STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lions Gate	1100 Laurel Oak Road Voorhees, NJ 08043

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41260 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that residents were served their meals in a manner that promotes respect and dignity for 2 residents (Resident #32 and #42) observed during a lunch meal service on 1 of 4 units (Skilled 2). This deficient practice was evidenced by the following: 1.) On 2/10/25 at 12:00 PM, the surveyor observed the lunch meal service in the Skilled 2 nursing unit dining room. Resident #32 was seated in a geriatric (geri) chair (a reclining chair) at a table with two other residents. At 12:38 PM, the surveyor observed Licensed Practical Nurse (LPN) #1 standing over Resident #32 while feeding the resident tomato soup and sips of his/her beverage. At 12:47 PM, LPN #1 stopped feeding Resident #32 as the resident had finished his/her soup. The LPN then walked away from the resident. At 12:55 PM, the Resident #32 was served an entree of pureed fettuccine and pureed broccoli. LPN #1 was now seated at a different table feeding another resident. There were no staff feeding Resident #32 his/her entree. At 1:03 PM, Certified Nursing Assistant (CNA) #1 walked over to Resident #32 and started to feed the resident his/her entree while standing over the resident. The CNA then left to feed another resident at a different table. Resident #32 was not finished eating the entree. At 1:12 PM, the CNA #2 walked over to Resident #32 and started to feed the resident his/her entree while standing over the resident. The CNA then left the resident to feed another resident seated at the same table. Resident #32 was not finished eating the entree. At 1:19 PM, LPN #2 walked over to Resident #32 and gave the resident sips of his/her beverage while standing over the resident. At that time, the resident was served a pureed dessert. The LPN fed the resident his/her dessert while standing over the resident. The resident ate 100% of the dessert. LPN #2 never offered the resident the rest of his/her entree and staff assisted the resident out of the dining room. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:27 PM, the surveyor interviewed LPN #1 who stated there were usually five CNAs who each had a resident on their assignments who required assistance with feeding. The LPN further stated that staff assisting residents with feeding should sit down in a chair side by side with the resident in order to monitor the resident during the meal. When asked about Resident #32, the LPN stated she fed the resident his/her soup and juice, but that she should have been seated next to the resident. The LPN further stated that residents should be fed within 10 minutes of their food being served. At 1:31 PM, the surveyor interviewed CNA #1 who stated staff should be eye level with the resident while assisting with feeding. When asked about Resident #32, the CNA stated she should have been eye level with the resident when assisting with feeding. The CNA further stated that residents should be fed within a minute or so to prevent the food from getting cold. At 1:35 PM, the surveyor interviewed CNA #2 who stated staff assisting residents with feeding should be sitting next to the resident. When asked about Resident #32, the CNA stated she could not sit next to the resident because there was not enough room, but that staff should be ensuring residents are positioned in a way that staff can be seated while feeding. The CNA further stated that staff should feed residents immediately when the food is served to prevent the food from getting cold. At 1:40 PM, the surveyor interviewed LPN #2 who stated staff assisting residents with feeding should probably be sitting next to the resident to maintain eye contact. When asked about Resident #32, the LPN stated she should have been seated while feeding the resident. The LPN further stated that staff should assist residents with feeding right away while the food is hot. The surveyor reviewed the medical record for Resident #32. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, dementia and muscle weakness. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/19/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident's cognition was severely impaired. Further review of the MDS included the resident was dependent on staff for eating. On 2/11/25 at 1:08 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA), who stated staff should sit next to the resident while assisting with feeding to maintain eye contact and to conversate with the resident. The DON further stated that resident should be fed immediately after the food is served so that the resident is not watching other residents eat, and so the food is warm and more pleasurable. A review of the facility's Assistance with Meals policy, undated, included Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. A review of the facility's Food Presentation Policy, undated, included, Timing and Freshness: Dishes should be prepared and served immediately after plating to maintain the freshness of the food and preserve its appearance. 37547 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) On 2/10/25 at 12:11 PM, the surveyor observed a menu posted outside of the Second Floor Skilled Nursing Unit Dining Room which featured tomato soup, grilled cheese, or fettuccine alfredo with broccoli and a soft cookie. Further review of the Menu indicated that lunch was scheduled from 12:00 PM to 1:00 PM. At 12:22 PM, a rolling cart was brought into the dining room with three meal trays on it which were passed out to the residents. Meal choices were given to the residents prior to meal service and alternatives were offered. At 12:30 PM, the surveyor observed Resident #42 seated in a wheel chair at the dining room table awaiting meal delivery. The resident's meal ticket was on the table and indicated that the resident was ordered a mechanical soft diet with thin liquids. The resident called out, I am very hungry. At 12:32 PM, Dietary Service Aide (DSA) #2 reviewed Resident #42's meal ticket and took the resident's meal order. The resident refused fettuccini alfredo with broccoli and instead requested a peanut butter and jelly sandwich. DSA #2 then offered Resident #42 mashed potatoes and broccoli and the resident stated yes to both. Resident #42 informed DSA #2 that he/she was, very hungry. At 12:43 PM, Certified Nursing Assistant (CNA) #3 was observed feeding tomato soup to an unsampled resident who was seated at the same table as Resident #42 . CNA #3 then proceeded to request soup for both Resident #42 and a second unsampled resident who was seated at the same table. At 12:45 PM, the second unsampled resident was served tomato soup while Resident #42 watched the two residents seated at the table eating their soup. Resident #42 had only been served a cold beverage at that point and stated, I am very hungry. At 12:47 PM, Resident #42 was served a peanut butter and jelly sandwich that was cut into four small pieces with the crust removed and had not received the mashed potatoes and broccoli that were ordered. The resident then proceeded to eat the sandwich independently. At 12:56 PM, the CNA #3 requested food for the table and DSA #2 stated, I have to serve the food table by table. At that time, Resident #42 stated, I like soup. Resident #42 then requested chicken noodle soup. CNA #3 stated that the facility only had tomato soup, to which Resident #42 did not respond. At 1:13 PM, the two unsampled resident's at Resident #42's table were served dessert. Resident #42 had finished his/her peanut butter and jelly sandwich and was not offered any dessert. At 1:17 PM, a Certified Nursing Assistant (CNA) asked Resident #42 if he/she were finished with their meal and failed to offer the resident dessert before they proceeded to remove the resident from the dining room. At 1:18 PM, the surveyor interviewed DSA #2 and asked her why Resident #42 had not received their mashed potatoes, broccoli, soup and dessert and she stated that there had been a mishap due to the staff not communicating. DSA #2 further stated that the resident did not like soup and would have wasted it if it were served. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:21 PM, the surveyor interviewed CNA #3 who stated that Resident #42 would not have eaten mashed potatoes and broccoli if they had brought it. CNA #3 stated that the resident only wanted chicken noodle soup, not tomato. CNA #3 stated that the resident liked to eat cake and would have eaten dessert if it would have been served. On 2/11/25 at 2:25 PM, the surveyor interviewed the Director of Nursing (DON) who stated that everyone should have been served at the same time for dignity. The DON stated that everyone should have been offered everything on the menu and should have been given a choice of every appetizer, entree and dessert on the menu. The DON further stated, The resident should be given a choice every single time. A review of the facility's undated Dignity policy included: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. A review of the facility's undated Assistance with Meals policy included: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. NJAC 8:39-4.1(a) 12

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Complaint #NJ179408 Based on interview, record review, and review of facility documents, it was determined that the facility failed to report an allegation of narcotic drug diversion to the New Jersey Department of Health and the Office of the Ombudsman for the Institutionalized Elderly in a timely manner in accordance with state and federal requirements. This deficient practice was identified for 1 of 1 Nurse (Licensed Practical Nurse (LPN) #4 and 3 of 3 residents (Resident #197, #198, and #199) reviewed for pain medication administration on 1 of 4 nursing units (Rehabilitation Unit #1) and was evidenced by the following: Refer to F755 On 2/11/25 at 8:48 AM, the surveyor reviewed the medical record of Resident #197. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, displaced fracture of base of neck of right femur (the bone of the thigh, between the knee and the hip), subsequent encounter for closed fracture with routine healing, and repeated falls. A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated 9/23/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS revealed the resident had experienced occasional pain that was described as moderate that occasionally interfered with therapy activities and day to day activities and that had rarely or had not affected the resident's ability to sleep. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 9/24/24, that the resident had acute/potential pain related to (r/t) immobility/fracture. Interventions included: Be alert to verbal/non-verbal signs and symptoms (s/s) of pain. Notify Nurse as needed if resident complains of (c/o) or shows s/s of pain. A review of the Order Summary Report (OSR) included the following physician's orders (PO): -A PO, dated 9/19/24, for Tramadol HCL oral tablet 50 milligrams (MG) give one (1) tablet every six (6) hours as needed for moderate pain for 14 days pain management. -A PO, dated 9/20/24, for Oxycodone HCL oral tablet five (5) MG give one (1) tablet by mouth every four (4) hours as needed for severe pain related to displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing for 14 days. On 2/11/25 at 8:48 AM, the surveyor reviewed the medical record of Resident #198. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission Record revealed the resident had diagnoses which included, displaced trimalleolar (ankle) fracture of right lower leg, subsequent encounter for closed fracture with routine healing and unsteadiness on feet. A review of the most recent comprehensive MDS, dated [DATE], included the resident had a BIMS score of 15 out of 15, which indicated the resident's cognition was fully intact. Further review of the MDS revealed the resident had not experienced pain or hurting at any time in the past five days during a pain assessment interview. A review of the ICCP included a focus area, dated 9/25/24, that the resident had a trimalleolar fracture right lower extremity (RLE) related to fall. Interventions included: Observed for verbal/nonverbal s/s of pain. Notify nurse as needed. A review of the OSR included the following PO: -A PO, dated 9/24/24, for Oxycodone HCL Tablet 5 MG give 1 tablet by mouth every 4 hours as needed for moderate pain (4-7) for 14 days. -A PO, dated 9/24/24, for Oxycodone HCL Tablet 5 MG give two (2) tablets by mouth every 4 hours as needed for severe pain (8-10). On 2/11/25 at 8:48 AM, the surveyor reviewed the medical record of Resident #199. A review of the Admission Record revealed the resident had diagnoses which included, acute kidney failure, unspecified, chronic gout (a complex form of arthritis), low back pain, unspecified, and wedge compression fracture of first lumear vertebra (a type of spinal fracture), subsequent encounter for fracture with routine healing. A review of the most recent comprehensive Minimum Data Set (MDS) dated [DATE], included the resident had a BIMS score of 15 out of 15, which indicated the resident's cognition was fully intact. Further review of the MDS revealed the resident had experienced occasional pain that was described as moderate that had rarely or had not affected the resident's therapy activities, day to day activities or the resident's ability to sleep. A review of the ICCP included a focus area, dated 8/30/24, that the resident had a risk of pain related to deconditioning and gout. Interventions included: Administer meds as ordered. Monitor effectiveness and for any adverse side effects and Assess need for pain meds prior to activities of daily living (ADLs)/and or therapy. A review of the OSR included the following PO: -A PO, dated 9/16/24, for Oxycodone HCL oral tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for moderate (mod.) pain for 14 days. -A PO, dated 9/16/24, for Oxycodone HCL oral tablet 5 MG Give 2 tablets by mouth every 4 hours as needed for severe pain for 14 days. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 12:01 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated the oncoming nurse, and the outgoing nurse should both count the narcotics and sign the book to ensure that the narcotic count was right, and the medications had not been compromised. LPN/UM #1 further stated that there was a recent problem with an agency nurse who signed out narcotics, but it was questionable whether the residents had received them. LPN/UM #1 stated that the incident was reported and was investigated by the Director of Nursing (DON). On 2/11/25 at 1:36 PM, the surveyor requested and received a copy of a Long-Term Care Reportable Event Survey that was reported to the New Jersey Department of Health on 10/4/24, for an event that occurred on 9/28/24 at 7:00 PM, six (6) days after the event, and detailed that there was a loss or theft of narcotics on the Rehab 1 Nursing Unit. A review of a narrative report detailed that on 9/28/24, it was noted that three (3) residents had narcotics removed and signed off from their narcotic inventory record, and none of the doses were signed off on their medication administration record (MAR). Two of the residents denied being medicated for pain and stated they were not medicated for pain by the nurse on this day. It was also noted that on 9/23/24, three doses of medication were removed from the inventory, however, were not signed off as administered and the resident stated that he/she has not taken anything for pain since 9/22/24. It was suspected that the same nurse removed these doses from inventory and changed the date and forged someone else's signature. The nurse was placed on the do not return list and it was reported to her agency. Further review of the Long-Term Care Reportable Event Survey revealed the Office of the Ombudsman for the Institutionalized Elderly was notified of the event on 10/4/24 at 4:45 PM, six days after the event occurred. Further review of the investigation included a Report of Theft or Loss of Controlled Substances (Drug Enforcement Agency (DEA) Form 106) which detailed that there were fourteen Oxycodone HCL immediate release (IR) 5 MG tablets reported stolen and one Tramadol HCL 50 MG tablet was reported stolen. On 2/11/25 at 2:06 PM, the surveyor interviewed the DON who stated that LPN #5 and LPN #6 reported odd behavior from LPN #4 (an agency nurse) which included hyperactivity to the supervisor. The DON stated that LPN #4, was observed down the hall passing medication past the shift change and had the narcotic inventory book opened, as she looked in the computer for a long time. The DON stated that the narcotic inventory was accurate when LPN #6 and LPN #4 counted at 7 PM. The DON stated that LPN #5 noted that narcotic medications were signed out on the time that she worked that were not her signature and she stated the forged signature raised a suspicion. The DON stated that the first instance was obvious for Resident #199, because the resident denied receipt of the medication and a review of the MAR did not reflect receipt. The DON stated that the resident stated that their last dose was on 9/22/25. At that time, the DON reviewed Resident #199's Individual Narcotic Record (INR) for Oxycodone IR 5 MG tablets which indicated that on 9/23/24 at 7 AM, on 9/23/24 at 11:30 AM, and on 9/23/24 at 4:00 PM, two tablets were signed out by someone other than LPN #5 who was assigned to the resident on this date, and the signature did not belong to LPN #5, or anyone who worked on that date. The DON further stated that LPN #4 was assigned to Resident #199 on 9/28/24 and signed out two tablets of Oxycodone IR 5 MG to the resident at both 12:20 PM and at 6:12 PM, for a total of ten tablets. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the DON stated that Resident #197 was unable to tell us if he/she was medicated for pain or not, but two tablets of Oxycodone and one Tramadol tablet were signed out on the INR and were not signed out on the MAR and there was an established pattern. At that time, the DON reviewed Resident #198's INR with the surveyor which indicated that on 9/28/24 at 9:30 AM and 6:40 PM, LPN #4 signed out two tablets of Oxycodone IR 5 MG tablets which had not been signed out on the MAR. On 2/12/25 at 2:26 PM, in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, the DON stated that she did not know when she was required to notify the NJDOH and the Office of the Ombudsman for the Institutionalized Elderly of a suspected and alleged drug diversion. The DON stated that it was not reported right away because of a delayed response on behalf LPN #4. The DON stated that she was unable to immediately confirm diversion and wanted to interview LPN #4 because she was not sure if it were actual diversion, and did not want to create a false report. The LNHA stated that she was not sure of what the required reporting timeframe was for notifying both the NJDOH and the Office of the Ombudsman for the Institutionalized Elderly of an alleged or suspected drug diversion. The DON further stated that the day that she reported, was the day she decided that she was going to treat it as drug diversion when LPN #4 failed to comply with a face-to-face interview. The DON further stated that she had not provided a summary and conclusion to the NJDOH yet because they had not requested it. A review of the facility's undated Reportable Event Policy included: Mandatory reporting of incidents that can affect the health, safety, or well-being of residents is required. .Reporting Procedure: .External Reporting: The Director of Nursing or Healthcare Administrator will determine the appropriate bodies that need to be informed such as the NJDOH, Ombudsman, Policy, Physician, local health department, and family. A review of the facility's undated Drug Diversion and Prevention Policy included: .Reports of confirmed drug diversion will be submitted to the NJDOH, law enforcement, and licensing boards as required . NJAC 8:39-9.4(f)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51707 Based on observation, interviews and review of pertinent facility records, the facility failed to develop and implement an individualized comprehensive care plan for a resident that was requiring an anti-anxirty and anti-psychotic medication. This deficient practice was identified for 1 of 5 residents (Resident #29) reviewed for medication regimen. On 2/10/25 at 10:00 AM, during the initial tour, the surveyor observed Resident #29 awake, and alert, fully dressed, sitting in a wheelchar in their room. The survyeor reviewed the medical record for Resident #29. A review of the Admission Record, an admission summary, revealed that the resident had the diagnosis which included, Systemic Lupus Erythematous (an autoimmune disease where the body's immune system mistakenly attacks the body's healthy tissues), major depressive disorder (a depression characterized by persistent sadness, loss of interest, fatigue, feelings of worthlessness), protein calorie malnutrition (when the body does not get enough protein or calories.) and primary insomnia (difficulty sleeping not related to medical or psychological conditions. A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment, dated 12/24/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident's cognition was intact. Further reveiew in Section M of the MDS indicated that the resident was receiving antipsychotic and antianxiety, and antidepressant medication. A review of the active Order Summary Report (OSR) for February 2025, included the following physician orders: A PO, dated 10/13/24, for Xanax 0.5 milligrams (mg), give 1 tablet by mouth as needed for major depressive disorder related to major depressive disorder. A PO, dated 10/14/24, for Abilify 2 mg by mouth. A review of the February 2025 Medication Administration Record (MAR) revealed that Resident #29 was receiving Abilify 2 milligrams (mg) by mouth daily and Xanax 0.5 mg by mouth at bedtime. A review of individualized comprehensive care plan (ICCP) did not include a care plan including interventions for an antipsychotic or antianxiety medication. On 2/10/25 at 11:00 AM, the surveyor requested from the Director of Nursing (DON) a copy of Resident #29's ICCP. Futher review of the ICCP, included a focus area for the use of Abilify and Xanax initiated on 2/10/25 after surveyor inquiry. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25 at 10:40 AM, the surveyor conducted an interview with the Registered Nurse (RN #3) who stated that when a resident had any suicidal ideation or behavior issues the Unit Manager (UM) should initiate a care plan immediately. She then stated that she could initiate the care plan as well. On 2/11/25 at 10:56 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #8) who stated that a resident with suicidal ideation or behavior should be care planned. She then stated that she would have to look at the policy. On 2/12/25 at 1:23 PM, the surveyor interviewed the DON who stated that when she was making copies of the care plans for surveyor, she noted the anti-psychotic medications were not on the care plan. The DON then stated that she could not provide copies of the ICCP without updating the care plan. The DON stated that the care plan should have been initiated within a short period of time. and that the Unit Manager, MDS coordinator or anyone could have initiated the care plan. A review of facility's Behavioral Management policy dated May 2024, included, that all residents receive care and services to assist him or her to reach their highest level of mental and psychosocial functioning through interdisciplinary evaluation and assessments. Procedure Guidelines 7. the RAI [Resident Assessment Instrument] care plan process resident behavior management plan, interventions and effectiveness will be reviewed. NJAC 8:39-11.1

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Lions Gate	1100 Laurel Oak Road Voorhees, NJ 08043

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41072 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to obtain a re-weight according to the facility's policy for a resident with a history of significant weight loss. This deficient practice was identified for 1 of 1 resident (Resident #51) reviewed for nutrition and evidenced by the following: On 2/10/25 at 1:01 PM, the surveyor observed Resident #51 in the first-floor skilled nursing unit dining room being served breakfast. The resident received pancakes cut into bite sized portions. The resident complained that the pancakes were cold and did not eat the pancakes. On 2/11/25 at 8:20 AM, the surveyor observed Resident #51 in the first-floor skilled nursing unit dining room being served breakfast. The resident received pancakes cut into bite sized portions. The resident ate about 50% of their meal. The surveyor reviewed the medical record for Resident #51. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, vascular dementia, gastro-esophageal reflux disease (GERD) and dysphagia (difficulty swallowing). A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 1/28/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS revealed the resident had a weight loss of 5% or more in the last month, or 10% or more in the last six months, while not on a physician-prescribed weight loss regimen. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 5/29/24, that the resident had nutritional problem related to dementia, anxiety, depression, diabetes, dysphagia, and mechanical altered diet. Interventions included: 5/29/24, monitor weight as ordered. Notify Registered Dietician (RD)/ Medical Director (M)D as needed of weight gain/loss. A review of the Order Summary Report (OSR), dated as of 2/11/25, included the following physicians' orders: A PO, dated 12/9/24, for carbohydrate, controlled diet. Mechanical soft- ground meat texture, thin liquids consistency. A PO, dated 1/27/25, for a supplement two times a day for weight loss. A PO, dated, 1/24/25, for weekly weights times 4 weeks one time a day every Wednesday for 4 weeks. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Dietician Note (DN), dated 1/27/24, included the resident had a significant weight loss in one month with multiple weight fluctuations in the past few months. Intake remains good, consuming 50% of meals. Further review of the DN included recommendations to monitor intake, weight trends and increased the supplement to twice a day. A review of the Weights and Vitals Summary, as of 2/10/25 included the following weights: On 12/1/24, the resident weighed 127 lbs.(wheelchair) On 1/1/25, the resident weighed 135 lbs. (wheelchair)- with incorrect documentation added by RD On 1/8/25, the resident weighed 121.3 lbs. (wheelchair)- with incorrect documentation added by the RD On 1/29/25, the resident weighed 133 lbs.(wheelchair) On 2/1/25 the resident weighed 121. lbs.(wheelchair) On 2/6/25, the resident weighed 107.9 lbs. (sitting) On 2/10/25, the resident weighed 110.4 lbs. (standing) A PO, dated 2/10/25, included an order to reweigh one time. A review of the February 2025 Medication Administration Record (MAR) revealed that a weight of 121 lbs. was documented in the MAR on 2/20/25 at 3:28 PM. A review of the Progress Notes (PN), dated 1/18/25 through 2/10/25, did not include evidence that a re-weight was attempted after the documented weight loss of more than five pounds, or that the RD or physician was notified of the significant weight loss on 2/1/25 and 2/6/25. On 2/11/25 at 9:52 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #4) who stated the nurse scheduled the weights that the CNAs needed to obtain weekly. The CNA further stated that she reports the weights to the nurse but does not look at the resident's weight history for comparison. CNA #4 explained that if a resident needed to be re-weighed, the nurse would instruct the CNA to obtain the weight at that time. CNA #4 stated that the nurse would put the weights in the electronic medical record (EMR). On 2/11/25 at 9:56 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #3) who she was the nurse for Resident #51 that day. LPN #3 stated that the nurse would put the residents who needed weights on the daily schedule, the CNA would obtain the weight, and the nurse would enter the weight into the EMR. If there was a significant weight change from the last weight, the nurse should reweigh the resident and if the weight was verified, then the nurse should contact the RD and the doctor. LPN #3 reviewed the documented weights with the surveyor and confirmed that the resident should have been reweighed and the RD and doctor should have been notified on 2/1/25 and 2/6/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 10:46 AM, the surveyor interviewed the RD who stated that the CNAs would obtain the weights, and the nurse would document the weights in the EMR. The RD explained that if a resident had a weight change since the last weight, a re-weight should be obtained immediately to confirm if the weight was accurate. The RD further stated that for true significant weight losses, the nurse would notify the RD and the doctor. The RD stated she was unaware of the weight obtained on 2/1/25, 2/6/25 and 2/10/25. The RD stated that on 1/27/25 she had increased the residents supplement to 2 times a day and had placed the resident on weekly weights and to monitor the resident's intake. On 2/11/25 at 11:33 AM, LPN #3 stated that she and CNA#4 reweighed the resident in the wheelchair and the weight obtained was 117.8 lbs. The RD and the doctor was made aware of the weight change. A review of the Dietician Note (DN), dated 2/12/25, the RD questioned the accuracy of the above weights. The note reflected that the weight loss likely due to a decline in intake and limited acceptance of prior supplement. The resident continued with fair appetite, consuming 25-50% of meals. The RD will honor preferences to encourage intake, will continue to monitor intake, weight trends and labs as available. On 2/12/25 at 12:15 PM, the surveyor interviewed the Director of Nursing (DON) who stated that when there was a discrepancy in Resident #51's weight obtained on 2/1/25, 2/6/25 and 2/10/25, the nurse should have reweighed the resident to confirm the weight loss, then notified the RD and the doctor. A review of the facility's Weight Policy, undated, included that any weight change of 5% or more since the last weight assessment is retaken for confirmation. If the weight is verified, nursing will immediately notify the dietician. NJAC 8:39 - 27.2 (a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Complaint #NJ179408 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure a.) that the wound treatment cart was locked when not in use b.) accountability for the completion of the narcotic shift-to-shift count logs in accordance with the facility policy b.) an accurate account of the administration and documentation of controlled medications c.) properly dispose of medications at the time of resident refusal and d.) that expired medical supplies were not available for use in resident care in the medication storage room and in the emergency crash cart. This deficient practice was identified during the medication storage task for 1 of 2 medication carts on 1 of 4 nursing units (Rehab 1 Nursing Unit), 1 of 2 medication rooms (Rehab 2 Nursing Unit Medication Room), and the Rehab 1 Nursing Unit Emergency Treatment Cart and was evidenced by the following: 1. On [DATE] at 10:36 AM, the surveyor, in the presence of Licensed Practical Nurse (LPN) #5, observed that the wound treatment cart was not locked. When interviewed, LPN #5 stated that she had just completed a wound treatment and had forgotten to lock the cart. LPN #5 stated that it was important to lock the Wound Treatment Cart when finished to ensure that no one accessed it. 2. On [DATE] at 10:37 AM, in the top drawer of the medication cart, the surveyor observed a Lidocaine Patch (a topical pain relief patch) that was previously opened and was dated ,d+[DATE]. When interviewed, LPN #5 stated that the Lidocaine Patch was endorsed by the ,d+[DATE] nurse because the resident did not want it at the time it was last scheduled. LPN #5 was unable to state which resident the Lidocaine Patch was ordered for. 3. On [DATE] at 10:45 AM, the surveyor, in the presence of Licensed Practical Nurse (LPN) #5, reviewed the shift-to-shift Controlled Drugs-Count Record and the surveyor observed that on [DATE] at 7:00 PM, the Nurse on Signature (oncoming nurse) was blank and the Nurse Off Signature (outgoing nurse) was signed by LPN #5. There was no further documentation on the form to indicate that the shift-to-shift narcotic count was performed on [DATE]. LPN #5 stated that when she came in the outgoing nurse reviewed the Controlled Drug-Count Record and the oncoming nurse reviewed the narcotic count. LPN #5 stated that on [DATE], she was the oncoming nurse and LPN #6 was the outgoing nurse who had forgotten to sign. LPN #5 stated that today both she and LPN #6 had completed the shift-to-shift narcotic count, but they had both forgotten to sign. LPN #5 further stated that there were no reported discrepancies identified in the narcotic count. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the Controlled Drugs-Count Record revealed that on [DATE], at 7:00 AM, the Nurse on Signature was blank, and a signature was noted in the space allotted for the Nurse Off Signature. On [DATE] at 7:00 AM, the Nurse on Signature was blank, and a signature was noted in the space allotted for the Nurse Off Signature. On [DATE] at 7:00 PM, a signature was noted in the space allotted for the Nurse on Signature and the Nurse Off was blank. LPN #5 stated that it looks like they forgot to sign. LPN #5 stated that both nurses should sign the Controlled Drugs-Count Record when they are finished counting. 4. At that time, in the presence of LPN #5, the surveyor reviewed the controlled substance logs for the Rehab 1 Nursing Unit medication cart and noted the following: Resident #201's prescription card (BINGO card, medication packaged in a blister package with cardboard backing) containing Tramadol HCL 50 MG (Half Tab=25 MG) tablets (opioid pain reliever) contained 20 tablets, but the declining inventory log indicated that there were 21 tablets remaining. LPN #5 stated that she must have gotten distracted and had forgotten to sign it out. LPN #5 stated that it was important to sign the medication out on the declining inventory sheet at the time of administration to ensure that the narcotic count was correct. LPN #5 stated that she did sign the medication out as administered on the resident's Medication Administration Record (MAR). Resident #201's prescription card containing Pregabalin 75 MG Capsule (used to treat nerve pain) contained 23 capsules, but the declining inventory log indicated that there were 24 capsules remaining. LPN #5 stated that she must have gotten distracted and had also forgotten to sign the dosages out. On [DATE] at 12:01 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that the oncoming nurse should count the narcotics, and the outgoing nurse should review the Controlled Drugs-Count Record Book to make sure that the narcotic count is right, and the medications are not compromised. LPN/UM #1 stated that the nurses were required to sign the book when they come in and when they go out. LPN/UM #1 stated that the Consultant Pharmacist came into the facility monthly and audited the narcotic book. LPN/UM #1 stated that the narcotic count has always been correct. LPN/UM # 1 stated that she would think that the nurses had not counted if they had not signed the Controlled Drugs-Count Record and narcotics could be missing. At that time, LPN/UM #1 further stated that narcotics should be signed for when they were removed from the medication cart. LPN/UM #1 stated that it was good practice because the narcotic count may be off if the nurse did not sign the book and only signed the Medication Administration Record (MAR). At that time, LPN/UM #1 further stated that the wound treatment cart should be locked at all times so that patients or families can not take anything out of it. On [DATE] at 1:52 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurses should count their controlled drug in the medication cart at the end of the shift for accuracy of narcotics. The DON further stated that the Unit Manager was responsible to review the narcotic book weekly for signatures being captured and to ensure accuracy of the documentation. At that time, the DON further stated that narcotic medication should be signed out upon removing it from the medication cart in the book. The DON stated that it was not sufficient to just sign the medication out on the Medication Administration Record (MAR) because you are required to sign the medication out when it is removed. The DON stated that the mismanagement of narcotics or missing dosages were a concern if narcotics were not signed out from the cart at the time of removal. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:53 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that she was at the facility last week and reviewed three random medication carts for the narcotic count. The CP stated that she checked the signature logs at the back of the book and sometimes there was one missed signature here and there. The CP stated that she had not performed medication pass observations at the facility as it was not part of their contract, but will going forward, as it was just initiated after surveyor inquiry. On [DATE] at 11:30 AM, the DON provided the surveyor with a Medication Pass Observation dated form dated [DATE], which revealed that LPN #5 had not received a medication pass observation on that date because the former CP indicated that LPN #5 had finished passing medications early due to a low census, and instead received a medication pass in-service with LPN #5 and reviewed administration of all types of meds. The facility failed to provide the surveyor with documented evidence that LPN #5 had received a medication pass observation when requested. On [DATE] at 2:41 PM, the DON stated that she was not aware that the CP was not doing medication pass observations at the facility and that they needed to be requested. At that time, the DON further stated that she was responsible to ensure that LPN/UM #1 completed the narcotic record review and had not informed the LPN/UM #1 that it was her responsibility to do so. The DON further stated that she was not aware of the frequency that the CP performed narcotic record review. 45589 5.) On [DATE] at 10:03 AM, during a tour of the Rehab 2 Nursing Unit Medication Room, in the presence of LPN/UM #1, the surveyor observed the following expired supplies in the second drawer adjacent to the sink: culture swabs with an expiration date of [DATE]; and greater than 25, disposable sampling swabs with an expiration date of [DATE]. On [DATE] at 10:23 AM, during a tour of the Rehab 1 Nursing Unit in the presence of LPN/UM #1, the surveyor observed the following expired items in the emergency crash cart: three suction connection tubing with an expiration date of [DATE]; one ChloraPrep swab with an expiration date of ,d+[DATE]; one dial-a-flow tubing (a medical device used to control the flow of fluid via an intravenous line) dated [DATE]; one box of size medium disposable examination gloves with an expiration date of ,d+[DATE]; one box of size large nitrile disposable examination gloves with an expiration date of ,d+[DATE]. On [DATE] at 10:28 AM, the surveyor interviewed LPN/UM #1 who stated that supplies should be within date to ensure proper function. LPN/UM #1 also stated that the night shift 11:00 PM to 7:00 AM nurse was responsible to the check the crash carts and that a staff member from Central Supply checked the carts monthly for expired items. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:15 PM, during tour of the first floor common area, inside of an emergency crash cart the following expired items were observed: two boxes of disposable examination gloves with an expiration date of ,d+[DATE]. A review of the facility's undated Administering Medications policy included: Medications should be administered in a safe and timely, manner, and as prescribed. .The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions . .During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide . A review of the facility's undated Narcotic Count Policy included: Purpose: To establish guidelines for the accurate and secure shift-to-shift counting of narcotics. .The facility (name redacted) shall ensure the secure and accurate counting of narcotics at each shift change to prevent discrepancies and ensure resident safety . Narcotic Count at Shift Change: At the beginning and end of each shift, the oncoming and outgoing licensed nurses shall conduct a joint count of all controlled substances. Both nurses shall verify the count against the narcotic record. Documenting and Record-Keeping: .All narcotic administration shall be documented in the resident's medication administration record . A review of the facility's undated Receipt, Usage, Disposition, and Reconciliation of Controlled Medications Policy included: .Each administration must be recorded in the Medication Administration Record (MAR) and the narcotic record. .A shift-to-shift controlled medication count shall be conducted and documented by outgoing and incoming licensed nurses. Monthly audits shall be performed to ensure compliance and identify any discrepancies. Any discrepancies must be reported immediately to the Nurse Manager or Nursing Supervisor and DON or Facility Administrator . A review of the facility's undated Crash Cart Policy policy included, 5. Routine Inspections: To ensure readiness .Weekly Checks: Review expiration dates and replace as necessary. A review of the facility's undated Emergency Cart Inspection and Inventory policy included, Procedures 2. Routine Inspections .Any missing, damaged, or expired items shall be replaced immediately. NJAC 8:,d+[DATE].7 (c); 29.2(d)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure food served to residents was palatable. This deficient practice was identified for 5 out of 5 residents (Resident # 29, #31, #37, #74 and #75) who attended the Resident Council meeting conducted by the survey team on 2/10/25 and confirmed during the lunchtime meal service on 2/11/25 for 1 of 4 nursing units (Skilled 1) tested for food palatability. This deficient practice was evidenced by the following: On 2/7/25 at 10:00 AM, during the initial tour of the Skilled 1 nursing unit, Resident #29 stated that the food was the worst and the meat was tough. At 10:13 AM, Resident #37 stated that the food was cold, and the meat was tough and inedible. At 10:34 AM, Resident # 31 stated that the food was inedible, cold, and the meat was tough. On 2/10/25 at 10:37 AM, the surveyor conducted a resident council meeting with five alert and oriented residents (Resident # 29, #31, #37, #74 and #75). All five residents stated the food was not good and the meat was tough. All five residents further stated that they had previously complained about the food at the monthly resident council meetings, but nothing had improved. Resident #29 stated that the chicken is served in a hard lump and cannot cut the chicken. Resident #75 added that the food stinks. On 2/11/25 at 12:00 PM, the Director of Culinary (DC) provided the survey team with two meal trays from the Skilled 1 nursing unit satellite kitchen - a regular consistency tray and a pureed consistency tray. Three surveyors tasted the food and observed the following: Regular Sloppy [NAME] - no concerns with palatability Regular Cauliflower - tasted bland and mushy Regular Peas/Carrots - tasted bland and the peas were hard Pureed Sloppy [NAME] - tasted pasty and the flavor did not match the regular texture sloppy joe Pureed Peas/Carrots - tasted bland Mashed Potatoes - tasted bland and floury On 2/11/25 at 1:08 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON), of the above findings. The LNHA stated that everyone's taste is different, but would prefer the residents to enjoy their meals. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Food Presentation policy, undated, included, Policy: to ensure that food is served in a visually appealing, safe, and consistent manner; to have the food taste and look good. NJAC 8:39-17.4(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41260 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On [DATE] at 9:50 AM, the surveyor conducted an interview with the Director of Culinary (DC) prior to the initial tour of the kitchen. The DC stated that items stored in the refrigerators and freezers should be labeled and dated with the received date, the opened dated, and the use-by date. The DC further stated that dishware should be inverted and air dried after washing. On [DATE] at 10:18 AM, the surveyor, accompanied by the DC, observed the following in the kitchen: In the Meat Refrigerator: 1. A shallow two-inch hotel pan of tilapia which was sealed with plastic wrap. The pan was not labeled to identify the food item or dated with a use-by date. At that time, the DC discarded the tilapia. In the Dairy Refrigerator: 2. Asiago cheese which was re-sealed with plastic wrap with a use-by date of [DATE]. The DC discarded the cheese. 3. A pan of marinara which was sealed with plastic wrap with a use-by date of [DATE]. The DC discarded the marinara. 4. A one-gallon container of creamed herring which was previously opened. The container was not labeled or dated with an opened or use-by date. The DC discarded the container of creamed herring. 5. A 16-ounce jar of capers which was re-sealed with plastic wrap. The jar was not labeled or dated with an opened or use-by date. The DC discarded the jar of capers. In the Dairy dish drying area: 6. Seven sixth pans stacked on the drying rack which were wet nested. The surveyor lifted the top pan which revealed liquid between the pans. 7. Three third pans stacked on the drying rack which were wet nested. The surveyor lifted the top pan which revealed liquid between the pans. In the Meat dish drying area: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Two stacks of hotel pans on the drying rack which were wet nested. The surveyor lifted the top pans of each stack which revealed liquid between the pans. On [DATE] at 9:33 AM, the surveyor, accompanied by Dietary Service Aide (DSA) #1, observed the following in the freezer portion of the refrigerator located in the Rehab 1 dining room: 9. A three-gallon tub of vanilla ice cream. The lid of ice cream tub was lifted and not properly sealed. The container was not labeled with an opened or use-by date. 10. A three-gallon tub of strawberry ice cream. The lid of the ice cream tub was lifted and not properly sealed. The container was not labeled with an opened or use-by date. 11. Four small, disposable cups covered with lids. The DSA identified the cups as ice cream which was previously portioned out and prepared. The containers were not labeled with a use-by date. At that time, DSA #1 discarded the ice creams. On [DATE] at 9:44 AM, the surveyor, accompanied by DSA #2, observed the following in the refrigerator located in the Skilled 2 dining room: 12. A 46-ounce container of nectar thick water which was labeled with a use-by date of [DATE]. 13. A 46-ounce container of nectar thick lemon-flavored water which was labeled with a use-by date of [DATE]. At that time, DSA #2 discarded the containers and stated that the DSAs and dietary supervisors were responsible for maintaining the refrigerators in the dining rooms. On [DATE] at 9:52 AM, the surveyor, accompanied by DSA #3, observed the following in the refrigerator located in the Rehab 2 dining room: 14. Three 46-ounce containers of nectar thick lemon-flavored water which had an expiration date of [DATE]. 15. A 46-ounce container of nectar thick water which had an expiration date of [DATE]. At that time, DSA #3 discarded the containers and stated the DSAs and dietary supervisors were responsible for checking the refrigerators in the dining rooms. On [DATE] at 10:30 AM, the surveyor interviewed the DC who stated the DSAs were responsible for maintaining the refrigerators in the nursing unit dining rooms. The DC further stated that the DSAs should check the refrigerators to ensure opened items are labeled with the opened date and use-by date. The DC also stated that the DSAs should discard items that are expired or past the use-by date. (continued on next page)

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	315499	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lions Gate	1100 Laurel Oak Road Voorhees, NJ 08043

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1:08 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated she expected food items to be labeled and dated appropriately, food items to be discarded upon expiration, and pans to be dried according to regulation. The LNHA further stated the dietary staff were responsible for maintaining the dining room refrigerators and should label and date food items appropriately and discard expired food items. A review of the facility's Operational Standards Refrigerator policy, revised ,d+[DATE], included, Food is properly stored in appropriate containers labeled with product name, date prepared/opened, use-by date and employee initials. A review of the facility's Refrigerators and Freezers policy, undated, included, All food is appropriately dated to ensure proper rotation by expiration dates, and Expiration dates on unopened food are observed and 'use-by' dates are indicated once food is opened. Further review of the policy included, Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past 'use-by' or expiration dates. A review of the facility's Pots, Pans, Utensils Washing and Air Drying policy, revised ,d+[DATE], included, All sanitized items must be air dried and cooled completely before stacking and storing. NJAC 8:,d+[DATE].2(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51707 Based on observation, interview, and review of facility documents, it was determined that the facility failed to maintain proper infection control practices to ensure a.) staff performed appropriate hand hygiene during meal service for 1 of 4 dining rooms observed (First floor Skilled Nursing Unit), b.) an ice scooper was used to obtain ice from the ice machine during dining observation of 1 of 4 dining rooms observed (First floor skilled nursing unit), c.) ensure respiratory equipment was stored in an appropriate way to prevent the spread of infection for 1 of 4 residents reviewed for use of respiratory equipment (Resident # 18) and d.) enhanced barrier precautions (EBP) was initiated for 1 of 4 residents (Resident #31) reviewed for infection control. This deficient practice was evidenced by the following: 1.) On 2/10/25 at 12:31 PM, the surveyor observed the lunch meal service in the first-floor skilled nursing unit dining room. The surveyor observed the Dietary Service Aide (DSA#5) had removed dirty plates from an unsampled resident at Table #5, scraped the food form the plate into the trash, then proceeded to go into the refrigerator, removed a bottle of juice, poured the juice into a cup and served this juice to another unsampled resident without performing hand hygiene (HH). On 2/11/25 at 8:12 AM, the surveyor observed the following during the breakfast meal service in the first-floor skilled nursing unit dining room. 1. DSA #5 cleaned a blue plastic tray with a rag, then poured coffee for Resident # 74, added cream and sweetener and placed a lid on the coffee cup without performing HH. 2. DSA #5 removed dirty dishes from another table and placed in the cart with the dirty dishes without performing HH. 3.DSA #5 served eggs and toast and jelly to Resident #55 without performing HH. 4. DSA #5 served oatmeal to Resident #29 without performing HH. 5.DSA #5 went to the refrigerator, removed a carton of milk, poured the milk into Resident #54's oatmeal bowl, without performing HH. 6. DSA #5 served the oatmeal to Resident #54, without performing HH. 7. DSA #5 walked to the refrigerator, removed a carton of honey thickened milk, and walked into the satellite kitchen area, poured the thickened milk into the oatmeal, added in sugar and stirred the oatmeal then served Resident #34 the oatmeal with performing HH 8. DSA #5 served oatmeal to Resident #71 without performing HH. 9. DSA #5 poured juice for Resident #34, then served an omelet and toast to Resident #74 without performing HH. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. DSA #5 served pancakes to Resident #51 without performing HH. 11. Resident #74 requested his/her toast be buttered, DSA #5 then donned (put on) gloves to both hands, buttered the toast, then removed the gloves without performing HH. 12. DSA #5 served an omelet to an unsampled resident without performing HH. 13. DSA#5 served Resident #51 pancakes without performing HH. 14. DSA#5 served Resident #29 pancakes without performing HH On 2/11/25 at 8:55 AM, the surveyor interviewed DSA #5 who stated that hand hygiene should be completed between serving residents. DSA #5 further stated that she washed her hands with soap and water in the sink in the satellite kitchen. On 2/11/25 at 10:03 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that hand hygiene should be performed in the dining room in between serving the residents their meals. On 2/11/25 at 10:55 AM, the surveyor interviewed the Director of Nursing (DON) who stated that hand hygiene should be completed in between serving residents their meals. The DON further stated that it was important to use hand hygiene between serving residents to prevent infection or contamination. On 2/11/25 at 12:15 PM, the surveyor observed the following during the lunch meal in the first-floor skilled unit dining room: 1. DSA #5 served the lunch meal to an unsampled resident without performing HH. 2. At 12:18 PM, DSA #5 assisted Resident #31 put on his/her sweater then served soup to several unsampled residents without performing HH. 3. At 12:25 PM, DSA #5 scraped dirty dishes into the trash, placed the dirty dish into the dishpan then served Resident #37 their lunch meal without performing HH. 4. At 12:27 PM, DSA #5 scraped dirty dishes into the trash, placed the dirty dishes into a dishpan then served Resident #29 their meal without performing HH. A review of facility's Handwashing/Hand Hygiene policy, reviewed December 2024 included, Indications for hand hygiene included: a. immediately before touching a resident, .c. after touching a resident, after touching a resident's environment, and .g, immediately after glove removal. A review of facility's Culinary Services Hand Washing Procedure revised May 024, included each employee will wash their hands frequently to eliminate visible dirt and to reduce bacterial load and cross contamination Before: .b. beginning a new task .and After O. removing or changing gloves, P. scraping trays, Q. physical contact with a residents, . and U. touching equipment such as, refrigerator doors or utensils that have not been cleaned or sanitized. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) On 02/10/25 at 12:20 PM, the surveyor observed the following during the lunch meal service in the first-floor skilled nursing unit dining room. The surveyor observed DSA #4 used a plastic drinking cup and with her bare hand, reached into the ice machine and scooped the ice into the plastic cup. At 12:29 PM, the surveyor observed DSA #4 again used a plastic drinking cup with her bare hand, reached into the ice machine and scooped the ice into the plastic cup. On 2/11/25 at 9:24 AM, the surveyor interviewed DSA #4 who stated that an ice scooper should be used to dispense ice form the ice machine. DSA #4 further stated that a plastic cup should never be used in the ice machine to obtain the ice. On 2/11/25 at 12:22PM, the surveyor observed DSA #5 during the breakfast meal service in the first-floor skilled nursing unit dining room. The surveyor observed DSA #5 used a resident plastic drinking cup with her bare hand, reached into the ice machine and scooped the ice into the plastic cup. On 2/11/25 at 10:55 AM, the surveyor interviewed the DON who stated that an ice scooper should be used when getting ice from the ice machine. The DON further stated that it was important to use an ice scooper to remove ice from the ice machine to prevent the spread of infection or contamination. On 1/13/25, the facility provide the surveyor an in-service titled Ice Scoop Training which included that ice scoops are to be used in all ice machines for safety .2. Ice scoops are the only tool to use when getting ice from the ice machine, 3. DO NOT use- glasses, cups, spoons, plastic cups or anything that is NOT an ice scoop. A review of the facility's Infection Prevention and Control policy revised December 2024, included S. Infection prevention and control program (IPCP) refers to a program (including surveillance, investigation, prevention, control and reporting) that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of infection. 45589 3.) On 2/7/25 at 10:37 AM, during the initial tour of the first-floor skilled nursing unit, the surveyor observed Resident #18 awake and alert sitting in his/her wheelchair in their room. The surveyor observed a nebulizer mask (a device that fits over the nose and mouth to deliver medication to the lungs) lying directly on the bedside table, not stored in a plastic bag. On 2/11/2025 at 10:09 AM, the surveyor observed Resident #18 sitting in his/her wheelchair in his/her room with their eyes closed. The surveyor observed a nebulizer mask lying directly on the bedside table, not stored in a plastic bag On 2/11/2025 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #3) who stated Resident #18 used the nebulizer as needed and would ask for it if needed. LPN #3 also stated that after using the nebulizer mask, the mask should be cleaned and then stored in a plastic bag. LPN #3 confirmed that the nebulizer mask in Resident #18's room was not stored in a plastic bag. LPN #3 further stated that it was important to store the nebulizer mask, when not in use, in a plastic bag for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11//2025 at 1:40 PM, the surveyor reviewed the medical record for Resident #18. A review of the admission record, an admission summary, revealed the resident had diagnosis which included, congestive heart failure, dementia, and anxiety. A review of the quarterly Minimum data Set (MDS), an assessment tool, dated 1/21/25, included the resident had a Brief Interview for mental status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. A review of the the physician's orders (PO) for Resident #18, which included the following: A PO, dated 1/30/2025, for Albuterol Sulfate Inhalation Nebulization Solution 1.25 Milligram (MG)/3 milliliters (Albuterol Sulfate)-1 vial inhale orally via nebulizer every 6 hours as needed for wheezing. A review of the individual comprehensive care plan (ICCP) included a focus area, dated 11/9/2023, that the resident had Congestive Heart Failure. Interventions included: to give medications (meds) as ordered. On 2/12/2025 at 12:15 PM, the surveyor interviewed the DON who stated that after use, the nebulizer should be cleaned, dry at room air, then stored and maintained in a plastic bag. The DON also stated that this was important to store the nebulizer mask in a plastic bag when not in use to prevent contamination from the environment. A review of the facility's undated Nebulizer Therapy Policy included, Procedures .3. Equipment Maintenance and Safety .Nebulizer mask and tubing shall be stored in a plastic bag when not in use and replaced weekly. 41072 4.) On 02/07/25 at 10:34 AM, the surveyor observed Resident #31 awake and alert, sitting in a wheelchair in their room. The surveyor observed an Intravenous (IV) pole located in the resident's room. Resident #31 stated that he/she had an IV inserted in his/her right upper arm about four (4) days ago for a Urinary Tract Infection (UTI). No Enhanced Barrier Precautions (EBP) signage was observed posted inside or outside the resident's room. On 2/10/25 at 12:22 PM, the surveyor observed Resident #31 not in his/her room. At that time, the surveyor observed an empty bag of IV antibiotic medication hanging from the IV pole in the resident's room. No EBP signage was observed posted inside or outside the resident's room. The surveyor reviewed the medical record for Resident #31. A review of the Admission Record, an admission summary, revealed the resident had diagnosis which included, Multiple Sclerosis (a chronic, autoimmune disease that affects the central nervous system) and urinary tract infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's quarterly MDS, dated [DATE], included the resident had a BIMS score of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed the resident was always incontinent of urine. A review of the ICCP included a focus area, dated 1/31/2025, that the resident had an infection of the urinary tract infection. Interventions included: administer antibiotic as per medical doctor (MD) orders. The care plan did not include EBP. A review of the Order Summary Report (OSR), dated as of 2/11/25, included the following physician's orders (PO): A PO, dated 2/4/25, for midline placement. A PO, dated 2/4/25, to check midline site every shift for signs and symptoms of infection every shift A PO, dated 2/3/25, to start on 2/4/25 for Aztreonam Injection Solution Reconstituted 1 Gram (an antibiotic). Use 1 gram intravenously two times a day related to UTI for 7 days, with end date of 2/11/25. A PO, dated 2/11/25, to remove Midline. A review of the Midline Insertion Documentation form from an outside company, dated 2/4/25, indicated the midline was placed to the right upper arm. On 2/11/2025 at 10:03 AM, surveyor interviewed the Infection Preventionist (IP) who stated that a resident who had a Midline catheter for IV antibiotics should be on EBP. The IP stated that Resident # 31 was not on EBP because she thought the resident had a peripheral IV site not a midline IV catheter. On 2/12/2025 at 12:15 PM, the surveyor interviewed the DON who stated that a resident who had a midline IV catheter should be on EBP. Reference: Center for Disease Control and Prevention, Long-Term Care Facilities, document titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes dated June 28, 2024, states, .22. What is the definition of indwelling medical device? An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)) . Although the data are limited, CDC does not currently consider peripheral I.V.s (except for midline catheters) . as indications for Enhanced Barrier Precautions . A review of the facility's Enhanced Barrier Precautions (EBP) policy, reviewed December 2024, included, EBP are required for patients with any of the following: 2. Indwelling medical devices: Midlines, PICC lines, Central lines. NJAC 8:39-19.4(n)