STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge at Montgomery Health Care Center	100 Hollinshead Spring Road Skillman, NJ 08558

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ 175572 Based on interview, record review and review of pertinent documents it was determined that the facility failed to ensure thorough investigations were conducted to ensure abuse or neglect had not occurred for a) a resident who was identified as having a new stage 3 wound that was identified during an outpatient (outside) physician visit conducted on 5/22/24 (Resident # 147), b) when a severely cognitively impaired resident was found laying on the floor in a pool of blood, from an unwitnessed fall that resulted in a head injury and required emergent transfer to the hospital on 6/2/25 (Resident #25), c.) Resident #44) who sustained an unwitnessed fall in the bathroom, and blood was also identified at the bedside on 11/4/24; and on 2/9/25 sustained another unwitnessed fall with skin tear. This deficient practice occurred for 3 of 3 residents reviewed for investigations and was evidenced by the following: a. On 6/18/25 at 4:10 PM, the surveyor reviewed the closed medical record (Electronic and Paper) for Resident #147. According to the admission Record, Resident #147 was admitted to the facility with diagnoses which included but were not limited to; Cirrhosis (a condition in which the liver is scarred and permanently damaged) of liver, Lymphedema (a long-term or chronic condition that causes abnormal and persistent swelling in your body), difficulty in walking and weakness. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 5/1/24, revealed that Resident #147 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicative of intact cognition. Further review of the MDS indicated that Resident #147 did not have any pressure ulcer to the Left hip upon admission. A review of the Nursing admission Evaluation (head to toe assessment) completed on admission, and dated 4/24/24 at 4:00 PM, reflected under skin condition, on page 2, that Resident #147 had redness to sacrum, peri area, redness to bilateral heels . and Right hip open area. There was no documented skin impairment to the Left hip area. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of a wound consultation report dated 5/22/24, revealed the following: the patient has New pressure ulcer (PU) on Left hip area probably from wheelchair. The wheelchair is too small. The patient needs a Bariatric wheelchair to accommodate their size. Ulcer is Stage 3. (Stage 3 ulcers involve full-thickness skin loss potentially extending into the subcutaneous tissue layer). There were no measurements for left hip stage 3 pressure ulcer documented on the consultation report. The facility did not measure Resident #147's PU upon return from the consultation. On 6/18/25 at 9:18 AM, the surveyor interviewed the Registered Nurse (RN #1) who stated a head to toe skin assessment was completed twice a week during shower days for all residents. RN #1 further stated the Certified Nurse Aide (CNA) would call the nurse during morning care if the resident had any new skin issues, then the nurse would assess the resident's skin and document any skin breakdown. RN #1 stated the nurse would initial the TAR if the skin was intact. If a skin breakdown was observed, the nurse would write a note and entered in the back of the TAR the documentation regarding the skin breakdown. On 6/24/25 at 10:45 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) in chrage of the unit. The LPN/UM confirmed that skin assessments were completed by the nurses twice a week during the shower days. The LPN/UM further stated there was an order in the Treatment Administration Records (TARs) to complete skin assessments, and if there were any alteration in skin integrity, the nurses would document and complete an incident report in the computer. The LPN/UM added, nurses were to complete a skin assessment on Day 1 (upon admission) and if a resident had any wounds, skin conditions/ alterations including edema (swelling) upon assessments all skin alteration would be documented. The LPN/UM further stated, if the resident had a new alteration to their skin during an assessment, that would also be documented. If the skin was not open, there would not be any measurements, but if the skin was open and it was measurable then the measurements would be documented. The LPN/UM stated if the resident was admitted with open skin/wounds, incident reports are not done but any skin alteration would be documented. The wound Care Team would be consulted depending on the severity of the wound. The LPN/UM stated she was familiar with Resident #147. The LPN/UM showed the surveyor the handwritten Receiving Report from the Hospital Form dated 4/24/24, which did not reflect any skin alterations to Resident #147's Left hip. The LPN/UM stated that her expectation from the admitting nurse would be to perform a head to toe assessment upon admission and document any skin breakdown. The surveyor inquired about the Stage 3 Left hip PU which was identified by the outside consultant physician on 5/22/24. The LPN/UM stated, I do not believe that it was measured after the resident returned from their visit. The LPN/UM stated Resident #147's shower days were Wednesdays and Saturdays, and resident had shower on Wednesday 5/22/24, before the resident went out for their vascular wound consult. The LPN/UM stated that the nursing staff was expected to do skin assessment on the shower days. In the presence of the surveyor, the LPN/UM reviewed the TARs, and could not find any documentation regarding the Stage 3 pressure ulcer identified during the vascular consultation. The nurse initialed the TAR that Resident #147 had intact skin prior to their outpatient vascular wound consult on 5/22/24. On 6/24/25 at 1:27 PM, the LPN/UM stated that she was not at the facility on 5/22/24 during the resident assigned shower day and could not comment on the incident. The LPN/UM further stated the recommendations from the vascular wound consult were reviewed by the nurse and discussed with the Nurse Practitioner (NP). The surveyor then inquired if the Left hip wound was measured upon Resident #147's return to the facility and the LPN/UM stated, I don't believe there were any measurements. The LPN/UM stated that the Director of Nursing (DON) was responsible for investigating new wounds. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 6/24/25 at 2:15 PM, two surveyors interviewed the DON and the Regional Nurse, the DON stated the skin assessments were performed on shower days. The Regional Nurse stated if the CNA observed any skin discoloration on shower days, they would notify the nurse because CNAs were not allowed to assess. The Regional Nurse further stated if Resident #147's skin was intact during the shower day of 5/22/24 and the resident returned with a Stage 3 PU to their Left hip, the wound should have been assessed, measured and an investigation should have been completed. On 6/25/25 at 8:50 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON and presented the above-mentioned concerns. The DON stated, I was not aware of the Stage 3 PU to Left hip. The DON further stated that she was not made aware of the wound consult that identified the new stage 3 PU to Resident #147's Left hip. The surveyor reviewed the TAR with the DON, and the DON verified that there were no measurements for the Stage 3 PU. The DON informed the survey team that the nurse who received and reviewed the recommendation, should have completed an incident report, measured the wound and report the incident to the Unit Manager for follow up. The DON acknowledged that she did not investigate Resident #147's wound. On 06/25/25 at 11:54 AM, during the pre-exit conference the LNHA and the DON informed the survey team that they did not have any additional information to present regarding Resident #147's wound. b. On 06/23/25 at 1:45 PM, Surveyor #2 reviewed the electronic medical record for Resident #25 which revealed: A Nurses Note signed by a Registered Nurse on 6/2/25 at 11:28 PM, which revealed details at time of fall: Occurred 6/2/25 at 17:30 (5:30 PM) in the resident's room and the resident was alone. Resident #25 was alert to self and confused. Narrative: Writer was informed by aide about resident on the floor. Writer found resident laying prone [face down] in room, head in a pool of blood on the floor. Further assessment revealed a hematoma (bruise) to the forehead of the resident. Wound was cleansed with NSS (normal saline solution) and pressure dressing applied. A 911 call was made and Resident #25 was transferred to the emergency room. A review of the Face Sheet (an admission summary) for Resident #25 revealed the resident was admitted with diagnoses including, but not limited to; Displaced intertrochanter fracture of the right femur, vascular Dementia, displaced fracture of second cervical vertebrae, bipolar disorder, difficulty in walking, and cognitive communication deficit. A review of the Initial Care Plan for Resident #25, Effective: 5/12/25, revealed a Problem: Resident at risk for falls. Requires assistance with transfers and physical functioning due to weakness and functional limitation of a fractured right hip and psychotropic drug use, dated 6/2/25; Fall in room, head injury sent to emergency room, Active 5/12/25; Goal: Will not have fall related injuries falls in the next 30 days, Active 5/12/25; The following Interventions, Active as 5/12/25: Administer psychotropic medications as ordered and monitor for side effects; Assist with transfers and with physical functioning; Ensure a safe and clutter free and well lighted environment; Lower bed to the floor. Provide frequent staff monitoring. Verbal and visual reminder to use call bell for assistance; Place call bell within reach and encourage to call for assistance; Tap call bell. A review of the admission MDS (an assessment tool) dated 4/22/25 revealed a Brief Interview for Mental Status Score of 1 which indicated a severely impaired cognitive status. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of the physician order sheet for 6/1/25-6/30/25 revealed the following: Divalproex, 125 mg capsule, delayed release sprinkle (1 capsule), three times per day, Order Date: 4/21/2025; Instructions: Diagnoses Bipolar Disorder was administered on 6/2/25 at 13:00 (2:00 PM) for the Behavior Symptom: Paranoia (extremely suspicious of others, believing others are trying to harm you). On 6/23/25 at 2:00 PM, Surveyor #2 requested all investigations for Resident #25. On 6/23/25 at 2:29 PM, the Charge Nurse (CN) provided one investigation for Resident #25, and confirmed it was the only investigation and it was the entirety of the investigation which was dated 6/2/25 at 5:30 PM. The investigation revealed: Type: Fall; Location: Resident Room; Witness/es: None; Cognition prior to occurrence: Confused; Cognition after occurrence: Confused; Injuries: Head Trauma; Location: Center side of Forehead; Details: Head Injury: Hematoma to forehead; Immediate Actions Taken: Pressure dressing applied, Notified immediate supervisor, Fall risk assessment completed, Placed in wheelchair, Pain assessment; Notes: Entered by Registered Nurse (RN #1) at 9:24 PM, Writer was informed by aide about resident on the floor. Writer found resident lying prone in room, head in a pool of blood on the floor. Further assessment revealed a hematoma to the forehead of the resident. Wound was cleansed with [normal saline solution] and pressure dressing was applied. A 911 call was made and resident was transferred to the [emergency room] for further evaluation. Resident statement of what happened written by resident entered by RN on 6/2/25 at 9:24 PM: Resident is confused at baseline but reports [they] were responding to a call by someone who told [them] to get out of [their] chair. Witness statement: N/A; Fall type: Found on floor; Position on Floor: [Left Blank]; Independent for toileting: no; Care prior to fall: visually observed 6/2/25 at 5:15 PM; Preventative measures at time of fall: Call light: off; Conclusion: Completed by the DON on 6/3/25 at 8:13 AM; Nursing supervisor alerted that resident noted on the floor. Nursing supervisor observed resident laying on the floor in prone position with head on the floor in a pool of blood. Resident assessed. Vitals signs [within normal limits]. Full range of motion noted to all extremities. Hematoma noted to forehead with fresh red blood. Area cleansed and pressure dressing applied. [Physician] and family notified. New order to send resident to [emergency room] for evaluation at treatment. Resident transferred via 911 at approximately 5:45 PM. Resident returned to facility at approximately 10:05 PM. All x-rays and scans negative. Physician and family notified of return to facility. Resident encouraged to call for assistance. All safety precautions in place and maintained. Care plan reviewed and updated. Medications reconciled. Root Cause: Factual description of incident added to nurse note, Due to resident action or internal risk factors: N/A; Resident state of motion at time of fall, Transferring; How many staff were in assistance, 2; Staff Interviews: No staff interviews available; Recommendations: none noted. One Individual Statement was attached to the investigation, dated 6/2/25, which revealed: room [ROOM NUMBER] at 5:30 PM, I went into resident's room to leave dinner tray and found resident on the floor. I immediately informed nurse on duty. There was no documentation in the investigation when the resident was last toileted or given fluids as both areas were documented as N/A, in the section Care Plan Prior to Fall although the resident was documented as no for independent with toileting. A review of the facility provided emergency room record dated 6/2/25, revealed CT (Computed Tomography- a detailed picture using scans and computer) of the head revealed There is a large area of left frontal scalp swelling with hematoma measuring approximately 4.5 X 3.7 centimeters. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 06/25/25 at 9:16 AM, Surveyor #2 informed the DON and LNHA of the above findings and asked what was the root cause for the fall that resulted in 911 transfer. The DON reviewed the incident report and statement and stated the Certified Nurse Aide found the resident on the floor when she went to pass the meal tray and the DON stated that the resident was confused. The DON stated the resident told RN #2 that someone told them to get out of the chair, The DON further stated that was the cause of the fall. The facility did not identify the causal factor of the fall. No other information was provided. c. On 06/18/25 at 1:12 PM, Surveyor # 2 reviewed the closed electronic medical record for Resident # 44 which revealed a Care Plan, Effective 9/10/24, with a Problem: Recent fall prior to admission, at risk for further falls due to difficulty with transfers and ambulation, weakness following hospitalization; 11/4/2024, Fall in bathroom skin tear to right elbow. A review of the Face Sheet (an admission summary) revealed the resident had diagnoses which included, but were not limited to; vascular Dementia, altered mental status, repeated falls, cognitive communication deficit, history of falling, and muscle weakness. The Quarterly MDS dated [DATE] revealed the resident was moderately cognitively impaired and required assistance for bed mobility, transfer and toileting. At that time, Surveyor #2 then requested all investigations for Resident #44. On 6/19/25 at 9:00 AM, Surveyor #2 reviewed the electronic medical record, the paper closed medical records along with two investigations provided by the facility which revealed the following: 1. On 11/4/24 at 12:35 AM, Resident #44 was confused and sustained an unwitnessed fall and sustained a skin tear to the right elbow, circular, measuring 1.1 x .5 centimeters (cm). The Nurses Note of what happened was documented by RN # 1 on 11/4/24 at 2:40 AM, which revealed: Aide called writer's attention about resident on the floor. Writer found resident on the floor in [their] bathroom, sitting up with [their] back against the toilet. Resident was confused and could not recollect exactly what happened. Resident was helped back into [their] bed. Resident had a skin tear measuring 1.1 x .5 cm to right elbow. Skin tear was cleaned with normal saline and covered with [gauze]. Resident denied hitting head, denied any other pain apart from the skin tear. Neuro checks initiated . Resident statement of what happened on 11/4/24 at 2:24 AM, Resident stated [they] were trying to go to bathroom. Resident confused, sometimes non-compliant to safety measures. The Conclusion documented by the DON on 11/4/24 at 11:45 AM revealed the CNA alerted the primary nurse that resident noted sitting on the floor. Primary nurse observed resident sitting in an upright position on the bathroom floor with [their] back against the toilet. Resident assessed . Resident denies any pain or discomfort at this time. Resident denies hitting [their] head. Skin tear noted to right elbow with fresh red blood noted. Skin tear cleansed and treatment in place. Resident encouraged to call for assistance. All safety precautions in place and maintained. Care plan reviewed and updated. Medications reconciled. There was one statement attached and signed by the CNA on 11/4/24, which revealed the date and time of incident, Room # 236 on 11/4/24 at 12:35 AM. The section titled to tell us step by step in your own words what happened . revealed: Resident's bathroom call bell was on and I entered the room, and saw blood on the floor next to the bed and then saw resident on bathroom floor sitting up with back against toilet. Resident stated [they] fell when trying to go to bathroom. Resident was bleeding from right elbow area. Nurses and supervisor was made aware. Care Prior to Fall: Visually Observed, 11/4/24 at 12:10 AM; Toileted: NA; Given Fluids: N/A: Repositioned: N/A. Preventable Mesures at time of fall: call light off. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	2. On 2/9/25 at 6:45 PM, Resident #44 sustained a skin tear to the left lower leg while an Agency CNA provided care and the Nurse documented on 2/9/25 at 11:31 PM, that This writer was informed by aide that resident had sustained a skin tear during care. Upon arrival resident was bleeding. Site was treated. Measuring 9 x 1 centimeter . Resident statement of what happened, doesn't know. Witness statement of what happened written by CNA, I saw a bleeding from the resident due to skin tear. Conclusion, signed by DON on 2/10/25 at 9:05 AM. Primary nurse alerted by CNA resident noted with skin tear. Primary nurse assessed resident .Skin tear noted to [left] lower leg measuring 9 x 1 cm with fresh red blood. Resident in bathroom by self when skin tear was noted. Skin tear was noted in direct line of door frame .Resident encouraged to call for assistance. One statement was attached from the Agency CNA, dated 2/9/25, which revealed: Resident was in the bathroom by self when I went to provide care. I noticed resident was bleeding due to skin tear on leg. I quickly notified the nurse of the incident around 6:54 PM. I saw bleeding from the resident due to skin tear. The investigation did not address that the CNA reported the resident sustained the skin tear during care to the nurse, and the activity that was documented as occurring was Dressing, or why the resident was found alone in the bathroom. On 06/18/25 at 2:41 PM, the survey team interviewed the Licensed Nursing Home Administrator (LNHA) who stated the DON was responsible to complete all investigations and he was responsible to ensure that an investigation was completed. On 06/19/25 at 9:28 AM, Surveyor #2 interviewed the [NAME] President of Clinical Services (VPC) and the DON, in the presence of the survey team, and inquired regarding the investigative process following an unwitnessed fall. The DON stated, the staff would alert the nurse and the nurse would complete an assessment of the resident. Surveyor #2 then asked who would be responsible to obtain statements. The DON stated the primary nurse was responsible to obtain statements from the CNA and the nurse would obtain resident's statement. According to the DON, the facility did not collect statements from any other staff on duty on the day of the incident. Surveyor #2 then asked the DON what was the purpose of an investigation? The DON replied, to investigate what happened. On 06/19/25 at 9:47 AM, Surveyor #2 read the CNA's statement regarding the incident and asked the DON if there was an investigation regarding the blood that was observed next to the resident's bed? The DON stated when she completed her investigation the following morning that she did not see the blood by the bed, and stated it was an Agency CNA. Surveyor #2 asked if the blood next to the bed was important to review and to determine what was the causal factor? The DON did not respond. Surveyor #2 then asked about the skin tear documented as happening during care, and what was determined as the causal factor of the skin tear, and what specific interventions were implemented as a result? The VPC requested to further review both investigations prior to proceeding with the surveyor inquiries. On 06/19/25 at 9:57 AM, Surveyor #3 asked the VPC when an injury of unknown origin occurs, who do you collect statements from? The VPC stated, we usually do a 24-hour look back and collect statements. On 06/25/25 at 11:54 AM, during a meeting with the LNHA and the DON, in the presence of the survey team, they did not have any additional information to provide regarding the causal factor for Resident #25 and #44's unwitnessed falls with injury, and for Resident #147's Stage 3 PU that was identified during an outpatient visit, to determine if the injuries were not related to neglect. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The Incident Reporting Policy Revised 9/16/24 revealed: Purpose: Incidents are defined as any event, occurrence, situation or circumstance, which is unusual or inconsistent with the policies, practices and routine operation of the community. It may be an accident or situation which may or may not result in bodily injury and/or property damage. Policy: It is the policy of the community that all incidents are properly reported, recorded and analyzed for causative factors and trends. Corrective and/or preventative measures shall be implemented as indicated. 2. Assure incidents are recorded and reported to the proper agencies and internal departments. 3. Analyze all incidents for risk potential implementing corrective and/or preventative actions as required. Procedure: Significant Event/Injury: A resident transported to a local medical facility for treatment related to the injury event. A fall that results in a fracture and or/multiple contusions. Event/injury related death. Incident Report Investigation Forms: 1. An investigation shall be initiated on all reported incidents. An incident investigation shall be completed at the time of the incident. 2. Document in the investigation section if facts relating the cause of the incident are known. Possible causes may be investigated but not documented until substantiated by facts. 3. All staff members assigned to the unit/area on the shift the incident occurred having knowledge of the incident should completed written statements. It is not necessary to obtain written statements from everyone, only those individuals with knowledge of the incident. Written statements should document the facts surrounding the incident. All statements must be signed by the authors/writers, including any statements obtained from residents. 4. All injuries of unknown origin, including skin tears and bruising, must be investigated immediately. All staff caring for the injured resident for the past 24 hours shall be interviewed and write and sign a statement regarding their knowledge of the injury and/or whether it was present during their shift. Further investigation and statements may be necessary based on findings and analysis of information obtained. Abuse Investigation. 1. An investigation shall be initiated by the community/ facility within twenty-four hours of the discovery of a resident with any injury of a suspicious or unknown origin or receipt of an allegation of abuse . NJAC 8:39-4.1(a)(5)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Complaint #: NJ 175572 Based on interview, record review and review of facility documents, it was determined that the facility failed to ensure that a resident who did not have a Pressure Ulcer (PU) upon admission and who was identified at risk of developing a PU, received care and services in accordance with professional standards of practice to prevent PUs. Resident # 147 developed a facility aquired Stage 3 left hip PU that was identified during an outpatient (outside) wound care physician visit/consult on 5/22/24. This deficient practice was identified for 1 of 1 resident (Resident #147) reviewed for wound care and was evidenced by the following: The surveyor reviewed the closed Medical Record (MR) for Resident #147. According to the admission Record, Resident #147 was admitted to the facility with diagnoses which included but were not limited to; cirrhosis of the liver (a condition in which the liver is scarred and permanently damaged), lymphedema (a long-term or chronic condition that causes abnormal and persistent swelling in your body), difficulty in walking and weakness. A review of the admission Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 5/1/24, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident had intact cognition. Further review of the MDS indicated that Resident #147 did not have any pressure ulcers upon admission, but the resident was at risk of developing pressure ulcers. A review of the New Jersey Universal Transfer Form (a form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs) dated 4/24/24 at 3:45 PM, indicated that Resident # 147 had vascular skin conditions to the bilateral lower extremities. There was no indication that the resident had a stage 3 left hip PU during the transfer from the acute hospital to the facility. A review of the May 2024 Physician Order Sheet reflected the following physician orders: Santyl-Polysporin 1:1 (10 Topical; Instructions: clean left thigh wound with Normal Saline Solution (NSS), apply a pea amount of Santyl to wound Bed BID (twice a day) until healed. Diagnosis (Dx): left thigh wound with a start date: 5/21/24. Triamcinolone Acetonide 0.1% topical cream (1) cream (Gram) Topical; Instructions: Apply pea amount to surrounding site BID (twice a day) until healed. Dx: Wound, with a start date: 5/21/24. A review of the Nursing admission Evaluation (head to toe assessment completed when a new resident is admitted at the facility) dated 4/24/24 at 4 PM, reflected under skin condition on page two that Resident #147 had redness to sacrum, peri area, redness to bilateral heels . and Right hip open area. An admission evaluation did not reveal that the resident had any wounds or open areas to their Left hip. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the Baseline Care Plan (CP) dated 5/10/24, indicated under skin concerns that Resident #147's skin was not intact. Under other skin concerns or wounds it revealed that resident had bilateral lower legs venostasis ulcers. The Baseline CP did not indicate that Resident #147 had a left hip PU upon admission. A review of the Comprehensive CP created on 5/21/24, reflected under Problem: I am at risk for skin breakdown due to bladder incontinence and impaired mobility. Goals included: I will not have skin breakdown and my skin will remain intact in the next 30 days. Interventions included but were not limited to: Monitor skin during care and weekly. A review of the Wound care physician consultation report dated 5/22/24, revealed a note marked with an asterisk (*) that the patient has NEW pressure ulcer (PU) on Left hip area probably from wheelchair. The wheelchair is too small. The patient needs a Bariatric wheelchair to accommodate his/her size. This ulcer needs to be washed daily, pat dry, apply thin layer of Santyl ointment (a topical medicine used to help clean and remove dead tissue from long-lasting skin wounds (ulcers)), and cover with mepilex dressing (used for draining wounds, such as pressure ulcers, leg and foot ulcers). The wound care physician underlined that the Ulcer is Stage 3 (ulcer involve full-thickness skin loss potentially extending into the subcutaneous tissue layer). There was no documented evidence of a wound measurement of the left hip stage 3 PU. A review of the Nurses Change in Condition Progress Note (PN) dated 5/22/24 at 7:38 PM, indicated that the nurse documented the resident came back from a wound consult. The PN revealed Identify Intervention: New recommendations received, transcribed and noted. Resident is alert and verbally responsive. No distress noted. Care continues. The PN was signed by a Licensed Practical Nurse (LPN). There was no documented evidence of a wound measurement of the left hip stage 3 PU. A review of the May 2024 Treatment Administration Record (TAR) revealed that skin Assessments were performed two times weekly for Resident #147 on the following dates: 5/1/24, 5/4/24, 5/8/24, 5/11/24, 5/15/24, 5/18/24, and 5/22/24. Under Action for skin intact .the nurses had checked Yes indicating that resident's skin was intact during the assessment dates. On 6/18/25 at 9:18 AM, the surveyor interviewed the Registered Nurse (RN) who stated the head-to-toe skin assessments were done twice a week during shower days. The RN further stated if the resident had any skin issues observed during morning care, then the resident's Certified Nurse Aide (CNA) would call me, and I would assess and document any skin breakdown. The RN stated the skin assessment would not be documented if the skin was intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315486	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge at Montgomery Health Care Center	100 Hollinshead Spring Road Skillman, NJ 08558

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/24/25 at 10:45 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated skin assessments were performed by the nurses twice a week during shower days. The LPN/UM further stated there was an order in the Treatment Administration Records (TARs) for skin assessments, and if there were alterations noted during the skin assessments, then the nurses would document and complete an incident report in the computer. The LPN/UM stated nurses would complete a skin assessment on Day 1 (upon admission) and if a resident had any wounds, skin condition/alterations including edema (swelling) would be documented. The LPN/UM further stated if the resident had a new alteration to their skin during an assessment, that would also be documented. If the skin was not open, there would not be any measurements completed but if the skin was open or had breakdown and it was measurable then the measurements would be documented. The LPN/UM stated if the resident was admitted with open skin/ wounds, incident reports are not done but everything would be documented that was seen on day one and after that the wound care physician would be consulted depending on the severity of the wound. The LPN/UM stated she was familiar with Resident #147. The surveyor inquired about Resident #147's Stage 3 Left hip PU which was identified by the outpatient wound care physician on 5/22/24. The LPN/UM stated, I do not believe that it was measured and documented in our computer and further stated that the resident came back from the wound care doctor and the orders were carried out. The LPN/UM stated Resident #147's shower days were Wednesdays and Saturdays, and resident had shower on Wednesday before the resident went out for their wound consult on 5/22/24. The LPN/UM stated that the nursing staff was expected to do a skin assessment on the shower days. In the presence of the surveyor, the LPN/UM reviewed the TARs, which reflected that the staff had documented that Resident #147 had skin intact prior to their outpatient wound consult. The LPN/UM stated the aides (CNAs) and the nurses performed the full body assessment and would report if they observed any abnormalities or skin alterations. The LPN/UM stated she was not at the facility on 5/22/24, and the resident went out to their wound care physician and the wound orders were carried out and the Nurse Practitioner (NP) was notified of the new orders. The LPN/UM further stated, I don't believe there are any measurements. The LPN/UM further stated if a new wound was discovered, the staff would measure the wounds for progress, but the measurements would not be documented. The LPN/UM stated that the Director of Nursing (DON) was responsible for investigating new wounds. The LPN/UM was not able to explain for how long and/or when Resident #147 developed the Left hip Stage 3 PU. There were no treatments that had been ordered for the Left hip Stage 3 PU prior to 5/22/24. On 6/24/25 at 2:15 PM, two surveyors met with the DON and the Regional Nurse. The DON stated the skin assessments were performed on shower days. The Regional Nurse stated if the aide noted any skin discoloration on shower days, they would notify the nurse because CNAs could not perform skin assessments. The Regional Nurse further stated if the resident had their skin intact documented for Resident #147 prior to leaving for their outpatient wound care appointment, and the resident returned with a documented new stage 3 PU or a new skin breakdown, then the wound assessments and investigations should have been done. On 6/25/25 at 8:50 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON and discussed the above concerns. The DON stated the nurses should be doing physical assessments upon admission. The DON stated, I did not know about the Stage 3 pressure ulcer. The DON further stated that she was never made aware of the wound consult and confirmed there were no measurements for the Stage 3 PU. The DON further stated the nurse should have completed an incident report with the wound measurements when the resident returned from their wound care consultation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility provided policy, General guidelines wound and skin care, revised 6/2025, included but was not limited to; Purpose: 1.) To provide a systematic approach for assessment of risk and monitoring skin integrity and pressure ulcer care. 2.) To prevent pressure ulcer formation for resident admitted without pressure ulcers, unless clinically unavoidable, by identifying those residents who are at risk for pressure ulcers and developing appropriate preventative interventions. 3.) To promote healing of pressure ulcers and prevention of additional pressure ulcers and provide comfort for residents admitted with skin breakdown. Objective: To maintain the integrity of residents skin admitted without wounds and promote wound healing on residents admitted with skin breakdown. Under section Documentation: 1. A complete wound assessment and documentation will be done weekly on all pressure ulcers until they are healed. The criteria to be included: a) site/location b) stage- this applies only to pressure ulcers. Wound healing is to be described by changes in the wound c) Size- length, width and depth measure in centimeters. The length is listed first d) Undermining/tunneling e) Drainage/exudates describe the amount, color, consistency and odor. A review of the facility provided Charting and Documentation included but was not limited to; Purpose: The purpose of charting and documentation is to provide: 1.) A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care. 2.) Guidance to the physician in prescribing appropriate medications and treatments. 3.) The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. Under section Rules for Charting and Documentation reflected: 1.) Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc., as well as routine observations. 20. Skin Lesions: Documentation pertaining to skin lesions (decubitus ulcers, abrasion, etc.) should include: a.) specific location of the skin care problem; b.) number, size, degree, and measurement of decubitus ulcers; f.) Documentation of the cause of decubitus ulcers developed in-house, as well as substantiation of preventing interventions; h.) any changes in the resident's condition or response to treatment; i.) Dates of occurrences of a skin problem or pressure sore as well as the date the problem was solved; j.) Progress, deterioration, or the development of new problems; l.) The cause of any bruise or wound. Section Nursing Summaries and/or Assessments included: When charting nursing summaries, or making assessments, included (as they may apply) the following data for: 18.) Skin-Hair-Scalp-Nails: Dry . Be descriptive of lesions, edema; discuss locations, size, depth, color, amount, and status of tissue and surrounding. Indicate type of treatment and how often treatment is administered. At 6/25/25 at 11:45 AM, the survey team met with the LNHA and the DON for additional responses. The LNHA and the DON did not provide any additional information. N.J.A.C. 8:39-27.1 (a)(e)