STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315462	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallwoods Care Center	18 Butler Boulevard Bayville, NJ 08721

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen equipment in a clean, safe and sanitary manner as evidenced by the following. On 11/19/25 at 10:47 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following in the kitchen:1. The can-opener blade had brown debris under the blade and screw area. The black interior removable sleeve of the can opener mount on the counter when removed had sticky, gelatinous substance on the outside and interior where the can opener shaft would rest . The FSD acknowledged and agreed it had not been cleaned or washed according to facility policy. 2. The microwave had multicolored food debris on the interior ceiling. The FSD acknowledged and agreed that it was not cleaned according to facility policy. 3. 3 of 4 convention ovens (2-upper and 1-lower unit), had baked on food debris on the two glass doors and on the inside surfaces. The 4th unit was not operational. The FSD did not have a cleaning schedule and acknowledged and agreed that it was not cleaned according to facility policy. 4. 1 of 3 coffee dispenser nozzles (center), had white hard build up on the outside of the dispenser and the top of the dispenser. The FSD acknowledged and agreed that it was not cleaned according to facility policy. 5. Two- (6 burner) stove tops, both were covered with debris on the grates and around the cooker hats. The catch trays (covered with foil) on both units were also filled with burnt food debris. Under the foil was a gelatinous slippery/greasy substance. The FSD acknowledged and agreed that it was not cleaned according to facility policy. 6. The steam table, (a 6 water well unit) had debris and sediment in every water well consisting of rice, peas, white and black flakes. The FSD acknowledged and agreed that it was not cleaned according to facility policy. 7. 4 slot-Toaster, white in color, had orange, brown splatter around the outside of the unit, the top of the unit was discolored and had food debris, the two catch trays were filled with brown and black debris up to and including the grip handle. The FSD acknowledged and agreed that it was not cleaned according to facility policy. 8. The ice machine had a black discoloration around the white rim on the interior of the unit. The FSD acknowledged and agreed that it was not cleaned according to facility policy. 9. The Ice Scoop on the side of the ice machine was in a blue holder. At the base of the blue holder there was discoloration in the corners and a piece of cardboard garbage at the base. The FSD acknowledged and agreed that it was not cleaned according to facility policy. He further stated, the cardboard looked to be the ripped top off a disposable glove box and it should not be there. 10. 7 of 7 -Cutting boards all had etching and black discoloration. The FSD stated that there were on the clean rack and had already been put through the wash machine. The FSD acknowledged and agreed that they were not cleaned according to facility policy. He further stated, he did not know when the cutting boards were replaced last. 11. The Oil Fryer- the oil was very dark in color; the interior bottom heating element was not visible to the surveyor or the FSD. The top of the oil had a ring of food debris and white sediment. The fryer interior ledge was filled with food debris and crumbs. The exterior sides of the unit had a clear greasy substance. The FSD stated it had not been used since the Wednesday (11/12/25, 1 week prior) before surveyor observation. The FSD acknowledged and agreed that it was not cleaned according to facility policy.12. The Griddle catch tray had copious amounts of black sediment and debris. The FSD acknowledged and agreed that it (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was not cleaned according to facility policy. On 11/19/25 at 11:30 AM, the surveyor interviewed the FSD, stated that the cleaning of equipment should be done on a schedule to prevent food borne illness and maintain a safe and sanitary environment for the staff. The FSD acknowledged the surveyors concerns and agreed they were not done according to facility policy.On 11/24/2025 at 09:16 AM, the surveyor met with Licensed Nursing Home Administrator (LNHA). The LNHA acknowledged the surveyor's concerns. He stated that the equipment should be cleaned and maintained to prevent food borne illness, contamination, or injury; to ensure the safety of the residents and staff.On 11/26/25 at 11:25 AM the survey team met with the LNHA and Director of Nursing, they acknowledged and agreed with the concerns of the team and had no more information to provide. A review of the facility's undated policy, Kitchen equipment Policy, revealed. Purpose: ensure all kitchen equipment is used, cleaned and maintained safely and in compliance with NJ department of Health requirements, CMS food safety standards and manufacturer guidelines.All food contact equipment must be cleaned and sanitized after use and at the minimum of daily.Cleaning must follow manufacturer's instructions and facility procedures. A review of the facility's policy, Kitchen Cleaning and Sanitation, dated November 5, 2023, revealed. this policy is to ensure all food service areas are maintained in a clean, sanitary and safe condition in compliance with state health codes and the FDA food Code. Proper cleaning reduces contamination risks, prevents food borne illness, and promotes a safe working environment. sanitize food-contact surfaces before and after each use.Immediately clean spills to prevent slips, pests, and contamination.keep all cleaning logs accurate and up to date.clean and sanitize equipment after each use (slicers, mixers, blenders, etc.clean stovetops, griddles, oven doors, microwave interiors, steam tables and warmers.A review of the facility policy, Tray Line Process dated 2/2025, to ensure.safe preparation.to residents in compliance with.food safety regulations.the tray line must be cleaned and disinfected after each meal service.water must be changed DAILY. A review of the facility undated, Can opener policy revealed.wash with hot soapy water. the blades and cutting area must be scrubbed to remove any residue, inspect for metal shavings, dullness, or residue.store in a clean, dry area (preferably .mounted)A review of the undated facility policy, Deep Fryer Policy revealed.daily cleaning on days used, skim crumbs and debris from oil, wipe fryer exterior after cooling, clean nearby surfaces and floors to remove grease and spills.drain oil, clean inside fryer following manufacturer guidance, rinse thoroughly, dry complexly and refill with fresh oil. NJAC 8:39-17.2(g)

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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. Complaint # 2638538Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure adequate procedures for maintaining accurate records, tracking, and timely investigation of discrepancies related to controlled substances leading to actual and potential drug loss or diversion. This deficient practice was identified for a.) 1 resident (Resident #78) reviewed for pharmaceutical services and for b.) 5 unsampled residents (Residents #45, #115, #134, #142, and #168) identified during medication storage inspection of 2 of 4 medications carts (Maple High, Pine Low, and Pine Swing) and was evidenced by the following:1.) On 11/19/2025 at 11:30 AM, the surveyor observed Resident #78 in bed awake. The resident stated that they were not in pain. When resident was asked if they have missed any dose of their pain medication in the facility, the resident stated they have not missed any pain medication and had no complaints. On 11/20/2025 at 9:39 AM, the surveyor reviewed the medical record for Resident #78.A review of the admission Record (admission summary) indicated that Resident #78 was admitted to the facility with diagnoses which included but was not limited to cellulitis (bacterial infection of deeper tissues causing pain in the area affected) of the right lower limb and changes in skin texture.A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 9/12/2025, indicated that Resident #78 scored a 15/15 on the Basic Interview for Mental Status (BIMS) which indicated that the resident had intact cognition. The MDS also reflected that the resident did not exhibit any untoward behaviors.A review of the Order Summary Report active as of 11/20/2025 included a physician's order for Percocet oral tablet 7.5-325 mg (oxycodone w/ acetaminophen) give 1 tablet by mouth four times a day for chronic pain started on 7/14/2025.A review of the September 2025 Medication Administration Record (MAR) reflected that the physician order for Percocet was administered to Resident #78 with no missed dose.A review of the form AA-45 (Facility Reportable Event) dated 10/7/2025, indicated that on an unspecified date, a suspected narcotic diversion of 1 blister pack (bingo card) containing 60 tablets of Percocet from a Registered Nurse (RN #1) was identified and reported by the facility to the Consultant Pharmacist, New Jersey Department of Health (DOH), New Jersey Board of Nursing (BON), the Drug Enforcement Agency (DEA), and the local law enforcement.A review of the facility investigation revealed that on 9/18/2025, two 60-count cards of Percocet was received by the facility from the pharmacy for Resident #78. On 10/5/2025, the first 60-count Percocet card was depleted. On 10/6/2025, the facility request for a refill of Percocet for the resident was declined by the pharmacy due to recent refill. Facility investigation identified discrepancies, including alterations and use of white-out eraser on the September 2025 narcotic inventory sheet NIS) of the Maple low unit, where Resident #78's medications were stored, dated 9/20/2025 on 11-7 and 7-3 shifts and on 11-7 shift of 9/21/2025. The facility concluded that the diversion was isolated to one agency nurse, RN #1 who worked on 9/20/2025 3-11 and 11-7 shifts until 4:00 AM of 9/21/2025.A review of September 2025 narcotic inventory sheet (NIS) for the Maple low unit by the surveyor revealed no signatures from the incoming and outgoing nurses on the 11-7 shift of 9/21/2025. According to the NIS, Must be counted and signed each shift. Supervisors to initial for all new additional narcotics. The box where the supervisor was supposed to sign when the 2 bingo cards of Percocet were delivered on 9/18/2025 at 11-7 shift was blank. A review of the NIS from 9/1/2025 to 9/30/2025, did not reveal any supervisor signature for all narcotics added to the inventory count. The surveyor noted white-out erasures and alterations on the number of cards for 11-7 and 7-3 shifts of 9/20/2025, and on 11-7 shift of 9/21/2025. On 9/20/2025, 26 narcotic cards were counted for 7-3 shift and out of the 26 cards, 2 cards were removed. Further review of the NIS revealed that the Individual Patient's Controlled Drug Record (IPCDR) sheets were not being counted to match the number of narcotic medication cards, boxes, bottles, and/ or bags and for comparison (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with every new narcotic medication received by the facility from the pharmacy. On 11/21/2025 at 11:32 AM, the surveyor interviewed the Pharmacy Consultant (PC) by telephone who stated that shift-to-shift report includes narcotic counting between 2 nurses must match and must be signed by 2 nurses.On 11/24/2025 at 10:22 AM, during an interview with the surveyor, Registered Nurse (RN #2) confirmed that they counted the narcotics in Maple low cart with RN #1 on 9/21/2025 at 4:00 AM. RN#2 was asked why the shift-to-shift NIS form was blank on 11-7 shift of 9/21/2025. RN #2 stated because there was no space on the form to sign at 4:00 AM.On 11/25/2025 at 9:43 AM, during an interview with the surveyor, the Director of Nursing (DON) was asked how the lost Percocet bingo card was not noted until 10/6/2025 when RN #1 last worked at the facility on 9/20/2025. The DON stated that RN #1 changed the bingo card count from 27 to 26 on 11-7 and 7-3 shifts of 9/20/2025 and 2 bingo cards were subtracted from the count resulting to just 24 cards which matched the number of cards counted by RN #2 who counted with RN #1 at 4:00 AM of 9/21/2025. The DON further stated that the nurses counted the narcotics bingo cards without confirming the medications in the cards they counted. The DON confirmed that the IPCDR for the Percocet sheet 1 went missing together with the medication. The DON was asked what happened to the 2 bingo cards that were removed from the narcotics inventory count on 7-3 shift of 9/20/2025. The DON stated that they have a tracking form for removal of narcotic cards, bottles, boxes, or bags. The DON stated that the 2 bingo cards removed from the inventory log on 9/20/2025 should have been entered on the tracking form but they were not entered. The DON stated that the unit managers review the tracking forms and submit them to the DON monthly. The DON was asked who reviewed the tracking form submitted by the unit managers for the month of September 2025. The DON confirmed that they reviewed it.A review of facility-provided undated policy titled Narcotic Medication process indicated the following under Counting controlled substances with transfer of the cart between nurses: .3.) Both nurses must look at each sheet and each card to ensure accuracy. 4.) Both nurses sign the controlled substance book immediately upon completion of a correct count. Under Discrepancies or changes in narcotic count: 1.) Must be reported to the DON immediately. 2) An investigation is conducted to reconcile any reported discrepancies. 3.) Any irreconcilable discrepancies get reported to the administrator and a further investigation is completed which may include law enforcement and other agencies. The policy did not address the monitoring and review of tracking form for narcotic card/ bottle/ box/ bag removal. The policy did not address the monitoring of IPCDR count to match the number of IPCDR sheets with the number of IPCDR of new narcotics delivered. 2.) On 11/21/2025 at 12:06 PM, during medication storage inspection of the Pine unit low and swing medication carts with unit manager (UM) #1, the surveyor noted multiple cross-outs on the November 2025 IPCDR (Individual Patient's Controlled Drug Record). A review of the narcotic logbooks revealed the following:Resident #115's IPCDR for tramadol 50 milligram (mg) tablet (tab) was crossed out on amount # 38 dated 8/4/2025 at 10:20 AM. Across it was another date 8/6/2025 at 2:00 PM with an arrow pointing to the crossed-out date and time. Amount #35 dated 8/29/2025 at 9:00 AM was crossed out. An arrow pointed to another date 9/2/2025 at 11:22 (unspecified whether AM or PM) from the crossed-out line.Resident #168's IPCDR for fentanyl 50 microgram/ hour patch was crossed out on amount # 5 dated 11/16/2025. An error was written above it and across it was written the date of 11/17/2025. On 11/21/2025 at 12:17 PM, during medication storage inspection of the Maple unit high medication cart with UM #2, the surveyor noted multiple cross-outs on the November 2025 IPCDR sheets. A review of the narcotic logbook revealed the following:Resident #45's IPCDR for hydromorphone 4 mg tab was crossed out on amount #49 dated 10/6/2025 at 9:00 AM. Waste was written on the same line. Amount #44 dated 10/18/2025 at 18:13 was crossed out and an arrow pointed to a written date of 10/19/2025 with illegible time. Amount #22 dated 11/14/2025 at 2:00 PM was crossed-out and on the same line another date and time were written, 11/15/2025 at 11:40 AM. Amount #21 dated 11/16/2025 at 9:05 was crossed-out and across the page was written an encircled #21 dated 11/17/2025 at 12:00 PM. Amount #20 dated 11/17/2025 at 12:00 PM was crossed out. Across the page was written an encircled #20 dated (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/20/2025 at 1:00 PM. Amount #56 dated 10/29/2025 at 5:45 AM was crossed out and an arrow pointed to another date 11/14/2025 at 2:00 PM.Resident #142's IPCDR for morphine sulfate 15 mg tab dated 11/14/2025 at 4 AM was crossed out at amount #59. Across it was written 11/14/2025 at 9:00 AM. Below it was dated 11/14/2025 at 9:00 PM was crossed out and marked error.Resident #134's IPCDR for pregabalin 25 mg capsule dated 11/5/2025 at 9:00 AM, was crossed out and marked refused.On 11/21/2025 at 12:17 PM, during an interview with the surveyor, UM #2 was asked why the residents were refusing pain medications that were already removed from the blister packs. UM #2 stated I guess because the nurses don't ask the residents if they want their meds.On 11/25/2025 at 9:43 AM, during an interview with the surveyor, the DON stated that cross-outs meant errors.On 11/25/2025 at 11:03 AM, during a meeting with the survey team, concerns for multiple crossed outs on IPCDR or narcotic declining sheets of Pine and Maple units were brought up to the administrator and DON.No further information was provided.A review of the facility-wide in-service by the DON dated 10/9/2025 titled Controlled Substance Accountability & Diversion Prevention for nurses included under Objectives: After this in-service, staff will be able to 1.) Demonstrate accurate documentation on the narcotic sign-in and count sheet. A review of the supplementary education sheet included in the in-service titled Controlled Drug Substance Accountability from the pharmacy consultant included under DO NOT . Use arrows, extraneous marks. A review of facility-provided undated policy titled Narcotic Medication Process reflected under Discrepancies or changes in narcotic count: 1.) Must be reported to the DON. 2.) An investigation is conducted to reconcile any reported discrepancies. 3.) Any irreconcilable discrepancies get reported to the administrator and a further investigation is completed which may include law enforcement and other agencies.N.J.A.C. 8:39 - 11.2 (b), 29.2 (a)(d), 29.4 (k), 29.7(c)

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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. Based on observation, interview, review of medical records and other pertinent facility documents, it was determined that the facility failed to use appropriate infection control practices to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice, by failing to 1.) follow appropriate disinfection of a shared resident care equipment during medication administration observation, and 2.) provide residents with appropriate products for hand hygiene during mealtime. This deficient practice was identified for 6 of 6 unsampled residents (Residents #163, #164, #104, #165, #166, and # 167) observed during medication administration and 1 of 3 dining room observations (1st Floor Pine Unit dining room). This deficient practice was evidenced by the following: 1.) On 11/20/2025 at 7:36 AM, during the medication administration observation with Registered Nurse (RN) #1, Surveyor #1 observed RN #1 take the blood pressure (BP) of Resident #163 from the right arm. The BP read as 126/72. RN #1 removed the BP cuff from the resident's right arm. RN #1 proceeded to administer the resident's medications. RN #1 did not sanitize the BP cuff prior to and after using it on the resident. On 11/20/2025 at 7:53 AM, the surveyor observed RN #1 take the BP of Resident #164 from the right arm. The BP read as 130/65. RN #1 proceeded to administer the resident's medications. RN #1 did not sanitize the BP cuff prior to and after using it on the resident. On 11/20/2025 at 8:02 AM, the surveyor observed RN #1 take the BP of Resident #104 from the left arm. The BP read as 131/69. RN #1 proceeded to administer the resident's medications. RN #1 did not sanitize the BP cuff prior to and after using it on the resident. On 11/20/2025 at 8:23 AM, the surveyor observed RN #1 take the BP of Resident #165 from the left arm. The BP read as 141/74. RN #1 proceeded to administer the resident's medications. RN #1 did not sanitize the BP cuff prior to and after using it on the resident. On 11/20/2025 at 8:41 AM, the surveyor observed RN #1 take the BP of Resident #166 from the left arm. The BP read as 111/63. RN #1 proceeded to administer the resident's medications. RN #1 did not sanitize the BP cuff prior to and after using it on the resident. On 11/20/2025 at 9:06 AM, the surveyor observed RN #1 take the BP of Resident #167 from the left arm. The BP read as 128/62. RN #1 proceeded to administer the resident's medications. RN #1 did not sanitize the BP cuff prior to and after using it on the resident. On 11/24/2025 at 10:22 AM, during an interview with the surveyor, the Infection Preventionist/ Registered Nurse (IP/ RN) stated that nurses need to wipe down the BP cuff with the purple- top container sanitizing wipes between each patient. On 11/24/2025 at 9:30 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that the nurses should be wiping down the BP cuff between residents using the purple-cap wipes. A review of the facility-provided policy revised on July 2024, titled Cleaning and Disinfection of Resident – Care Items and Equipment indicated under Policy Interpretation 1.) . c. non-critical items are those that come in contact with intact skin but not mucous membranes. (1) Non-critical (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	items include bedpans, blood pressure cuffs, crutches and computers. (2) Most non-critical reusable items can be decontaminated where they are used (as opposed to being transported to a central processing location) . 7.) Intermediate and low-level disinfectants for non-critical items include a. Ethyl or isopropyl alcohol; b. Sodium hypochlorite (5.25 – 6.15 % diluted 1:500 or per manufacturer's instructions); c. Phenolic germicidal agents; d. Iodophor germicidal detergents; and e. Quaternary ammonium germicidal detergents (low-level disinfection only). N.J.A.C. 8:39 – 19.4 (a) 2.) On 11/20/2025 at 12:27 PM, Surveyor #2 observed dining for lunch on the 1st floor Pine Unit dining room. The Certified Nurse Assistant (CNA) assisted two residents with hand hygiene using alcohol free baby wipes with aloe (AFBW). She did not perform hand hygiene between assisting the residents. During an interview with Surveyor #2 on 11/20/2025 at 12:35 PM, the CNA stated that the AFBW were the type of hand wipes the facility used to perform residents' hand hygiene before meals. She acknowledged that she should have washed her hands between assisting residents to comply with infection control. During an interview with Surveyor #2 on 11/24/2025 at 12:45 PM, the Infection Preventionist (IP) reported that she has worked as the IP nurse for seven and a half months and had been employed at the facility for over one year. The IP stated that residents should have had alcohol-based wipes placed on their meal trays; however, if those wipes were not available, staff may use AFBW. She was unsure whether staff should be using AFBW for hand hygiene, noting that baby wipes did not contain alcohol and would not be effective at killing germs. She also confirmed that CNAs should perform hand hygiene between assisting each resident to maintain proper infection control. During an interview with the surveyor on 11/25/2025 at 11:20 AM, the Licensed Nursing Home Administrator (LNHA) was unsure whether staff should be using AFBW for hand hygiene. A review of the facility's undated policy titled Infection Control Policy and Procedure revealed that The facility shall establish an Infection Prevention and Control Program that will follow national standards and guidelines. The hand hygiene procedure is to be followed by staff involved in direct resident contact. Staff are required to follow hand hygiene practices consistent with accepted standards of practice. N.J.A.C. 8:39-19.4(a)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on observation, interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to initiate a physician's order (PO) for a resident's code status (refers to a patient's decision regarding the level of medical intervention they wish to receive in the event of a life-threatening crisis, such as cardiac or respiratory arrest). This deficient practice was identified for 1 [one] of 29 residents (Resident #139) reviewed was evidenced by the following:On 11/20/25 at 10:03 AM the surveyor observed Resident #139 lying in bed and watching TV. The Resident stated, the staff known I do not want nothing done and that I signed papers about my choice. On 11/20/25, at 10:20 AM, the surveyor reviewed the medical record for Resident #139. The admission Record (admission summary) dated 9/12/23 reflected that the Resident was admitted to the facility with the diagnoses that included but was not limited to chronic respiratory failure with hypoxia (lung disease with low oxygen levels in the blood), chronic obstructive pulmonary disease (difficulty breathing caused by damage to the lungs), and chronic congestive heart failure (a condition that causes fluid to buildup in the body). A review of section C for cognitive patterns of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate and manage care dated 9/30/25, revealed the Resident had a Brief Interview of Mental Status of 13, meaning the resident was cognitively intact. The Advance Directive (a living will/health care proxy) status on the admission summary was blank and was not completed to indicate the Resident's code status. The signed Physician Orders for Life Sustaining Treatment (POLST), [medical orders that indicate preferences regarding treatment to sustain life], dated 10/21/23, indicated the Resident's goals of care and code status as do not resuscitate (DNR) and do not intubate (DNI). The active Order Summary Report (OSR), dated 6/24/25, did not include physician's orders (PO) for the Resident' code status of DNR/DNI as indicated in the POLST. The individualized Comprehensive Care Plan (ICCP) initiated on 5/25/25 did not contain a focus area or interventions to direct the care consistent with the Resident's POLST. A review of the Nurse Practitioner's (NP) progress notes dated 9/17/2023 at 12:28 PM, revealed the following: Spoke to POA (Power of Attorney) and brother-in-law (name redacted) and wife (name redacted) via telephone, and discussed goals of care, advance directives, and resuscitation status, and they elected a DNR/DNI status. However, the resident's status was not reflected in the PO. A review of the Nurse's Notes for 9/17/2023 at 7:06 PM indicated that Resident is DNR/DNI. Social services (SS) note on 10/12/23 at 4:11PM indicated that the SW met with the Resident at request of the POA and the Resident's sister-in-law as the Resident had requested to be DNR DNI, to let him go. A recent monthly MD/NP progress note on 11/1/25 at 11:01 PM, confirmed the Resident's code status as DNR/DNI. Yet a PO was not entered to reflect the Resident's preference. 11/20/2025 11:02 AM The surveyor interviewed the Licensed Practice Nurse/Unit Manager (LPN/UM), who stated that all residents must have an order for the code status indicated by their Advance Directive or POLST to dictate their care. When asked why it was important for staff to be aware, the UM responded, it is important so that staff provided the care to reflect the Resident's choice. On 11/20/25 at 11:21 AM, the surveyor interviewed about the process for residents' code status. The DSS explained that if a resident's code status is obtained on admission, it is verified with the resident and discussed during the initial care plan meeting, an order is obtained from the provider. On 11/24/25 at 11:56 AM, the surveyor interviewed the Director of Social Services (DSS), about the process for resident's code status. The DSS explained that the SW meets with the Resident and the Resident's family to discuss the code preferences. The Resident completes a POLST which is signed and uploaded to the chart. The MD's order is entered in the Resident's chart for the code status and is discussed in care conference. The DSS explained that having an order for a resident's code status is important especially if it is DNR/DNI so that the Resident's preferences can be honored if the Resident has to be transferred to another facility. The surveyor interviewed the Director of Nursing (continued on next page)

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	315462	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallwoods Care Center	18 Butler Boulevard Bayville, NJ 08721

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON), on 11/21/25 at 11:21 AM who explained that the ICP was resident specific and should provide an accurate description of the resident's needs. On 11/26/25 at 10:10 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who acknowledged that he was not aware of the residents' DNR, DNI code status needed to be included in the ICP but that the code status should be included in the Resident's PO. The LNHA stated that having an order for the Resident's code status was important to respect the Resident's wishes. The facility's Advance Directive Policy and Procedure, dated 2025, indicated that the purpose was to provide an atmosphere of respect and caring and to ensure that each resident's ability and right to participate in medical and mental health decision making is maximized, and to ensure that residents have the means to establish an advance directive relating to the provision of health care in the event the resident is incapacitated. N.J.A.C. 8:39-4.1(a)4

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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. 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 3 units (Pine Unit).This deficient practice was evidenced by the following: On 11/20/2025 at 9:00 AM, in the lower side Pine Unit shower room, the surveyor observed that the ceiling vent contained black debris, and a piece of the drop ceiling was missing. A section of the drop ceiling was bulging, and the metal framing of the ceiling was stained red and brown. The first shower stall had hair in the drain and tan debris on the shower tile. The third shower stall was blocked off with yellow caution tape, and the drain was missing, leaving standing water that contained brown debris. Additionally, a motorized wheelchair was stored in the shower room, covered in a white, furry substance, with a torn cushion and pieces of fabric missing. On 11/20/2025 at 9:15 AM, in the high-side Pine Unit shower room, the surveyor observed that a toilet was missing its tank and had a pink out of order sign on top, and that several pieces of the shower stall trim were missing. During an interview with the surveyor on 11/20/2025 at 9:45 AM, the Housekeeping Director (HD) stated that the unit uses both the low-side and high-side shower rooms. The shower room tiles are supposed to be power washed every Sunday; however, there is no formal schedule, and cleaning depends on staffing. Tiles should also be scrubbed monthly and cleaned twice daily. Currently, shower room tiles are not cleaned daily or monthly as required, and power washing occurs only on weekends. She was unsure who the wheelchair in the shower room belongs to and noted that housekeeping should have notified nursing staff to have it removed. During an interview with the surveyor on 11/24/2025 at 12:30 PM, the Director of Maintenance (DOM) stated he has worked at the facility for 25 years. He reported that the motorized wheelchair in the shower room, which was covered in a white, furry substance, is not acceptable, and he is unsure who it belongs to. He stated that housekeeping or nursing should have identified the owner and removed it if it was not in use. The DOM also stated that the third shower stall had a clogged drain for one week, which could not be addressed sooner due to staffing priorities. He noted that all maintenance issues should be recorded in the maintenance log at each nursing station, which is checked daily. Building rounds were completed Monday through Friday, 2-3 times per day, with additional visits as needed. Minor maintenance issues were typically resolved within 1-2 days, depending on parts availability. The toilet in the high-side shower room had been out of service for two weeks due to a needed tank part. In addition, although the shower stall floors in the high-side shower room were relatively new, the flooring and trim in the shower area had been delaminating for approximately one month. The DOM explained that the flooring company would address the issue when their schedule allowed. The DOM emphasized that the current condition of the shower rooms did not provide a homelike environment and was not acceptable for residents living standards. During an interview with the surveyor on 11/24/2025 at 12:36 PM, the Certified Nurse Aide (CNA) stated that she had worked at the facility for 17 years. She indicated that she was not sure if housekeeping cleaned the shower room every day; if staff needed something cleaned, they would request housekeeping, and it was then addressed. She was unsure who the wheelchair in the shower room belonged to but noted that it had been there for quite some time. In the high-side shower room, the third shower stall had been broken for several months and could not specify exactly how long. She confirmed that the condition of the shower room did not meet infection control standards, was not sanitary, and was not a homelike environment. During an interview with the surveyor on 11/25/2025 at 11:20 AM, the Licensed Nursing Home Administrator (LNHA) stated that showers were cleaned daily, with power washing or deep cleaning performed weekly to remove mineral deposits, which could be difficult to eliminate. The LNHA stated that maintenance repair timelines varied depending on the nature of the issue and part availability. He stated that urgent or safety-related issues were addressed immediately or within a few hours, while (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	routine repairs were generally completed within 1-3 days if parts were available. Overall, expectations for repairs and housekeeping depended on the complexity of the issue and availability of resources. A review of the facility's undated policy titled Housekeeping Policy revealed that The purpose of this policy is to ensure that TWCC maintains a clean, safe, and sanitary environment for residents, staff, and visitors in accordance with New Jersey Department of Health (NJDOH) regulations and federal long-term requirements. N.J.A.C. 8:39-31.4(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, medical record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident's Interdisciplinary Care Plan (ICP) was resident specific and reflected accurate resident care. This deficient practice was identified for 1 (one) of 29 residents (Resident #139) reviewed was evidenced by the following: On 11/20/25 at 10:03 AM, the surveyor observed Resident #139 lying in bed, watching TV. The surveyor interviewed the resident regarding their code status (refers to a patient's decision regarding the level of medical intervention they wish to receive in the event of a life-threatening crisis, such as cardiac or respiratory arrest). The Resident stated, the staff know I do not want nothing done and that I signed papers about my choice. On 11/20/25, at 10:20 AM, the surveyor reviewed the medical record for Resident #139. The admission Record (admission summary) dated 9/12/23, reflected that the Resident was admitted to the facility with the diagnoses that included but was not limited to chronic respiratory failure with hypoxia (lung disease with low oxygen levels in the blood), chronic obstructive pulmonary disease (difficulty breathing caused by damage to the lungs), and chronic congestive heart failure (a condition that causes fluid to buildup in the body). The Advance Directive (a living will/health care proxy) status on the admission summary was not completed. The quarterly Minimum Data Set (MDS), an assessment that facilitates a resident's care dated 9/30/25, indicated that the resident had a Basic Interview for Mental Status (BIMS) score of 13, which indicated that the resident was cognitively intact. The signed Physician Orders for Life Sustaining Treatment (POLST), [medical orders that indicate preferences regarding treatment to sustain life], dated 10/21/23, showed the Resident's status was Do not resuscitate (DNR) and do not intubate (DNI). The active Order Summary Report (OSR), dated 6/24/25, did not include physician's orders (PO) for the Resident' code status. The ICP initiated on 5/25/25, did not reflect a focus area or intervention for DNR, DNI consistent with the POLST. A review of the Nurse Practitioner progress notes dated 9/17/2023 at 12:28 PM, stated: Spoke to POA (Power of Attorney) and brother-in-law (name redacted) and wife (name redacted) via telephone, and discussed goals of care, advance directives, and resuscitation status, and they elected a DNR/DNI status. However, the resident's code status was not reflected in the physician's order (PO). On 11/20/2025 at 11:02 AM, the surveyor interviewed the Licensed Practice Nurse/Unit Manager (LPN/UM), who stated that all residents must have an order for their code status indicated by their Advance Directive or POLST to dictate their care. When asked why it was important for staff to be aware, the UM responded, it is important so that staff provided the care to reflect the Resident's choice. On 11/20/25 at 11:21 AM, the surveyor interviewed the Director of Social Services (DSS), about the process for residents' code status. The DSS explained that if a resident's code status was obtained on admission, it was verified with the resident and discussed during the initial care plan meeting. She also indicated that an order was to be obtained from the provider. On 11/21/25 at 11:21 AM, the surveyor interviewed the Director of Nursing (DON), who explained that the ICP was resident specific and should provide an accurate description of the resident's needs and preferences. On 11/26/25 at 10:10 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who acknowledged that he was not sure of the residents' DNR, DNI code status or if it needed to be included in the ICP. He confirmed that the code status should be included in the Resident's PO. The LNHA agreed that a PO for a resident's code status was important and should be included in the ICP to direct the Resident's care. The facility's Comprehensive Person-Center Care Planning Policy and Procedure, dated 2025, indicated that the facility provide each and every resident with the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility that is consistent with the resident's comprehensive assessment and baseline plan of care that is culturally competent and trauma-informed. NJAC 8:39-27.1(a)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, it was determined that the facility failed to: ensure that a resident received care and services for the provision of observation, documentation, and dressing changes to IV catheter, (a small plastic tube, placed in a vein for intermittent access) site consistent with professional standards of practice and facility policy. The deficient practice was identified for one (1) of one (1) resident reviewed for medication administration (Resident #120).As evidenced by the following: On 11/19/25 at 12:12 PM, the surveyor observed Resident #120 had an IV Catheter located in the right forearm. The surveyor observed the dressing was not labeled, dated, and loose. The adhesive of the dressing was peeling the entire circumference form the skin of the resident. The clip on the IV catheter was in the un-locked position. On 11/20/25 at 10:00 AM, the surveyor observed Resident #120 had an IV Catheter located in the right forearm. The surveyor observed that the dressing was not labeled, dated, and loose. The adhesive of the dressing was peeling the entire circumference of the resident's skin. The clip on the IV catheter (a backflow device which prevents blood from flowing back inti the catheter and causing a blood clot) was in the un-locked position. On 11/20/25 at 10:30 AM, the surveyor and the Infection Preventionist (IP) together, went to observe the IV site of Resident #120. During this time, the surveyor interviewed the IP who confirmed that the IV dressing was not dated, the dressing was loose, and the lock/clip on the IV tubing was not set in the locked position. She further stated, it should not look like that and it was not maintained according to facility policy. She stated that the policy was in place to protect the residents and prevent infection or infiltration of the IV. On 11/21/25 at 12:04 PM, the surveyor reviewed the medical record for Resident #120 which reflected the following information: A review of the admission Record Sheet (an admission summary) indicated that Resident #120 was admitted to the facility with medical diagnoses which included but was not limited to, cerebral infarction (stroke), unspecified, urinary tract infection, hemiplegia (paralysis) and hemiparesis (weakness). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 9/14/25, reflected that the Resident #120 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated a moderately impaired cognition. A review of the Medication Administration Record (MAR) dated, 11/1/25-11/31/25, revealed the following physician orders (PO): -Vancomycin HCL IV solution 1000 milligrams/ 200 milliliters IV for infection, dated 11/17/2025. - Vancomycin HCL IV solution 750 milligrams / 150 milliliters IV, daily for 5 days for infection, start date 11/18/2025, Discontinue date 11/19/25. -Meropenem IV 1 gram every 8 hours for bacteremia for 7 days, start date 11/19/2025. -change peripheral IV site every 3 days (every 72 hours) for infection prevention and iv site maintenance with a start date of 11/21/25 at 2:30 PM. The following A review of the Treatment Administration Record (TAR) dated, 11/1/25-11/31/25, reflected an ordered: Monitor IV insertion site for redness, swelling, warmth, tenderness, drainage or dislodgement. Action: document findings per facility policy. Notify provider immediately if any abnormalities are noted, every shift monitoring, start date 11/21/25 at 11:59 PM. This PO was obtained after surveyor inquiry. A review of the Individualized Care Plan (ICP) revealed a focus of I am receiving antibiotic therapy related to a bloodstream infection.dated 11/19/2025. The interventions: monitor and change according to facility policy. On 11/21/25 at 10:55 AM, the surveyor interviewed the Director of Nursing (DON) who stated that all dressings should be dated to allow all staff to know exactly when the dressing was changed to prevent infection and incompletion of the treatment. She also confirmed that all IV sites should be monitored and maintained according to nursing standards of practice and facility policy. On 11/26/25 at 12:16 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON who all acknowledged the surveyor's concerns and had nothing more to provide. A review of the facility's undated policy titled IV policy and procedure, included steps site assessment: monitor every shift, document findings.dressing: transparent dressing applied, keep clean, dry and intact, change dressing every 72 hours and sooner if needed.documentation: record: insertion site date and time, site, size of catheter, assessments, flushes, dressing changes and removal. NJ 483.25(h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review and review of pertinent documents, it was determined that the facility failed to: a.) ensure that all oxygen supplies were cleaned and stored according to nursing standards of practice and per facility policy b.) post cautionary signage to indicate that continuous oxygen therapy was in use for 1 of 2 residents (resident # 10). These deficient practices were evidenced by the following:On 11/19/25 at 10:54 AM, the surveyor observed on the door frame of residents #10 room. There was not any indication the resident was on oxygen (O2). Upon entering the room, the surveyor observed the resident on continuous O2, the concentrator had a humidified bottle and the setting was at 3 liters per minute (LPM), the nebulizer compressor and equipment (Small volume 5 milliliter (mL) nebulizer medication cup with mouthpiece, anti-spill T-piece, tubing) were out on the resident's nightstand, and the mouth piece was attached and hooked around siderail via the extension tubing and swinging in the open air. The medication cup was still attached to the mouthpiece, and it was not emptied of residual medication or dried. It was not in a bag. On 11/20/25 at 09:58 AM, the surveyor observed resident # 10, the nebulizer equipment was in the resident's nightstand with the drawer open, tubing hanging out of the drawer and the mouthpiece with medication cup still attached was laid on top of the compressor inside the drawer. The medicine cup on the mouthpiece had not been cleaned or bagged after medication administration. On 11/21/25 at 09:58 AM, the surveyor reviewed the medical records for resident #10. The admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnosis that included but was not limited to chronic obstructive pulmonary disease (COPD, (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). A review of the quarterly Minimum Data Set (MDS) reflected a Brief Interview for Mental Status (BIMS) score of 13 of 15 indicating a cognitive function and decision making were intact. A review of the Care Plan revealed a need, dated 7/31/25, I have COPD and at risk for shortness of breath (SOB), hypoxia, respiratory infections. Interventions: administer bronchodilators as prescribed. Monitor and document any side of effects and effectiveness. A review of the Treatment Administration Record dated 10/1/25-11/30/25, revealed a treatment assessment for SOB. A review of the Medication Administration Record revealed an order for Brovana Inhalation Nebulizer Solution 15 micrograms (MCG)/ 2 milliliter (ML), inhale orally via nebulizer two daily, start date 7/24/25. On 11/20/25 at 9:35 AM, the surveyor interviewed the Licensed Practical Unit Manager (LPNUM) who stated, if a resident was on O2 the nurse should follow the prescribed order and place a sign outside of the resident's room to indicate the resident was on O2. If a resident is on nebulizer treatments her expectation and facility policy is to administer the nebulizer treatment according to standards of practice and per facility policy. the medicine cup should be rinsed out and dried, then placed in a bag with the mask or mouthpiece until the next use to prevent infection. On 11/21/25 at 9:34 AM, the surveyor interviewed the Director of Nursing (DON) who stated, O2 use, and nebulizer treatments should be administered according to policy and nursing standards of practice. The DON acknowledged and agreed with the surveyor's concerns. A review of the policy titled, Oxygen Therapy revised date 4/5/25, Place oxygen in use sign on the outside of the room entrance door. A review of the policy titled, Respiratory Equipment policy-Oxygen and Nebulizer Therapy effective date 8/25/25, indicated nebulizer machines and tubing must be cleaned per manufacturer instructions after each use.nebulizer masks and tubing must be stored in clean, sealed baggies to prevent infection. NJAC 8:39-11.2 (b); 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. Complaint # 2638538Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to properly store a controlled substance securely inside the medication room. The deficient practice was identified for 1 of 3 medication rooms inspected during the medication storage and labeling task was evidenced by the following: On 11/21/2025 at 11:48 AM, during an inspection of the Pine unit medication room with Unit Manager/ Licensed Practical Nurse (UM/ LPN) #1, the surveyor observed the metal narcotic box unlocked. Inside the narcotic box was a packaging labeled Lorazepam Intensol oral concentrate 2 milligram (mg) per milliliter (ml). Inside the packaging was a bottle filled with fluid labeled Lorazepam Intensol 2 mg/ml and a medicine dropper. UM/LPN #1 stated to the surveyor that the narcotic box should be locked at all times. On 11/24/2025 at 9:30 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that narcotic boxes should be kept locked. A review of facility- provided undated policy titled Controlled Medication Storage Policy reflected the following under Procedures: 1.) All controlled substances must be stored in a double-locked system. N.J.A.C. 8:39 - 29.4 (h)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, it was determined that the facility failed to provide a safe environment for its staff and its residents. This deficient practice was observed in the facility kitchen and was evidenced by the following:On 11/19/25 at 10:47 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following in the kitchen: Two- 6 burner units in the kitchen. On 11/19/25 at 11:15 AM the surveyor interviewed the Food Service Director (FSD) who stated that only 4 burners on each stove were operational (totaling 8 of 12), They have not worked since he was employed and that he told maintenance about the issue, but it was never fixed. The FSD was unable to provide documentation of the notification to maintenance. Ie . (email, or maintenance log) of the 4 -faulty burners reporting to provide to the surveyor. He further stated the licensed nursing home administrator (LNHA) was aware. The FSD did not think it mattered since they have gotten by with 8 of the 12 burners to cook on. The surveyor observed debris in the grates, cooking hats and stove surface as cited in F812. The FSD acknowledged the surveyors concerns and agreed that it could be a safety issue and / or a fire hazard for the staff and the facility Residents.On 11/20/2025 at 09:16 AM, the surveyor met with Licensed Nursing Home Administrator (LNHA). The LNHA acknowledged the surveyor's concerns. He stated that the equipment should be repaired timely and maintained to prevent a safety hazard or injury; to ensure the safety of the residents and staff.On 11/26/25 at 11:25 AM the survey team met with the LNHA and Director of Nursing, they acknowledged and agreed with the concerns of the team and had no other information to provide.A review of the facility's undated policy, Kitchen equipment Policy, revealed. Purpose: ensure all kitchen equipment is used, cleaned and maintained safely and in compliance with NJ department of Health requirements, CMS food safety standards and manufacturer guidelines.All food contact equipment must be cleaned and sanitized after use and at the minimum of daily.Cleaning must follow manufacturer's instructions and facility procedures. A review of the facility's policy Food Service Equipment Damage and Reporting Policy: dated 11/5/23, revealed.the procedures the food service staff must follow when equipment is damaged or malfunctioning. It ensures a safe work environment.inspect equipment at the start of each shift for damage or malfunction.A review of the facility's undated policy Maintenance Policy: revealed .the purpose is to ensure all.equipment.are in a safe, functional and sanitary condition in compliance with New Jersey Department of Health regulations and applicable federal guidelines. Proper maintenance supports resident safety, comfort and quality of life. Immediately report hazards, malfunctions or unsafe conditions to the maintenance department.staff submits maintenance requests through the facility designated system or form.NJAC 8:39-31.2(e), 31.4(a), 31.4(f),