STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315456	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Meadows Rehabilitation and Nursing Center	151 Ninth Avenue Little Egg Harbor Tw, NJ 08087

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, review of medical records and other pertinent facility documents, it was determined that the facility failed to treat each resident with respect and dignity in an environment that promotes maintenance or enhancement of their quality of life by maintaining cleanliness and dignified appearance of the resident's motorized wheelchair. This deficient practice was identified in one of one resident (Resident #80) reviewed for dignity and was evidenced by the following:On 12/4/2025 at 10:57 AM, during the initial tour of the facility, the surveyor observed Resident #80 ambulating in the hallway on a motorized wheelchair. The surveyor observed the motorized chair to be heavily soiled with fresh and dried food crumbs, dusts, and other unidentified debris on the bilateral front and rear wheels, all wheel fenders, bilateral seat side rails, footrest, seat board, controller, power base and leg rest hangers. The resident was unable to recall when the chair was last cleaned.The surveyor reviewed the medical record for Resident #80.A review of the admission Record revealed Resident #80 was admitted to the facility with diagnoses which included but not limited to cerebral palsy (a condition marked by impaired muscle coordination) and depression.A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 11/15/2025, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated an intact cognition. The MDS also indicated that the resident had impairments on both upper and lower extremities and that the resident needed clean-up assistance.A review of the resident's comprehensive care plan did not include a focus for usage of motorized wheelchair.On 12/9/2025 at 9:02 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that the housekeeping department maintained the cleanliness of the wheelchairs in the facility by power washing them monthly or on as needed schedule. The DON stated that the nurses would let the unit managers know about the need for more frequent cleaning of the wheelchairs and the unit managers would let the housekeeping director know about it. On 12/9/2025 at 12:18 PM, during an interview with the surveyor, the housekeeping director stated that all the wheelchairs in the facility are scheduled on a monthly or on as needed basis. The surveyor asked the housekeeping director for a list of residents whose wheelchairs were cleaned monthly for the past 6 months. A review of the monthly list of units whose wheelchairs were cleaned revealed that Resident #80's wheelchair was last cleaned in October 2025. On the wheelchair cleaning schedule for November and December 2025, a cross mark on the resident's unit was indicated under week 1 with no specific name of the residents whose wheelchairs were cleaned.No further information was provided.A review of the facility-provided undated policy titled Routine Cleaning and Disinfection revealed the following under Policy Explanation and Compliance Guidelines: 4.) Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include but not limited to . i.) Resident chairs. N.J.A.C. 8:39 - 4.1 (a) (11) (12)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, review of medical record and other pertinent facility documents, it was determined that the facility failed to respect the resident's right to confidentiality of personal and medical records from unauthorized disclosure without the resident's consent by leaving the resident's private health information exposed on an open and unattended computer screen in an area accessible to the public. This deficient practice was identified for one of four unsampled residents (Resident #21) during medication administration observation.The deficient practice was evidenced by the following:On 12/5/2025 at 7:54 AM, during the medication administration observation in the long-term care unit, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medications to Resident #21. After administering 1 tablet of metformin 500 milligrams and applied prednisolone acetate ophthalmic suspension to both eyes of the resident, LPN #1 returned to the medication cart located in the hallway, to place the ophthalmic suspension bottle inside the top drawer. The surveyor observed LPN #1 leave the medication cart with the computer screen open on the page showing the resident's photograph, name, location, gender, date of birth , age, physician, allergies, code status, physician orders, current vital signs including weight, and medical condition. LPN #1 went inside the resident's room to speak to the resident with their back facing the doorway. The medication cart was not on LPN #1's line of vision. The computer screen on top of the medication cart faced the hallway. There were no residents or staff in the hallway at that time. The surveyor called the attention of LPN #1 and asked the nurse if the computer screen showing the resident's private health information is supposed to be left exposed in the hallway while the medication cart was unattended. LPN #1 stated that the computer screen should be on locked mode at all times while unattended meaning it should be on a blank page and not showing the resident's information.On 12/9/2025 at 8:57 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that during medication administration, the nurses should be pressing the computer screen lock button to protect the residents' private information from being viewed by other people when they leave the cart.A review of facility- provided policy titled Medication Administration revised on November 11, 2024, included under Policy Explanation and Compliance Guidelines: . 7.) Provide privacy. NJAC 8:39-4.1(a)18NJAC 8:39-35.2(i)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to maintain a homelike environment that was clean, safe, and sanitary. This deficient practice was identified for 1 of 4 units ([NAME] Unit).This deficient practice was evidenced by the following: On 12/08/2025 at 10:00 AM, in bedroom [ROOM NUMBER] on the [NAME] Unit, the surveyor observed multiple black debris scattered across the A-side wall. On the B-side, the cloth material behind the bed was torn in several places. In the bathroom, the heater vent had unfinished spackling around it, and five holes were noted on the bathroom wall, all with incomplete spackling. On 12/08/25 at 10:00 AM, in the shower room on the [NAME] Unit, the surveyor observed that the entrance door had brown, flaking metal with crumbling edges, and paint was peeling away. Molding on the wall adjacent to the entrance door showed missing and bulging paint, exposing open wall spaces. Additionally, a sharp container was tilted and hanging, filled to the top with multiple blue razors, with its top open, exposing the contents. During an interview with the surveyor on 12/09/25 at 1:20 PM, the Licensed Nursing Home Administrator (LNHA) stated that maintaining a homelike environment was important for residents' dignity and comfort. The LNHA also explained that any environmental issues were addressed promptly by maintenance, with response times prioritized based on the severity of the issue. During an interview with the surveyor on 12/10/25 at 11:15 AM, the Maintenance Director (MD) stated that he completed rounds around the facility three times daily and addressed issues promptly, depending on their severity. He stated that the maintenance department was responsible for emptying sharps containers and monitored them during rounds to determine when they needed to be emptied. The MD explained that he was unaware of the issues in bedroom [ROOM NUMBER], shower room and that the sharps containers should have been emptied for safety reasons. He acknowledged that the environment was not homelike for residents and stated that he would address the issues immediately. A review of the facility's undated policy titled Homelike Environment revealed that Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent as possible. N.J.A.C. 8:39-31.4(a)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and pertinent facility documentation, it was determined that the facility failed to ensure that the resident was free from physical restraint for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. This deficiency was identified for 1 of 1 resident reviewed for physical restraints (Resident #9).This deficient practice was evidenced by the following: On 12/08/25 at 10:02 AM, the surveyor observed Resident #9 on the [NAME] unit in the day room, seated in a geriatric chair (a wheelchair designed for older adults, providing comfort, safety, and support for limited mobility), watching television with peers. A yellow tab alarm device (a personal alert device used in healthcare that triggers an alarm when a resident attempts to get up from a bed, chair, or wheelchair) was clipped to Resident #9 shirt. According to the admission record, Resident #9 was admitted to the facility with diagnoses including, but not limited to, dementia (a brain condition that affects memory, thinking, and daily functioning, making it difficult to remember, make decisions, or manage everyday tasks). A review of Resident #9's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 09/19/25, included a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated that the resident had severe cognitive impairment. Further review of Section P: Restraints and Alarms revealed that the resident did not use any alarms. A review of Resident #9's individual comprehensive care plan (ICCP) revealed that the facility did not include a focus area or interventions for any personal alarms. A review of Resident #9's medication administration record (MAR) and treatment administration records (TAR), dated as of 12/25, did not contain any physician orders for personal alarms. A review of Resident #9's electronic medical records (EMR) revealed that the facility did not perform a restraint assessment for the use of personal alarms. There was no information in the resident's medical record for any type of assessment related to the use of personal alarms. During an interview with the surveyor on 12/08/25 at 1:10 PM, the Licensed Practical Nurse (LPN) stated that she has worked at the facility for approximately one year and that Resident #9 had always had a tab alarm in place. The LPN stated the resident wore the alarm at all times; however, there was no physician order for its use. The LPN further stated that the resident should not be wearing the alarm because it was considered a restraint, and that the facility did not use restraints. During an interview with the surveyor on 12/08/25 at 1:15 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that Resident #9 had always had a chair alarm. The LPN/UM indicated that she did not consider the tab alarm to be a restraint, but however confirmed that a physician's order, care plan, consent, and MDS documentation should be in the resident's chart for the use of the personal alarm. During an interview with the surveyor on 12/08/25 at 1:25 PM, the Registered Nurse /MDS Coordinator stated that she had been working at the facility completing MDS assessments since 04/2020. She explained that the tab alarm should have been coded as a restraint and noted that there was no physician order in place; therefore, it was not coded. She stated that a comprehensive assessment of the resident was completed quarterly and explained that the tab alarm should have been included in the resident's comprehensive care plan so that it ensured all staff were aware of the required interventions. During an interview on 12/09/25 at 1:20 PM, the Director of Nursing (DON) stated that restraints included anything that prevented a resident from performing activities independently and that the facility did not use physical restraints. The DON explained that the personal tab alarms were used for safety only after physician consultation. She stated that proper documentation should have been included in the care plan, nurse notes, and MDS. The DON stated that Resident #9's tab alarm was previously discontinued on 08/25 because it was no longer needed, and the resident had not had an alarm since. The DON noted that facility staff, including CNAs, could have placed the alarm on the resident because tab alarms were accessible to staff and were stored in (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the same supply closet as batteries and other equipment. She stated that she unsure why the alarm had been placed on the resident but would continue to investigate and provide staff education. A review of the facility's undated policy titled Use of Restraints revealed that Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. NJAC 8:39-4.1(a)6

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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. Based on observation, interview, record review, and review of facility policies, it was determined that the facility failed to meet professional standards of nursing practice with respect to following physician's orders. This deficient practice was identified for one (1) of thirty-four (34) residents reviewed, Resident #56. This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 well-being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. On 12/4/2025 at 10:56 AM, the surveyor observed Resident #56 sitting in their wheelchair (W/C) outside of the day room. The Resident was not wearing the derma-legs, paperless gloves, or Geri-sleeves. The resident was not able to be interviewed due to cognitive deficits. On 12/4/25, at 10:20 AM, the surveyor reviewed the medical record for Resident #56 which revealed the following information: Review of the admission Record (admission summary) dated 9/18/24, reflected that Resident #56 was admitted to the facility with diagnoses which included but were not limited to: systemic inflammatory response syndrome (SIRS), [a life-threatening medical emergency characterized by inflammation throughout the body], protein-calorie malnutrition (inadequate intake of nutrients), and heart failure (inability of the heart to pump blood effectively). Review of the quarterly Minimum Data Set (MDS), an assessment tool utilized to manage a resident's care dated 10/1/25, indicated that the resident displayed both short-term and long-term memory problems. Review of the Individual Comprehensive Care Plan (ICCP) reflected a focus area, dated 2/3/25, that Resident #56 was at risk for bruising/bleeding/skin tear related to (r/t) aspirin therapy and physiological changes in skin secondary to aging. Interventions included: always apply derma-legs to both legs except during care, apply derma-sleeves at all times except during (activities of daily living) ADLs, apply Geri-sleeves to both arms at all times except during ADLs, and encourage resident to keep Geri and derma sleeves on, reapply when removed. Subsequently, the surveyor observed Resident #56 not wearing the prescribed skin protectors on multiple occasions: 12/4/25 at 10:56 AM, 12/8/25 at 10:56 AM, 12/8/25 at 12:58 PM, and 12/9/25 at 8:53 AM. The physician Order Summary Report (OSR), dated as of 12/9/25, included the following physician orders (PO): (1). A PO dated 4/2/25, for derma-sleeves at all times except during care, every shift for skin protection.(2). A PO dated 2/3/25 for Geri-sleeves at all times except during care, every shift for skin protection.(3). A PO dated 10/10/25 for fingerless gloves every shift for skin protection. The Treatment Administration Record (TAR) for December 2025 indicated the skin protectors were documented as applied every shift. However, the surveyor observed Resident #56 multiple times not wearing the skin protectors. On 12/8/2025 at 1:10 PM, the surveyor interviewed the Certified Nursing Assistant (CNA), who stated that the Resident should wear the derma-legs, paperless gloves, and Geri-sleeves at all times. On 12/8/25 at 1:20 PM the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the Resident should wear the derma-legs, paperless gloves, and Geri-sleeves at all the times. The LPN further reported that the resident sometimes removed the skin protectors. When asked about documentation to support the Resident's removal of the skin protectors, the surveyor did not find any documentation verifying the Resident's removal of the skin protectors. On 12/9/2025 at 9:00 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who confirmed that the Resident should wear the derma-legs, paperless gloves, and Geri-sleeves at all times. The RN/UM further stated that if the Resident removed the skin protectors they should be reapplied, and staff should document any removal. On 12/9/25 at 12:12 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the skin protectors should be applied as ordered by the physician. The DON further agreed that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff should reapply the skin protectors if the Resident removes them and document the removal in the Progress Notes.^ A review of the facility's policy Dressings, Dry/Clean, revised 9/23, indicated that staff were to verify that there was a physician's order, review the resident's care plan, current orders, and diagnoses and check the treatment record. NJAC 8:39-27.1(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, review of the medical record, and other facility documents, it was determined that the facility failed to ensure that a resident who was identified as having a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity or rigidity of joints) received recommended services to prevent further decreased in range of motion (ROM). This deficient practice was identified for 1 of 1 resident reviewed for positioning and mobility, (Resident #4) and was evidenced by the following:On 12/4/2025 at 9:45 AM, during the initial tour of the facility, the surveyor observed Resident #4 in bed while being rendered morning care.On 12/4/2025 at 10:34 AM, the surveyor observed Resident #4 ambulating in the hallway using their left hand to move the wheelchair. The resident's right leg was up on the leg rest on immobilizer boot. The resident's right arm was bent on the elbow and kept close to the body. The resident's right hand was flexed and being held by the left hand. The resident did not wear a splint or hand roll on the right arm and the right hand. The surveyor did not see any hand splint or hand roll in the resident's room.On 12/8/2025 at 9:40 AM, the surveyor observed Resident #4 ambulating in the hallway using their left hand to move the wheelchair. The resident's right leg was up on the leg rest on immobilizer boot. The resident's right arm was bent on the elbow and kept close to the body. The resident's right hand was flexed and being held by the left hand. The resident did not wear a splint or hand roll on the right arm and the right hand. The surveyor did not see any hand splint or hand roll in the resident's room.The surveyor reviewed the medical record for Resident #4.A review of the admission Record revealed Resident #4 was admitted to the facility with diagnoses which included but not limited to hemiplegia (paralysis) affecting right dominant side and personal history of transient ischemic attack and cerebral infarction (stroke).A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 10/24/2025, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated an intact cognition. The MDS also reflected that the resident had impairment on one side of the upper and lower extremities and was dependent on staff for their activities of daily living.A review of the Clinical Physician Orders (CPO) active as of 12/4/2025 did not include any order addressing the resident's right upper extremity's mobility. An order for right hand anti-spasticity hand roll splint to be worn as needed, on in the AM, off in the PM, remove for hygiene was ordered on 12/12/2024 and discontinued on 2/15/2025.A review of the resident's comprehensive care plan included a focus for the resident's decreased passive range of motion on the right wrist/ hand due to contractures revised on 10/28/2025. Interventions included the following: To wear right resting hand splint for 4 hours during daytime after morning care.A review of the occupational therapy evaluation and plan of treatment dated 10/24/2025 included recommendations for resting hand splint, as tolerated, remove for hygiene for right hand contracture.On 12/9/2025 at 9:05 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that the Director of Rehabilitation (DOR) issued orders for assistive devices.On 12/9/2025 at 9:45 AM, during an interview with the surveyor, the DOR stated that they issue the orthotics (artificial devices such as splints and braces) orders and had access to the resident's electronic medical record to write orders which would need to be confirmed and approved by the resident's physician.On 12/09/2025 at 11:10 AM, the surveyor observed Resident #4 inside their room facing the dresser. On top of the dresser was a blue-colored hand splint. The resident pointed to the hand splint and stated to the surveyor that they were handed the blue- colored splint today.A review of the CPO active after the surveyor's inquiry about the resident's orthotics, revealed an unconfirmed physician order for applying right resting hand splint on daytime as tolerated created on 12/9/2025 by the DOR but was backdated to 10/24/2025 by the DOR.A review of the facility-provided policy titled Provision of Rehab Services created in 2025, included the following under Policy: 2.) Physician orders are required, or there is a change in the resident/ patient's (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition, the interdisciplinary team will contact the physician. Any changes in the plan of care must be approved by the physician and documented in the resident/ patient's record. N.J.A.C. 8:39 - 27.2 (m)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to follow facility policy and procedure for weekly weights for 1of 2 residents (Resident #1) on 1 of 3 units (Comfort Care). This deficient practice was evidenced by the following: On 12/05/2025 at 7:59 AM Resident#1 was observed in bed. Resident #1 was slightly agitated and did not prefer to communicate with the surveyor. The breakfast tray was observed on the over the bed table. The tray was observed to be untouched. Resident 31 stated that he/she was in pain and had no appetite. Resident #1 would not tell the surveyor how long their appetite had been poor, then stated, yesterday. Staff were observed to attend to Resident#1 after the surveyor had left the room. Staff were observed by the surveyor to provide assist with setting resident up to eat and opening cold cereal and pouring milk.A review of Resident #1's admission Record revealed that Resident #1 was admitted to the facility with the following but not limited to diagnoses: Congestive heart failure (a chronic condition where the heart can't pump enough blood to meet the body's needs, leading to fluid buildup in the lungs, legs, and other areas, causing shortness of breath, swelling, and fatigue), sepsis (blood infection), malignant neoplasm of unspecified female breast, dementia, anxiety disorder, edema, and cachexia (a severe, involuntary loss of muscle and fat mass).A review of Resident #1's comprehensive Resident Assessment Instrument Minimum Data Set (MDS, an assessment tool, dated 11/14/2025 revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. According to Section F of the MDS, Resident #1 required supervision or touching assistance with eating. Section K of the MDS revealed that Resident #1 had complaints of difficulty or pain with swallowing, received a mechanically altered diet while a resident and received a therapeutic diet while a resident. Section K did not reveal that Resident #1 had significant weight gain or decline. Section indicated that Resident #1 received a daily diuretic and opioid medication.A review of Resident #1's Order Summary Report with active orders as of 12/09/2025 revealed Resident #1 had the following physician orders: No Added Salt diet, chopped texture, regular fluid consistency, order date: 11/07/2025. House Supplement Shake, one time a day for nutrition support provide 4 oz (ounce) by mouth, order date: 11/14/2025. Weekly weights every day shift every Wednesday for monitoring after weight loss for 3 weeks, order date: 12/03/2025. Dietary/Dietician consult cachexia, order date: 11/10/2025. Weight on admission and Weekly x 4 weeks every day shift every Friday for weight protocol for 28 days, order date: 11/07/2025. Furosemide Oral Tablet 40 MG (milligrams) (Furosemide) give 1 tablet by mouth one time a day for leg edema, order date: 11/07/2025. Spironolactone Tablet 25 MG give 1 tablet by mouth one time a day for hypertension/CHF (congestive heart failure), order date: 11/23/2025.A review of the Medication Administration Record (MAR, dated 11/1/2025-11/30/2025 revealed the following weekly weights: 11/14: 126.2, 11/21: 129, and 11/28: 128.A review of the comprehensive, person-centered care plan revealed the following care plan Focus: I have a nutritional problem or potential nutritional problem r/t (related to) need for therapeutic diet, need for mechanically altered diet, congestive heart failure, malignant neoplasm of breast, atrial fibrillation (an irregular and often very rapid heartbeat), hypertension, dementia, osteoarthritis, COPD (chronic obstructive pulmonary disease), anxiety, depression, GERD (gastroesophageal reflux disease), malignant pleural effusion, and history of significant weight changes. Interventions/tasks included but were not limited to the following: Weigh weekly x 4 weeks post weight loss, then monthly per protocol. Date Initiated: 11/10/2025. On 12/05/2025 at 12:54 PM, the surveyor reviewed the medical record for Resident #1. The following weights were documented: 11/7/2025: 133.0, 11/14/2025: 126.2, 11/21/2025: 129.0. 11/28/2025: 128.0 and 12/2/2025: 122.2. Resident #1 had a 6.8-pound weight decrease over a one-week period from 11/7/2025 to 11/14/2025.On 12/09/2025 at 9:38 AM, the surveyor conducted an interview with the Certified Nursing Assistant (CNA #). When asked what her responsibility was concerning weekly weights, CNA # told the surveyor that she was responsible for obtaining the weekly weight of (continued on next page)

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	315456	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1. CNA # further explained that I get the weight and write it down on a piece of paper and give it to the nurse on the unit.On 12/09/2025 at 9:47 AM, the surveyor conducted an interview with the Unit Manager/Registered Nurse (UM/RN #) assigned to Resident #1's unit. When asked to explain the weekly weight process UM/RN # told the surveyor that the CNA's and nurses are responsible for obtaining weekly weights. Once the weight is obtained it is entered into PCC (Point Click Care, an electronic medical record) and it would then populate on the TAR (Treatment Administration Record) and in the weights/vitals section. UM/RN # further explained that they would compare the weight to the previous weeks weight. If there was a +/- 3 -pound change in one week we will conduct a re-weight that day or the in the next 24 hours and document the re-weight. If the weight decline was accurate then I notify the dietitian verbally because I see him every day. The dietitian will evaluate, and we also evaluate as a team. The surveyor then asked UM/RN # if a weight decline of 6.8 pounds in one week would require a reweight. UM/RN # stated, Yes. A loss of 6.8# pounds in a week would generate a reweight. The surveyor then asked UM/RN # why a reweight was not conducted for Resident #1 for the documented weight loss of 6 pounds from 11/7/2025 to 11/14/2025. UM/RN # told the surveyor that the reweight was done but I didn't document it. The surveyor asked UN/RN # if the reweight should have been documented and UM/RN # replied Yes, it should have been documented so we can address the issue (weight decline) right away. On 12/09/2025 at 10:46 AM, the surveyor conducted an interview with the facility Registered Dietitian (RD). The RD told the surveyor that Resident #1 was on weekly weights which we do for all new admissions. He further stated that the nursing staff reports outlying weights to him, and I also review the weights myself for those who are on weekly weights. The surveyor asked the RD if Resident #1 should have had a reweight conducted for the documented 6.8-pound weight decline from 11/7 to 11/14/2025. The RD replied, Yes, Resident #1 had a weight change of greater than 3 pounds and it should have been a reweight and documented. The RD also explained that he also did re-weights, so it was not all on the nursing staff. The surveyor then asked the RD what the importance was of an accurate reweight and the RD responded that it was important so we can intervene and evaluate the resident to help prevent further weight decline.On 12/09/202 at 1:10 PM, the surveyor conducted an interview with facility administrative staff. The surveyor asked the facility Director of Nursing (DON) about the weekly weight process. The DON told the surveyor that we go over the residents on weekly weights and we have a weekly weight meeting. She further explained that nursing was responsible, and the dietitian was responsible for documenting the weights in the medical record. The surveyor asked the DON if a reweight should have been conducted and documented for the 6.8-pound weight decline in one week from 11/7 to 11/14/2025. The DON responded, I agree that we did not document the re-weight on 11/14/2025 when Resident #1 had a 6.8# weight discrepancy.The surveyor reviewed the facility provided policy titled Weight Assessment and Intervention, Revision Date: December 1, 2025. The following was revealed under Weight Assessment:Residents are weighed upon admission and at intervals established by the interdisciplinary team.Weights are recorded in each unit's weight record chart and in the individual's medical record. Any weight change of 5lbs (pounds) or more (in 1 month) or 3lbs or more (in 1 week) will be retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietitian in writing.NJAC 18:39-27.1(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. Based on observation, interview, and review of facility documents, it was determined that the facility failed to a.) ensure respiratory tubing was maintained in sanitary condition while being used by the resident and a nebulizer (a machine used to administer medication in the form of a mist inhaled into the lungs) mask was stored in protective covering to prevent the spread of infection and b.) follow physician orders and provide oxygen (O2) tubing to accommodate the respiratory needs of a resident ordered O2 in accordance with professional standards of practice. This deficient practice was identified for two of three residents (Resident #83 and Resident #56) reviewed for respiratory care.This deficient practice was evidenced by the following: 1.) On 12/4/2025 at 11:02 AM, during the initial tour of the facility, Surveyor #1 observed Resident #83 from the hallway, sleeping in bed connected to an oxygen concentrator running at 2 lpm (liters per minute) via a nasal cannula (NC) (a tube used to deliver oxygen though the nostrils). The surveyor observed the middle part of the oxygen tubing inside the trash bin located on the left side of the resident's bed. The oxygen tubing was observed touching the trash inside the trash bin. The oxygen tubing was unlabeled. There was no signage inside or outside the resident's room indicating oxygen is being used. On 12/5/2025 at 12:42 PM, the surveyor observed the resident in bed connected to the oxygen concentrator via a nasal cannula. The surveyor observed an unbagged nebulizer mask on the bedside table, lying sideways exposing it to air. The surveyor reviewed the medical record for Resident #83. A review of the admission Record revealed Resident #83 was admitted to the facility with diagnoses which included but not limited to chronic obstructive pulmonary disease (COPD) and heart failure. A review of the resident's most recent Minimum Data Set (MDS), an assessment tool dated 11/23/2025, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated an intact cognition. The MDS also reflected that the resident received respiratory treatment which included oxygen therapy. A review of the Clinical Physician Orders (CPO) active as of 12/4/2025 included the following orders: Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) mg/ 3 ml, 3 ml inhale orally 3 times a day for COPD ordered on 11/6/2025 and started on 11/7/2025. Oxygen PRN (as needed) via NC at 2 liters per minute as needed for SOB (shortness of breath). A review of the corresponding Medication Administration Record (MAR) in December 2025 revealed that nebulization on the following dates and times was signed administered on 12/5/2025 at 9:15 AM, 1:00 PM, and 5:15 PM. The order for oxygen treatment as needed was not signed administered for the month of December 2025. A review of the comprehensive care plan revised on 6/27/24 reflected a focus for oxygen therapy related to anxiety. The interventions included the following: Give medications as ordered by physician. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I, use oxygen therapy, 2 liters per minute via nasal cannula while sleeping. On 12/9/2025 at 8:58 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that nebulization mask should be stored in plastic bag when not in use. The DON also stated that oxygen tubing should not touch the trash bin. A review of facility provided policy titled Oxygen Administration revised in October 2010, indicated under Steps in the Procedure: .2.) Place an Oxygen in Use sign on the outside of the room entrance door. Close the door. 3.) Place an Oxygen in Use sign in a designated place on or over the resident's bed. Under Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record; 1.) The date and time that the procedure was performed, 2.) The name and title of the individual who performed the procedure. The policy did not address nebulization treatment and storage. 2.) On 12/5/2025 at 7:56 AM, the surveyor observed Resident #56 sitting in their wheelchair (W/C) in their room. No O2 tubing was observed in the Resident's room. On 12/4/25, at 10:20 AM, the surveyor reviewed the medical record for Resident #56. A review of the admission Record (admission summary) dated 9/18/24, reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to: Systemic Inflammatory Response Syndrome (SIRS), [a life-threatening condition involving widespread inflammation], protein-calorie malnutrition (inadequate intake of nutrients), and heart failure (inability of the heart to pump blood effectively). A review of the quarterly Minimum Data Set (MDS), an assessment that facilitates the management of a resident's care, dated 11/1/25, indicated that the Resident had both short-term & long-term memory problems. A review of the Individual Comprehensive Care Plan (ICCP) included a focus area dated 11/5/25, that the Resident was to have O2 therapy as needed for shortness of breath. The ICCP did not include any interventions related to O2 tubing. A review of the physician Order Summary Report (OSR), dated 12/9/25, included the following physician orders for Resident #56 (PO): A PO dated 11/4/25, for AHC: O2 tubing storage. Keep tubing in a bag when not in use, every shift, for low O2 less than 92%. A PO dated 11/4/25, for AHC: respiratory bag change. Change and date bag every night shift, every Tuesday, for O2 less than 92%. A review of the Treatment Administration Record (TAR) for December 2025 showed that the O2 tubing tasks were documented as completed every shift. However, during observations conducted on 12/5/25 at 7:56 AM, 12/8/25 at 1:30 PM, and 12/9/25 at 8:56 AM, the surveyor did not observe any O2 tubing in Resident #56's room. On 12/9/2025 at 9:00 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who confirmed that Resident #56 had an active order for O2 tubing but did not have the tubing in their (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. When asked about the O2 tubing task being signed off on the TAR, the RN/UM stated that the task should not have been signed off because the Resident did not have O2 tubing in their room. On 12/8/25 at 1:20 PM the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that based on PO, Resident #56 should have O2 tubing stored in a bag in the room. When asked about the importance of following the PO for O2 tubing, the LPN responded that it was important to have the O2 in the Resident's room in case of an emergency, particularly because the Resident is on hospice. On 12/9/25 at 12:12 PM, the surveyor interviewed the Director of Nursing (DON). The DON acknowledged that the oxygen (Oˆ) tubing should have been stored in the Resident's room as ordered and agreed that staff should not document completion of the O2 tubing task on the TAR as the tubing was not present. The DON also affirmed that it is especially important for a hospice resident to have O2 tubing readily accessible in the event of an emergency. A review of the facility's policy and procedure titled Oxygen Administration, revised October 2024, indicated that the purpose of the procedure was to provide guidelines for the safe oxygen administration. N.J.A.C. 8:39 - 27.1 (a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to store medications securely inside the medication cart by keeping it locked while unattended. The deficient practice was identified for 1 of 4 unsampled residents (Resident #21) observed during medication administration. The deficient practice was evidenced by the following:On 12/5/2025 at 7:54 AM, during the medication administration observation in the long-term care unit, the surveyor observed Licensed Practical Nurse (LPN) #1 administer medications to Resident #21. After administering 1 tablet of metformin 500 milligrams and applied prednisolone acetate ophthalmic suspension to both eyes of the resident, LPN #1 returned to the medication cart located in the hallway, to place the ophthalmic suspension bottle inside the top drawer. The surveyor observed LPN #1 push the drawer close but did not lock the medication cart. LPN #1 went inside the resident's room to speak to the resident with their back facing the doorway. The medication cart was not on LPN #1's line of vision. The opening of the medication cart faced the hallway. There were no residents or staff in the hallway at that time. The surveyor called the attention of LPN #1 and asked the nurse if the medication cart is supposed to be left unattended unlocked in the hallway. LPN #1 stated that the medication cart should be locked at all times.On 12/9/2025 at 8:57 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that medication carts should be locked at all times.A review of facility- provided policy titled Medication Storage revised on 5/30/2023, included under Policy General Guidelines: a.) All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) .c.) During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/ cart. N.J.A.C. 8:39 - 29.4 (h)

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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** Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to ensure a safe, and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to provide residents with appropriate products for hand hygiene during mealtime, and staff did not follow hand hygiene practices consistent with accepted standards of practice. This deficiency was identified in 1 of 4 dining room observations ([NAME] Unit dining room).This deficient practice was evidenced by the following: On 12/08/25 at 11:10 AM, the surveyor observed dining for lunch on the [NAME] Unit dining room. The Certified Nurse Assistant (CNA) assisted two residents with hand hygiene before lunch using a folded wet napkin for each resident. However, the CNA did not perform hand hygiene herself between assisting each resident. During an interview with the surveyor on 12/08/25 at 11:14 AM, the CNA stated that during mealtimes she uses folded wet napkins, which do not contain alcohol, to perform hand hygiene for residents. She further reported that she also uses the same folded wet napkins to perform hand hygiene on herself. During an interview with the surveyor on 12/09/25 at 1:20 PM, the Licensed Nursing Home Administrator (LNHA) stated that hand hygiene should be performed using soap and water when hands are visibly soiled and alcohol-based hand sanitizer when appropriate, including between contact with residents. During an interview with the surveyor on 12/10/2025 at 11:02 AM, the Infection Preventionist (IP) stated that the folded wet napkins used by the CNA did not contain alcohol. She explained that hand hygiene wipes should contain at least 70% alcohol. The IP noted that the CNA should not have performed hand hygiene on residents using the folded wet napkins and should have used either 70% alcohol-based hand gel or soap and water between residents for proper infection control. A review of the facility's undated policy titled Infection Prevention and Control Program revealed that All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. N.J.A.C. S 8:39-19.4(a)