cognitive impairment. The MDS further revealed that the resident required maximum assistance from staff for personal hygiene, and he/she was always incontinent of bowel and bladder. The surveyor reviewed Resident #87's ICPs which revealed there were no care plans initiated that focused on the resident's Bowel and Bladder Incontinence. On 11/4/24 at 1:34 PM, the survey team met with the Licensed Nursing Home Administrator and Director of Nursing (DON) to discuss the above observations and concerns. The DON confirmed that incontinence rounds should be done every two hours and that no resident should have two incontinence briefs. The DON further stated that bladder pads should be used only if the resident requests. On 11/6/24 at 2:15 PM, the surveyor interviewed the DON who stated that all residents who were incontinent of bowel and bladder should have a care plan in place since incontinence care was part of the resident's care. The surveyor attempted a phone interview with the 12:00 AM-8:00 AM, CNA who was assigned to Resident #22, #109 and #87. The surveyor left a voice message with no return call. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-27.1 (a), 27.2 (h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER: Peace Care St Joseph's		STREET ADDRESS, CITY, STATE, ZIP CODE: 537 Pavonia Avenue, Jersey City, NJ 07306	

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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 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. 36419 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer oxygen therapy according to the physician's order for 1 of 1 resident, (Resident #6). This deficient practice 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 10/31/24 at 12:25 PM, the surveyor observed Resident #6 in bed on a specialty mattress with his/her eyes closed and the head of the bed elevated. The surveyor observed the tube feeding (TF) running via a machine. The surveyor observed Resident #6 wearing a nasal cannula (NC) with an oxygen concentrator on and the gauge was set at 4 liters per minute (LPM). A review of Resident #6's Admission record revealed Resident #6 was admitted to the facility with diagnoses that included but were not limited to Alzheimer's disease, pressure ulcer of sacral region, stage 3 (a wound that involves full thickness loss of skin) and gastrostomy status (a tube that is surgically inserted into the stomach to provide nutritional support). A review of Resident #6's annual Minimum Data Set (MDS), an assessment tool, dated 8/6/24 revealed Resident #6 had aphasia (inability to speak), was unable to make him/her self-understood and was unable to understand others. The MDS further assessed that Resident #6 was dependent on staff for Activities of Daily Living (ADLs), had a stage 3 pressure ulcer, and received oxygen therapy. A review of the Individual Care Plan (ICP) initiated on 2/21/24 reflected a focus area: resident has shortness of breath with interventions that included but were not limited to Oxygen continuous at 2 LPM via NC. A Review of the November 2024 Order Summary Report (OSR) revealed an active physician order (PO) with an order date of 2/28/23 for Oxygen 2 LPM via NC every shift for shortness of breath (SOB). (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/24 at 1:07 PM, the surveyor observed Resident #6 in bed with the head of the bed elevated, the TF running via a machine. The surveyor observed Resident #6 wearing a nasal cannula (NC) with an oxygen concentrator on and the gauge was set at 4 LPM. On 11/1/24 at 1:10 PM, the surveyor asked the Licensed Practical Nurse (LPN) to accompany her to Resident #6's room. The surveyor and the LPM entered Resident #6's room, and both observed the resident in the bed with the head of the bed elevated, and a TF running via a machine. The resident was wearing a NC and the oxygen concentrator was on with the gauge set at 4 LPM. The LPN confirmed the concentrator was on and the gauge was set at 4 LPM. On that same day at the same time, the surveyor and the LPN together reviewed the electronic medical record (EMR) for the resident's order for oxygen. The LPN stated that the resident's PO was for 2 LPM, not 4 LPM and acknowledged the PO should have been followed. On 11/1/24 at 1:29 PM, the surveyor discussed the above observations and concerns with the Director of Nursing (DON) who confirmed the PO should have been followed for the administration of Oxygen. A review of the facility's Oxygen Therapy policy and procedure dated 5/24 indicated .The purpose of oxygen therapy is to administer oxygen in cases where insufficient oxygen is carried to the tissues by the blood . oxygen therapy is administered only as ordered by a physician .the physician's order will specify the rate of oxygen flow. 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 19106 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide (CNA) to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum . (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports (AAS-11 and AAS-12) for the 11/07/2024 Standard survey at Peace Care St. Joseph's revealed the following. There were no deficient practices identified for Registered Nurse staffing as submitted for the 2 weeks of AAS-12 staffing from 10/13/2024 to 10/26/2024. The facility was deficient in CNA staffing for residents on 4 of 14 day shifts for the 2 weeks of AAS-11 staffing from 10/13/2024 to 10/26/2024, as follows: -10/13/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -10/18/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -10/19/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -10/20/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. On 11/4/24 at 12:30 PM, the surveyor observed Resident #87 in bed. The resident stated that she/he had not been changed or bathed all morning and further stated that she/he wanted to get washed up and changed. On 11/4/24 at 12:35 PM, the surveyor interviewed the CNA who stated that Resident #87 was on her assignment. The CNA confirmed that she had 10 Residents on her assignment and had not yet provided care to Resident #87. At that time, the CNA and the surveyor entered Resident #87's room. The CNA exposed Resident #87's incontinence brief which was wet, and both the surveyor and the CNA observed the resident had a bladder pad inserted within the incontinence brief. The CNA stated that she doesn't use bladder pads on resident. She stated that it was the night CNA who put it there. On 11/4/24 at 1:34 PM, in the presence of the survey team, the Director of Nursing (DON) stated that incontinence care should be provided to the residents every 2 hours. The surveyor informed the DON and Licensed Nursing Home Administrator of the staffing ratio concerns on 11/7/24 at 1:00 PM. No further information was provided to the surveyor by the facility administration. Refer to F677D NJAC 8:39-5.1(a); 27.1(a); 27.2(d); 27.2(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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45449 Based on observation, interview, record review and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a.) consistent maintenance of the system of record keeping of the Drug Enforcement Agency (DEA) order Form-222 (a federal narcotic requisition form), that enabled accurate reconciliation of controlled-dangerous substances (narcotic medications, that due to their high potential for abuse, are tracked with a degree of detail and attention) that was ordered and received, b) the development and implementation of policy and procedure for DEA order Form-222, c) removal and disposition of a discharged Resident's medication from the active inventory, and d.) properly label an opened blood glucose test strip. The deficient practice was identified for five (5) of 12 DEA Form-222s reviewed, one (1) of two (2) medication storage rooms, one (1) of three (3) medication carts inspected during the medication storage and labeling observation. The evidence was as follows: Reference: 21 CFR 1305 Part 1. Purchaser Information 6.Purchaser must make a copy of the order form for its records before mailing the original to the supplier. Part 5 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item. 21 CFR 1305.16 6. Lost or stollen order forms must be documented and reported to your local DEA office. 21 CFR 1305.18 7. Unused order forms should be voided and returned to Drug Enforcement Administration . 1.) On 11/6/24 at 12:11 PM, the surveyor and the newly appointed Director of Nursing (DON) reviewed the DEA Form-222 together. The DON informed the surveyor that the Consultant Pharmacist was at the facility the day before to organize the facility's record keeping file for the DEA Form-222. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the DEA Form-222 from September 2023 revealed the following: -231381123 and 231381124 were missing. -240365257 had the incorrect address. -240365258 and 240365259 were at that time, missing, (which was later found), unexecuted (not used), not voided and had the incorrect address. Further review of the DEA Form-222 revealed the staff did not consistently complete Part 5, as instructed on the front of DEA Form-222 (for the accurate reconciliation and accountability of the ordered narcotic medication against the received narcotic medication from the supplier). The discrepancies were identified on the following forms: -231381125 the number received, and the date received were blank and had no packing slip (facility signed invoiced quantities received from the supplier). -240531774 the number received, and the date received were blank. Part 1 of the requirement for this form was to enumerate the total quantity ordered. This line item was also blank. -231381120 the number received, and the date received were blank and had no packing slip. -231381119 the number received, and the date received were blank and had no packing slip. On 11/6/24 at 3:06 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns regarding the inconsistencies in reconciliation, accountability for the narcotic medications ordered and received utilizing the DEA Form-222. On 11/7/24 at 10:07 AM, in the presence of the survey team, the LNHA stated that when the previous DON had left (no longer employed in the facility) he took all the unused DEA Form-222 for safe keeping. The LNHA also stated that the DON was responsible for ensuring the tracking and accountability of the narcotic medication ordered and received. At that time, the LNHA provided the surveyor the unused/unexecuted DEA-Form 222 (240365258 and 240365259), acknowledged that those forms had the incorrect address and voided the forms. At that time, the new DON informed the LNHA that the same forms had to be returned to the DEA. On 11/7/24 at 10:10 AM, in the presence of the survey team, the DON confirmed and acknowledged that there were errors, and the evidence of the tracking and accountability was not present. The DON stated that moving forward she would track all the DEA-Form 222 and its associated requirements. 2.) At that time, the surveyor requested for the facility's policy and procedures for controlled dangerous substance/ narcotic medications for the discrepancies identified with the DEA Form-222 (the process the facility follows for resolving discrepancies, process for accurate ordering, receiving, administering of narcotic medications, and when drug diversion was found). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/7/24 at 12:01 PM, in the presence of the survey team, the DON stated that there were no other policies for the tracking, ordering, and receiving, identification of diversion of controlled dangerous substance/narcotic medications in relation to the DEA Form-222. 3.) On 11/6/24 at 9:43 AM, in the presence of the Registered Nurse/Nurse Supervisor (RN/NS) the surveyor began the medication room observation located on the First floor. At that time, the surveyor and the RN/NS observed 2 clear plastic bags, that had a pharmacy label for Resident #179 and reflected the following: Rx 84570805 contained 2 bottles of Retacrit (injectable medication for anemia with increased risks, that includes death and stroke, requiring monitoring of blood levels prior to administration) dated 9/21/24. Rx 85083139 contained 1 bottle of Retacrit dated 10/27/24. At that time, the RN/NS stated that Resident #179 was discharged last week, and the resident's medication should have been removed from the active inventory to prevent medication administration errors. All nurses on all shifts were responsible to ensure discontinued medications and discharged residents' medication were removed from active inventory, returned to the pharmacy, or disposed. The RN/NS stated that she would remove the medication, return to the pharmacy, and inform her supervisor. 4.) On 11/6/24 at 10:39 AM, in the presence of the RN, the surveyor began the medication cart observation located on the Third floor. At that time, the surveyor and the RN observed an opened bottle of the blood glucose test strip that was opened and not dated. The RN stated that the test strips should have been dated immediately after it was opened to know the use by date. The RN stated she would dispose of the undated, opened blood glucose test strop and replace it with a new one. According to the blood glucose test strip manufacturer's package insert, under storage and handling, reflected instructions that included, to use within 6 months of first opening or the expiration date on the label, whichever comes first. On 11/6/24 at 3:06 PM, in the presence of the survey team, the LNHA and the DON, the surveyor discussed the concern regarding the discharged resident's Retacrit and the opened and undated blood glucose test strips. At that time, the DON acknowledged the concerns and informed the surveyor that she was made aware of the observation by the nurses. The DON confirmed the Retacrit should have been removed and the test strip should have been dated. A review of the facility policy provided; Medication Storage dated/revised 1/1/24 included the following: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and /or medication rooms according to the manufacturer's recommendations . Policy Explanation and Compliance Guidelines 2.Narcotics and Controlled Substances: c. Any discrepancies which cannot be resolved mist be reported immediately as follows: (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Notify the DON, charge nurse, or designee and the pharmacy. ii Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted . 8. Unused Medications: all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medication with worn, illegible, or missing labels. These medications are destroyed in accordance with our destruction of unused drug policy. No further information was provided. NJAC 8:39-29.4 (c)(g)(h)(k),29.7(c)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 34421 REPEAT DEFICIENCY Based on interview and record review, it was determined that the facility failed to assure that the required staff attended the quarterly Quality Assurance (QA) meetings. This was identified for 4 of 4 quarterly QA meetings reviewed. This deficient practice was evidenced by the following: On 10/31/24 at 10:00 AM, upon entrance conference, the surveyor requested to review the QA meeting sign in sheets for the last few quarters of QA meetings held. On 11/4/24 at 10:30AM, the surveyor received QA meeting sign in sheets dated, 10/17/24, 7/18/24, 4/18/24 and 1/18/24, which revealed that the Infection Preventionist (IP) was not in attendance for any of those scheduled meetings. At 10:35 AM, the surveyor interviewed the Administrator who stated that if the IP is in the building during the QA meeting, then, she will attend and could not explain why she was not in attendance for those 4 QA meetings. The surveyor reviewed the Infection Preventionist policy and procedure, dated 2/2024, which revealed that the facility's IP must have time necessary to participate in required committees such as QAA. The surveyor reviewed the Quality Assurance and Performance Improvement policy and procedure, dated 3/2024, which revealed the QA committee shall consist of a minimum of . The Infection Preventionist. N.J.A.C. 8:39-33.1 (b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19106 Based on observation, interview, and record review it was determined that the facility failed to a) maintain infection control standards and procedures during wound care treatments for 2 of 5 residents (Resident #181, #6) reviewed for care and services for pressure ulcers, b) provide a safe and sanitary environment to prevent the potential spread of infection and cross-contamination to both residents and staff by sharing personal care items between residents and a linen cart which contained linen for multipe residents was brought into a Resident room (room [ROOM NUMBER]) and then back out into the hallway, observed for 1 of 3 CNAs (CNA #1) on 1 of 4 nursing units, (4th-floor unit) and c) failed to practice acceptable hand hygiene as recommended by the CDC. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. The surveyor observed Resident #181 on 11/1/24 at 9:30 AM sitting up in bed eating breakfast. A review of the electronic medical record revealed the following. The resident's Admission Record noted the resident was admitted with Parkinson's disease. The 8/17/24 Admission Minimum Data Set assessment tool (MDS) indicated the resident was cognitively intact as referenced by a score of 15 on the Brief Interview for Mental Status (BIMS) in Section C. Section M indicated the resident was at risk for developing pressure ulcers. The 11/1/24 Wound Assessment Report included documentation regarding a sacral pressure ulcer. The ulcer was noted to have initially been identified as a full thickness wound which was currently improving without complications. The treatment recommendation (which was reflected in the November 2024 physician's order summary) was for the following treatment to be performed twice daily and as needed - cleanse with normal saline, pat dry, apply 0.5% Dakin's solution (a topical antiseptic) moistened fluffed gauze, and cover with a bordered gauze. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor observed the pressure ulcer treatment on 11/6/24 at 11:24 AM. The treatment was performed by RN #1 who was assisted by RN #2. After reviewing the physician's treatment order, RN #1 proceeded to the resident's bathroom to perform hand washing. RN #1 wet her hands, applied soap, and lathered outside of running water for 10 seconds. RN #1 turned off the faucet handle with bare wet hands. RN #1 set up the clean field and wound treatment supplies on the sanitized over bed table and proceeded to Resident #181's bedside to begin the treatment. RN #1 removed the soiled dressing from the resident's sacral area, removed her gloves, and proceeded to the bathroom to perform hand washing. RN #1 lathered outside of running water for 5 seconds, rinsed and dried her hands, and closed the faucet with a wet paper towel. RN #1 applied clean gloves and cleansed the wound by wiping in a circular motion from inside the wound bed to the outside peri-wound area (the correct method to keep from re-introducing bacteria into the wound bed). The second cleansing was performed by wiping from inside the wound bed to the outside peri-wound area and back into the wound bed. RN #1 wearing the same gloves (now considered soiled) patted the wound with a dry gauze pad. RN #1 wearing the same soiled gloves poured Dakin's solution onto a clean gauze pad and pulled the gauze pad apart to fluff it. RN #1 placed the area of the gauze pad which had been touched by soiled gloves into the wound bed. The bordered gauze dressing was placed over the wound while RN #1 wore soiled gloves. RN#1 reached into her uniform pocket with soiled gloves to obtain a pen. She wrote the date and her initials on the bordered gauze which had already been applied to the resident's sacrum. RN #1 placed the pen which she had handled with soiled gloves back into the uniform pocket. The surveyor interviewed RN #1 after she had completed the treatment. RN #1 stated the facility policy for handwashing required to lather outside of running water for at least 20 seconds. She stated the wound should be cleansed from in to out only. She stated she knew she erroneously wiped back in again contaminating the wound . She acknowledged she should have dated the dressing prior to placing it on the resident's body. The surveyor discussed the treatment observation with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) on 11/06/24 at 3 PM . The DON stated the resident was an agency nurse and he would contact the nursing agency to see if there was education done for hand hygiene and pressure ulcer treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/24 at 10:17 AM the LNHA stated he was unable to obtain nurse education for RN #1 from the nursing agency. At that same time the DON provided a photocopy of a remedial treatment observation and handwashing evaluation performed with RN #1 on 11/6/24. The documents indicated hands should be lathered outside of running water for 20 seconds before rinsing. A new paper towel should be used to turn off faucets. Gloves should be discarded when soiled. The method for cleaning the wound was not addressed, nor was the correct method for documenting on the bordered gauze cover dressing. 36419 2. The surveyor observed Resident #6 on 10/31/24 at 12:25 PM, in bed on a specialty mattress with their eyes closed, and the head of the bed elevated. The surveyor observed the tube feeding (TF) running via a machine and the Oxygen concentrator on with the gauge set on 4 LPM via a nasal cannula. A review of Resident #6's medical record revealed the following. The resident's Admission Record noted the resident was admitted with diagnoses that included but were not limited to Alzheimer's disease, pressure ulcer of sacral region, stage 3 (a wound that involves full thickness loss of skin), and gastrostomy status (a tube that is surgically inserted into the stomach to provide nutritional support). A review of the November 2024 Physician Order Summary (POS) included a physician's order dated 11/3/24 to cleanse the sacral opening with Normal Saline, pack the sacral wound with moistened soaked gauze of 1/4 strength Dakins solution, apply skin prep to the outer wound and periguard to the surrounding area every day and evening shift and when needed. A review of the quarterly Minimum Data Set (MDS) dated [DATE], an assessment tool, indicated that Resident #6 had aphasia (inability to speak), was unable to make him/herself understood and was unable to understand others. The MDS further assessed that Resident #6 was dependent on staff for Activities of Daily Living (ADLs), had a stage 3 pressure ulcer, and received oxygen therapy. A review of the Individual Care Plan with a focus area indicated the Resident had an impairment to their skin integrity r/t history of stage 4 pressure wound to sacrum upon admission with interventions which included but were not limited to wound consult weekly if needed, weekly skin assessment by nurse, air mattress, incontinence care every 2 hours and to keep skin clean and dry. The surveyor observed the pressure ulcer treatment on 11/4/24 at 11:10 AM. The treatment was performed by the Licensed Practical Nurse (LPN) who was assisted by the Certified Nursing Assistant (CNA #1). After reviewing the physician's treatment order, the LPN proceeded to the resident's bathroom and performed hand washing. The LPN set up the clean field and wound treatment supplies on the sanitized over-bed table and proceeded to Resident #6's bedside to begin the treatment. The supplies included a full package of 4x4 gauze pads, a bottle of Dakin's 1/4 Strength Solution, a bottle of Normal Saline (NSS), skin prep pads, a full tube of periguard, and 6 bordered dressings. All supplies were contained in a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The LPN donned a disposable gown and gloves and removed the soiled dressing from the resident's sacral area. The LPN described the dressing as having a copious amount of serosanguinous exudate. The LPN removed her gloves and washed her hands. The LPN applied clean gloves, reached into the package of 4x4 gauze pads, wet the pad with NSS and in a circular motion cleansed the peri-wound area. The LPN discarded the gauze pad and using the same gloves, reached into the package of 4x4 gauze pads and removed another pad. The LPN wet the pad with NSS, cleansed the peri-wound, and then using the same contaminated gauze pad, cleansed the inside of the wound bed. The third cleansing was performed by wiping from the outside of the peri-wound area back into the wound bed. The LPN removed the gloves, sanitized her hands using Alcohol Based Hand Rub (ABHR), poured Dakin's solution onto a cleanse gauze pad placed it inside the wound bed, and placed the dated, initialed bordered gauze dressing over the wound onto the excoriated peri wound without first applying the Perigaurd. The LPN applied the Periguard to the portion of the peri-wound that was not covered and then covered the area with another bordered dressing. The LPN brought all of the supplies out of the room and put them back into the treatment cart. The surveyor discussed the breaks in technique with the LPN on 11/4/24 at 11:45 AM. The LPN stated that the wound should be cleansed from the center of the wound to the peri wound. The LPN acknowledged that she should have only brought the supplies needed for the treatment into the resident's room and should have discarded the bag of contaminated 4x4 gauze pads and the contaminated bottle of NSS. The LPN confirmed that she should have applied the Periguard to the peri-wound before she applied the first bordered dressing. The surveyor interviewed the Infection Control Nurse (ICN) on 11/4/24 at 12:55 PM, who confirmed the supplies brought into the resident's room should have been discarded, not put back into the treatment cart. On 11/4/24 at 1:34 PM, the surveyor discussed the observations and concerns with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON confirmed only supplies needed for the wound treatment should be brought into the resident's room. A review of the Treatment Observation Protocol included .Treatment Procedure .understands steps of wound care procedure; follow treatment order as written .cleanse wound as per MD order and pat dry with sterile 4x4. Preparing Treatment .tubes of cream and ointments are kept out of resident rooms .place amount needed on sterile 4x4 .place used supplies in receptacles . 3. On 11/4/24 at 12:00 PM, the surveyor observed CNA #1 obtained a bag of personal care supplies from the resident in room [ROOM NUMBER] bed 1 and used the same personal care items for the resident in 417 bed 2 (Resident #22). At that same time, the surveyor observed the linen cart that contained linens for multiple residents on the 4th floor unit was inside room [ROOM NUMBER]. After the CNA had provided care for Resident #22, CNA #1 put the bag of personal care items she had used for both residents in room [ROOM NUMBER] onto the linen cart and pushed the cart out into the hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, CNA #1 acknowledged she should not have shared the personal care items between residents and that the items should be kept in each resident's room. CNA #1 confirmed that only the linen needed for each resident should be brought into the room not the entire linen cart for infection control reasons. On 11/4/24 at 12:50 PM, the surveyor interviewed the Registered Nurse/ Unit Manager on the 4th-floor unit who stated that linen carts should remain outside of rooms, only linen needed for each resident should be brought into the room, and personal care items should be used for only one resident, not shared between residents. On 11/4/24 at 1:34 PM, the surveyor discussed the above observations and concerns with the LNHA and DON. 4. On 11/4/24 at 12:40 PM, the surveyor observed CNA #2 entered the bathroom in Resident room [ROOM NUMBER]. The surveyor observed CNA #2 applied soap to her hands and immediately placed her hands under the stream of running water without first lathering her hands outside of the running water. At that same time, the surveyor interviewed CNA #2 who acknowledged that she should have applied soap and then lathered her hands for 20 seconds outside the stream of water. On 11/4/24 at 1:34 PM, the surveyor discussed the above observations and concerns with the LNHA and DON. NJAC 8:39 19.4 (a) (n)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on observation, interview, and record review, it was determined that the facility failed to ensure pneumococcal vaccination was offered according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations for Residents #23, #36 and #83. This deficient practice was identified for three (3) of five (5) residents reviewed for immunization status. The deficient practice was evidenced by the following: Reference: A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 9/12/24, included the following. The CDC recommends a single dose of PCV21 (pneumococcal 21-valent conjugate vaccine; Capvaxive), PCV20 (pneumococcal 20-valent conjugate vaccine), or PCV15 (pneumococcal 15-valent conjugate vaccine) greater than or equal to 1 year after the last PPSV23 (pneumococcal 23-valent polysaccharide vaccine; Pneumovax23) dose. Reference [previous guidelines] A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 3/15/23, included the following: The CDC recommends a single dose of PCV20 or PCV15 greater than or equal to 1 year after PPSV23. On 11/4/24 at 1:13 PM, during an interview with a surveyor, the Registered Nurse/Infection Preventionist stated that the pneumococcal vaccine offered at the facility was the PCV21 (Capvaxive) and that she was aware of the new guidelines for the pneumococcal vaccine. At that time, the RN/IP stated that the facility had not offered the newest pneumococcal vaccine to residents who had previously received the vaccine. 1.) On 10/31/24 at 11:13 AM, the surveyor observed Resident #23 seated in a wheelchair, mobile and conversant. The resident informed the surveyor of their diagnosis of heart failure and how they have worked hard during rehabilitation treatment to achieve the mobility they currently have. The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #23. According to the Admission Record (AR; an admission summary) reflected Resident #23 was admitted to the facility with diagnoses which included but were not limited to type 2 diabetes (high blood sugar) heart failure, and chronic obstructive pulmonary disease (a condition that causes airflow blockage and breathing-related problems). Resident # 23's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 8/6/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out 15 which indicated the resident's cognition was intact. Further review of the qMDS dated [DATE], under section O0300 A. Is the resident's Pneumococcal vaccine to date? The response was marked 1, which reflected Yes. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the electronic Medical Record (eMR) reflected Resident #23 had received Pneumovax on 11/22/22. A review of the paper-based chart for Resident #23 did not reveal documentation that the pneumococcal vaccine was offered, or was declined, and that education was provided to the resident in 2023. 2. On 10/31/24 at 10:48 AM, the surveyor observed Resident #36 in bed with oxygen infusing at 3 liters per minute (lpm) via a nasal cannula (a device used to deliver supplemental oxygen), and the head of the bed was elevated approximately 40 degrees. According to the AR Resident #36 was admitted to the facility with diagnoses which included but were not limited malignant neoplasm of the colon (colon cancer) and chronic obstructive pulmonary disease (a condition that causes airflow blockage and breathing-related problems). Resident # 36's most recent Annual Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care, dated 9/18/24, reflected that the resident had a BIMS score of 15 out 15 which indicated the resident's cognition was intact. Further review of the AMDS dated [DATE], under section O0300 A. Is the resident's Pneumococcal vaccine to date? The response was marked 1, which reflected Yes. A review of the eMR reflected Resident #36 had received Pneumovax on 8/4/21. A review of the paper-based chart did not reveal documentation that the pneumococcal vaccine was offered, or was declined, and that education was provided to the resident in 2023. 36419 3. On 10/31/24 at 11:45 AM, the surveyor observed Resident #83 ambulating on the 4th floor unit. According to the AR Resident #83 was admitted to the facility with diagnoses which included but were not limited to dementia, anxiety, and hypertension. Resident #83's most recent quarterly MDS dated [DATE] reflected the resident had a BIMs score of 6 out of 15 which indicated a severe cognitive impairment. Further review of the qMDS , under section O0300 A. Is the resident's Pneumococcal vaccine to date? The response was marked 1, which reflected No. Under section 0300 B. If Pneumococcal vaccine not received state the reason .the box was left blank. A review of the eMR reflected Resident #83 had received Pneumovax on 11/12/22. On 11/6/24 at 3:06 PM, the surveyor requested any documentation showing that the resident was offered and or had declined the Pneumococcal Vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/24 at 3:06 PM, in the presence of the survey team, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the concern regarding Resident #23, #36 and #83 who were not offered pneumococcal vaccination according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations. On 11/7/27 at 10:10 AM, in the presence of the survey team, and the LNHA, the DON confirmed that there was no further information that could be provided regarding the concerns for the pneumococcal vaccine. A review of the undated facility policy for Pneumococcal Vaccine included: It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations (policy references included CDC dated 10/26/24). No further information was provided. N.J.A.C. 8:39-19.4 (i)